AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, APRIL 30, 2012
1:30 P.M. - STATE CAPITOL ROOM 437

VOTE-ONLY CALENDAR

ITEMS TO BE HEARD

VOTE-ONLY

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

VOTE-ONLY ISSUE 1: RETENTION AND EVALUATION ACTIVITIES INITIATIVE

Through a Spring Finance Letter, the Office of Statewide Health Planning & Development (OSHPD) is requesting an increase in federal fund expenditure authority of $162,000 in 2012-13 for the Retention and Evaluation Activities (REA) Initiative. Current year (2011-12) funding for this project was approved through the Section 28 Budget Revision process. The REA Initiative requires grant funds to be expended by September 30, 2013.

In 2011, utilizing American Recovery and Reinvestment Act (ARRA) funding, the federal Health Resources Services Administration (HRSA) awarded the OSHPD a grant of $625,000 for 2 years for the REA Initiative, the first federally-funded program for states to perform activities to retain clinicians in underserved communities and to analyze the impact of such activities. The OSHPD will develop and administer activities that support the retention of ARRA-funded clinicians and scholars within health professional shortage areas (HPSAs); provide technical assistance to clinical sites related to retention; measure the effectiveness of interventions; and, evaluate the impact of ARRA funding on communities. The OSHPD states that through the activities performed under the REA Initiative, a foundation will be developed for a statewide and national understanding of clinician retention issues facing underserved communities.

To address the new workload associated with this project, workload from a recent vacancy will be distributed temporarily among several staff throughout the Healthcare Workforce Development Division so that another position can be filled temporarily to support this project through the end of 2012-13. The OSHPD also retained a sub-contractor to assist with the logistical needs of the project.

VOTE-ONLY ISSUE 2: SONG BROWN FUNDING

The Governor's Budget proposes a $5 million General Fund reduction, to reflect permanent funding from the California Health Data and Planning Fund (CHDPF), for the Song-Brown Primary Care Practitioner Training program.

Furthermore, due to the CHDPF's significant balance, the Administration is also proposing a reduction in the assessment rate on hospitals and long-term care facilities that support the CHDPF. The annual assessment rate to hospitals and long-term care facilities would be reduced from 0.034 percent to 0.027 percent for hospitals and 0.025 percent for long-term care facilities. The OSHPD states that this will allow a $12 million loan to the General Fund to be repaid in 2014-15.

The Song-Brown Program plays a critical role in improving access to health care for California's low-income and uninsured population. There are approximately nine million Californians living in medically underserved areas, with few or no primary healthcare providers. The Song-Brown Program is responsible for increasing the number of family practice physicians, primary care

physician's assistants (PA), family nurse practitioners (FNP), and registered nurses (RN) to address access to health care and the critical health workforce shortages.

The Song-Brown Program partners with accredited Family Practice Residency Training Programs and PA, FNP, and RN programs as well as hospitals and other health care delivery systems to increase the number of students and residents training in primary care. By providing financial support via a competitive grant program to these training and education programs, the Song-Brown Program increases the supply of primary care providers practicing in California's underserved areas.

Prior to 2008-09, the Song-Brown Program was funded 30 percent from the CHDPF and 70 percent from the General Fund. Since 2008-09, the Song-Brown Program has been funded 100 percent from the CHDPF through annual legislative or administrative proposals and the fund is able to permanently support the costs of this program.

Funding the Song-Brown Program at 100 percent from the CHDPF saves $5 million General Fund each fiscal year and sustains funding for valuable health workforce education and training programs that provide a critical source of health care services to California's rural and low-income communities.

VOTE-ONLY ISSUE 3: MENTAL HEALTH LOAN ASSUMPTION PROGRAM AWARDS

Through a Spring Finance Letter, the OSHPD is requesting an increase of $5,122,000 in 2012-13 and $5,144,000 ongoing (Mental Health Services Act funding) and 2.0 new permanent positions in order to double the annual number of awards, from 600 to 1,200, and to manage the increased workload that will result.

The Mental Health Services Act (MHSA) was approved by voters in 2004 and imposes a 1% tax on personal income in excess of $1 million to support the Public Mental Health System. One of the key components of the MHSA is the Workforce, Education and Training (WET) Program that assists counties on developing and maintaining a culturally competent workforce. As part of the WET program, the Department of Mental Health entered into a memorandum of understanding with the Health Professions Education Foundation (Foundation) to develop, and implement the Mental Health Loan Assumption Program (MHLAP) to provide loan repayments of up to $10,000 to mental health practitioners in exchange for a 12-month service obligation in California's public mental health system. The Foundation is the state's only statutorily-created non-profit, public benefit corporation. It was created in 1987 to provide financial assistance to health providers throughout California who agree to practice in medically underserved areas and it is housed within the OSHPD.

The MHLAP awards grants to mental health practitioners working in the public mental health system in hard to fill or retain positions. Eligible professions include licensed psychologists, registered psychologists, postdoctoral psychological assistants, licensed clinical professional counselors, licensed marriage and family therapists, and others.

According to the U.S. Department of Health and Human Services, more than 3.9 million Californians currently live in a federally-designated Mental Health professional Shortage Area. Approximately 4.9 million Californians have stated that they need help for a mental or emotional health problem and more than 1 million report symptoms associated with serious psychological distress. Mental health disorders ranked third in total economic expense, costing the U.S. an estimated $216.7 billion annually and accounting for nearly 70 percent of all health care visits. Overall, the U.S. experiences 30.3 million reported cases, $45.8 billion in treatment costs, and $170.9 billion in lost productivity.

Funding for awards has increased from $2.5 million in 2008-09 to $5 million in 2010-11 and would increase to $10 million in 2012-13 with approval of this proposal. Awards are reviewed and scored by MHLAP's Advisory Committee, which is comprised of representatives of the County Mental Health Directors Association, licensing board, academia, and community organizations.

The following chart illustrates the significant, and still unmet, demand for the program:

Mental Health Load Assumption Program Summary of Statistics					
Workload Measure	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Applications Received	1,065	1,269	1,011	1,659	5,004
Applications Awarded	283	309	474	550-600*	1,666*
Amount Requested	$58.3m	$76.7m	$66.4m	$105.6m	$307.1m
Amount Awarded	$2.2m	$2.3m	$4.4m	$5.0m	$13.9m

The Department of Mental Health (DMH) coordinated an advisory committee with stakeholders on April 7, 2008 to gather recommendations on MHSA funding. The meeting, titled the MHSA Government Partners Meeting, included representatives from key stakeholder organizations including the Mental Health Services Oversight and Accountability Commission, California Mental Health Director's Association, and California Mental Health Planning Council. As a result of that meeting, the Government Partners presented recommendations to the DMH on MHSA WET funding, which were reviewed and approved by DMH. As a result, the DMH approving the following funding for MHLAP:

- $2.5 million per year for 2 years;
- $5 million for another 2 years; and,
- $10 million for Fiscal Year (FY) 2012-13 and onward.

The FY 2012-13 administrative costs are $122,000 with ongoing FY 2013-14 costs at $144,000. The annual increase for loan repayments is $5,000,000 per year.

4150 DEPARTMENT OF MANAGED HEALTH CARE

VOTE-ONLY ISSUE 1: PREMIUM RATE REVIEW CYCLE II FEDERAL GRANT

For the second cycle of the federal Premium Rate Review Grant, the Governor's Budget requests spending authority of $755,000 for FY 2012-13, $691,000 for FY 2013-14, and $72,000 for FY 2014-15, and 2.0 two-year limited term positions. The Administration requested spending authority of $645,000 for the current year through a Section 28 letter to the Legislature in the fall of 2011.

The Affordable Care Act of 2010 (ACA) makes several fundamental changes to the private health insurance market including a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The ACA directs states to establish a formal process for the annual review of health insurance premiums to protect consumers from unreasonable rate increases. To support this, the federal government established grant opportunities that states may apply for to help develop or improve and enhance their current health insurance rate review process.

On September 30, 2010, California passed SB 1163 (Leno), Chapter 661, Statutes of 2010, as conforming legislation to begin aligning California's laws with the ACA. With the passage of the ACA and SB 1163, Knox-Keene licensed full-service health plans are now required to file premium rate data for their individual, small employer, and large employer products with DMHC, and DMHC is required to review these premium rate filings for unreasonable premium rate increases and issue guidance regarding compliance.

In August 2010, DMHC applied for and received a federal grant (Cycle I) in the amount of $1 million to be shared with the California Department of Insurance (CDI); the DMHC received $608,000 of this grant. These funds were used to: 1) implement the National Association of Insurance Commissioner System for Electronic Rate and Form Filing; 2) enhance DMHC's information technology capacity to support rate review activities; 3) enhance DMHC's website; 4) provide transparency in rate filing information and allow public comments on rate filings; and, 5) obtain actuarial services. The Cycle I grant ended December 31, 2011. In September 2011, DMHC was awarded this Cycle II grant of $2.1 million for October 1, 2011 through September 30, 2014.

This request is for authority to implement Cycle II of this grant, which the DMHC applied for in August of 2011. This grant is intended to enhance the DMHC's capacity to collect premium rate data, improve rate filing requirements, enhance the rate review process, report-required data to the U.S. Department of Health and Human Services and the California Health Benefit Exchange, and disclose rate information to consumers. As with the Cycle I grant award, the Cycle II grant funds will be split between the DMHC and CDI.

VOTE-ONLY ISSUE 2: TRANSFER OF DMHC TO HEALTH & HUMAN SERVICES AGENCY

Through a Spring Finance Letter, and in compliance with AB 922 (Monning), Chapter 552, statutes of 2011, effective July 1, 2012:

1. The DMHC will transfer its budget authority of $53.097 million and 366.0 authorized positions from the Business, Transportation and Housing (BT&H) Agency to the Health and Human Services (HHS) Agency;

2. The Office of Patient Advocate (OPA) will separate from the DMHC and become an independent entity within the HHS, transferring its budget authority of $2.184 million and 12.0 positions from the DMHC to the OPA;

3. The DMHC will transfer 1.0 position to the Department of Health Care Services (DHCS) and $242,000 to the OPA to reimburse DHCS for its IT services;

4. The DMHC will transfer 1.0 position to the Department of Social Services (DSS) and $80,000 to the OPA to reimburse DSS for its administrative services support.

This proposal also includes a request for $242,000 in reimbursement authority for the DHCS.

Per AB 922, the DMHC is requesting authority for the transfer of resources from BT&H to the HHS, and the transfer of resources associated with the removal of the Office of Patient Advocate (OPA) from DMHC and establishment of it as an independent entity under the HHS Agency effective July 1, 2012. AB 922 mandates this transfer to be effective January 1, 2012, however the Administration is completing the transfer on July 1, 2012 (the start of a new fiscal year) for ease and efficiency of budgeting purposes.

The OPA was created in AB 78 (Gallegos), Chapter 525, Statutes of 1999; in order to help health plan enrollees secure the health care services to which they are entitiled. The OPA develops and distributes educational materials describing enrollee rights and responsibilities, and compiles and publishes an annual public quality of care report card on health plans. Currently, the OPA's activities are supported by funding from the Managed Care Fund (MCF), the revenue source for all DMHC functions and activities. In order to respond to the myriad of changes to health care that are, or soon will be, occurring, and the challenges those present to consumers, AB 922 both transfers the OPA out of the DMHC and expands its duties and responsibilities to include:

- Providing outreach and education about health care coverage, including how to apply, costs, renewal processes, transitions between programs and information and assistance with different coverage programs;

- Coordinating with other state and federal agencies on implementation of the ACA;

- Referring consumers to the appropriate regulatory agencies for filing complaints, grievances, claims or payment problems; and,

- Tracking and analyzing data on consumer issues, including demographic data, source of coverage, regulator, complaint resolution, and timeliness of resolution; the OPA will provide this data to the federal government in accordance with the ACA.

To support the OPA's current and expanding responsibilities, AB 922 establishes the Office of Patient Advocate Trust Fund (OPATF), for which funding will be provided from the MCF and the California Department of Insurance (CDI) Insurance Fund. Funding contributions are to be based on the number of covered lives enrolled either in health plans regulated by the DMHC or health insurance policies regulated by the CDI. The DMHC states that assessment rates on managed care plans are based on anticipated DMHC costs; therefore, going forward, the assessment rates will be based on costs that incorporate the costs of the OPA. This applies to both full-service plans and specialty plans. With regard to the CDI, some non-health insurers have expressed concerns about wanting to ensure that they are not required to cover any of the costs of the OPA. In the Assembly, the CDI's budget is handled through Budget Subcommittee #4, and therefore these concerns will be addressed by that Subcommittee.

4260 DEPARTMENT OF HEALTH CARE SERVICES

VOTE-ONLY ISSUE 1: MONEY FOLLOWS THE PERSON PROGRAM

The DHCS is requesting: 1) federal expenditure authority of $892,000; 2) authority to extend three existing limited-term positions (set to expire June 30, 2012) until March 31, 2016; and, 3) authority to establish five new limited-term positions to maintain the current Money Follows the Person (MFP) program, meet program benchmarks, expand MFP into additional counties, and implement Minimum Data Set (MDS) 3.0 Section Q (a new federal code requirement that addresses discharge planning for nursing home residents).

The term of the five new positions would be from July 1, 2012 to March 31, 2016, to coincide with the federal grant, and they would be responsible for:

- Training nursing facilities and Local Contact Agencies (LCAs) on MDS 3.0 Section Q requirements;
- Automating several accounting and data collection activities (staff currently processes every piece of data manually);
- Ensuring that CMS mandated Quality of Life surveys are completed correctly and timely; and,
- Adjudicating treatment authorization requests from home and community-based providers for California Community Transitions participants.

California received a MFP grant in January 2007 and developed the California Community Transitions (CCT) project. This grant funds efforts that target Medicaid enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal is to offer a menu of social and medically necessary services to assist them to remain in their home or community environments. In 2010, MFP transitioned 205 individuals from a health facility into the community.

On October 1, 2010, the federal CMS required certified nursing facilities to begin using a new iteration of the MDS (3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated LCAs. By providing participants long-term services and supports in their own homes for one full-year, after discharge from a health care facility, the state receives an 87 percent federal fund match.

VOTE-ONLY ISSUE 2: BREAST & CERVICAL CANCER TREATMENT PROGRAM

The DHCS is requesting an increase of $537,000 ($269,000 General Fund) to continue six limited-term positions until December 31, 2013 to conduct eligibility processing for the Breast and Cervical Cancer Treatment Program (BCCTP).

Unlike other Medi-Cal programs, for which county eligibility workers make determinations, the DHCS staff performs all the eligibility activities for the BCCTP. This processing includes compliance with federal requirements such as citizenship verification, redetermination functions, and new applications.

The DHCS states that continuation of these positions are necessary for completing redetermination reviews, obtaining retroactive coverage, and to ensure that people are able to access treatment services in a timely manner. The DHCS expects current workload to continue and possibly increase due to increasing caseload trends.

The positions and key activities include:

- Associate Governmental Program Analysts (AGPA). A total of four AGPA positions are requested for extension. These positions: 1) perform initial eligibility determination for new applicants; 2) perform determinations for annual review; 3) perform determinations for retroactive coverage; and, 4) provide other assistance related to this work.

- Staff Service Manager I. This position is responsible for: 1) supervising; 2) reviewing cases for accuracy in eligibility; 3) interpretation of changes to Medi-Cal as they pertain to this program; and, 4) updating policies and procedures.

- Office Technician. This position is responsible for: 1) organizing all new applications; 2) assigning cases; 3) sets up forms and redetermination packets; 4) files closed cases; and, 5) various support activities related to this work.

Established in 2002, this federal program provides cancer treatment services through Medi-Cal as appropriate, contingent upon eligibility. AB 430 (Statutes of 2001) established a corresponding state-funded program for women and men who do not meet the eligibility criteria for the federal program.

Approximately 4,200 BCCTP applications are received annually. BCCTP staff must complete annual redeterminations each year on 12,136 of the 12,710 active, ongoing BCCTP cases. The remaining cases are state BCCTP cases that do not receive federal funding and are therefore not subject to the federal annual redetermination requirement. As of June 30, 2011, there were 6,864 federal cases overdue for an annual redetermination.

VOTE-ONLY ISSUE 3: GROUND EMERGENCY MEDICAL TRANSPORTATION RESOURCES REQUEST

To implement the provisions of AB 678 (Pan), Chapter 397, Statutes of 2011, the DHCS is requesting one and a half (1.5) positions and reimbursement authority for internal accounting and legal services efforts to initiate the Medi-Cal Ground Emergency Medical Transportation (GEMT) Services Program. The annual cost for this proposal is $238,000 ($119,000 reimbursements and $119,000 federal funds).

In their first response capacity, local fire departments participate in transporting Medi-Cal patients at an increasing rate. For example, ambulance transports of Medi-Cal enrollees increased 19 percent from 2006 to 2009. In response to this trend, AB 678 allows GEMT service providers owned or operated by public entities to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment that these providers would otherwise receive, up to 100 percent of their actual allowable costs. The non-federal share of the supplemental reimbursement will be funding from specified governmental entities through certified public expenditures (CPE). The intent of this legislation is to relieve the financial burden of these eligible public entities by providing supplemental reimbursement at no cost to the state. AB 678 also authorizes the reimbursement of DHCS administrative and staffing costs, so that the General Fund is not affected.

VOTE-ONLY ISSUE 4: JUVENILE INMATE INPATIENT COSTS

To implement AB 396 (Mitchell), Chapter 364, Statutes of 2011, the DHCS is requesting one permanent position to assist in the development of a process to allow counties and the California Department of Corrections and Rehabilitation (CDCR) to receive available federal funds for inpatient hospital services and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates off the grounds of a correctional facility. The cost of this position is $99,000 ($49,500 reimbursement from counties and $49,500 federal funds).

Current law provides Medi-Cal eligibility to adults incarcerated in a state correctional facility if the individual receives inpatient hospital services off the grounds of a correctional facility. AB 396 allows counties and CDCR to receive any available federal financial participation for acute inpatient hospital services and inpatient psychiatric services provided to juvenile inmates, who are admitted as patients to a medical institution off the grounds of the correctional facility, and who, but for their institutional status as inmates, are otherwise eligible for Medi-Cal benefits. The DHCS is responsible for developing a process that would allow the CDCR and counties that elect to provide the nonfederal share of expenditures, to be able to claim for federal funds.

VOTE-ONLY ISSUE 5: LEA BILLING OPTION RESOURCES REQUEST

The DHCS is requesting authority to convert 14 limited-term positions into permanent positions to perform financial oversight requirements of the "Local Educational Agency" (LEA) billing option provided under the Medi-Cal Program. The positions are funded $820,000 from federal funds and $820,000 from LEAs; it does not require any General Fund.

There are approximately 471 LEA providers participating in the LEA billing option program. The LEA billing option provides the federal share of reimbursements for health assessments and treatment for Medi-Cal eligible children and family members within the school environment. The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

As California's lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being expended appropriately. These limited-term staff are in the process of completing the reconciliation and audits of the 2006-07 (392 reports), 2007-08 (403 reports), and 2008-09 (422 reports) cost reimbursement reports. The DHCS estimates that these activities alone would take at least three years. Additionally, it anticipates 450 reports would need to be reviewed for 2009-10.

In the past, the federal CMS has deferred payments to LEAs pending the DHCS's completion of cost reimbursement report audits. The DHCS notes that if it does not complete these audits, it is likely that CMS will resume deferring LEA claims and disallow $134 million in deferral claims in response to the department's failure to comply with oversight requirements.

VOTE-ONLY ISSUE 6: TARGETED CASE MANAGEMENT

The DHCS is requesting authority to covert 8 limited-term positions into permanent positions to support the federal oversight and corrective action for the Targeted Case Management (TCM) Program. These positions are to be funded with $445,000 in reimbursement from Counties and $445,000 in federal funds.

Targeted Case Management provides comprehensive case management services to Medi-Cal eligibles in six target populations—public health, adult probation, outpatient clinics, public guardian, community, and linkages. Local government agencies (LGAs) (mainly counties) use a "certified public expenditure" (CPE) approach to obtain federal reimbursement. Without this federal reimbursement, many of these services would cease.

In 2005-06, the federal CMS determined that the DHCS was out of compliance with federal regulations that prohibit payments to exceed actual expenditures incurred by LGAs. In addition, CMS could not determine whether the CPE expenditures incurred were eligible and properly certified by the LGA. Consequently, CMS placed TCM LGA claims on deferral in 2003-04 and has continued to defer claims through the 2006-07 budget year for a total of $39 million. CMS notified DHCS that it would disallow $18.9 million of the $39 million of deferred claims and the federal funds must be returned. The DHCS has the responsibility to recover these funds from LGAs.

During this timeframe, CMS sent notifications requesting the DHCS to respond to corrective actions to resolve the claims. These corrective actions included performing desk reviews and audits of cost reports and claims to examine the encounter rates, service costs, and CPEs. The DHCS states that these functions need to continue and be expanded for all of the fiscal years in question and going forward.

VOTE-ONLY ISSUE 7: ACCESS MONITORING PROGRAM

The DHCS is requesting two permanent positions to comply with new federal requirements to establish a system for continuously monitoring Medi-Cal beneficiaries' access to health care services. These positions are in addition to one permanent position to be redirected within the DHCS to this program. The DHCS is also requesting $334,000 in contract dollars to hire consultants to assist with stakeholder meetings and monitoring methodology. The cost of the positions and contract would be $564,000 ($282,000 General Fund and $282,000 Federal Funds).

AB 97 (Budget Committee), Chapter 3, Statutes of 2011, requires DHCS to implement a 10 percent provider payment reduction. Prior to implementation, the DHCS had to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) to modify its Medicaid State Plan via a State Plan Amendment (SPA). New requirements set forth by CMS for approval of SPAs necessitate California to develop and implement a system for monitoring healthcare access for its Medi-Cal beneficiaries.

In the past few months, the DHCS has been working with CMS to establish a health care monitoring plan for Medi-Cal's beneficiaries enrolled in fee-for-service. The proposed plan includes 22 measures and focuses on provider availability, service utilization, and outcomes. Similarly, the Bridge to Reform 1115 Waiver requires the department to evaluate health care access for the populations enrolled under the Waiver.

Monitoring of these measures would occur on a quarterly basis. The DHCS would publish results from a full year of health care access monitoring in the form of an annual report, which would be made available to the public. CMS is also requiring that states implement an ongoing mechanism allowing beneficiary feedback, such as information collected through surveys, hotlines, or beneficiary Ombudsman offices. Currently, California does not have a mechanism in place to receive information from enrollees pertaining to health care access issues in the Medi-Cal program. Therefore, the addition of a Medi-Cal beneficiary help-line, similar to that implemented for Medi-Cal Managed Care, will be established to meet this new requirement.

VOTE-ONLY ISSUE 8: INTEREST RATES ON MEDI-CAL OVERPAYMENTS

The DHCS is proposing trailer bill legislation that would require the DHCS to assess interest against Medi-Cal provider overpayments at the higher of: 1) the Surplus Money Investment Fund (SMIF) rate; or 2) seven percent per year (annum). The legislation would also require the DHCS to pay interest at the same rate to a provider who prevails in an appeal of a payment disallowed by the DHCS. This is expected to result in $1.5 million ($750,000 General Fund) savings in 2012-13 and $3 million ($1.5 million General Fund) savings in 2013-14.

The Third Party Liability and Recovery Division (TPLRD) is responsible for ensuring that the Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties to pay for health care services to beneficiaries, and for taking all reasonable measures to ensure that the Medi-Cal program is the payer of last resort. The TPLRD's Overpayments (OP) Section is responsible for enforcing fiscal compliance with Medi-Cal laws and regulations by Medi-Cal providers and beneficiaries and to recover funds due to the Medi-Cal program for overpayments made to those providers and beneficiaries. In fiscal year 2010-11, the OP Section recovered over $204 million (Total Fund).

Overpayment cases are referred to the TPLRD by the Audits and Investigations (A&I) Division and by the Medi-Cal Fiscal Intermediary. Once an audit identifies that an overpayment has been made to a Medi-Cal provider, the DHCS issues a demand for payment. If the provider does not pay the overpayment in full within 60 days, the DHCS assesses interest on outstanding overpayments in accordance with the State Controllers Office's SMIF rate.

The 47-year average for the SMIF rate is 5.5 percent; however, the average SMIF rate over the last 20 years is 2.75 percent. The current SMIF rate is 0.480 percent and is far below the current lending rates of financial institutions and the state's borrowing rate. Since the current borrowing rate is higher than the SMIF rate, providers have little or no incentive to repay overpayments within the first 60 days or to secure financing from an alternate source. Providers opt to either allow DHCS to offset their claims flow until the overpayment is fully reimbursed, make partial payments, or enter into a repayment agreement with the DHCS rather than paying the overpayment obligation immediately and/or obtaining financing from a financial institution.

Until recently, federal law required the DHCS to return the federal portion of an overpayment to CMS within 60 days of discovery of the overpayment regardless whether DHCS has recovered the overpayment from the provider. In 2010, the Affordable Care Act extended the timeframe states have to reimburse the federal portion of an overpayment to one year from the date of discovery. If the state recovers the overpayment from the provider prior to the one-year deadline, the federal portion must be returned at the time the state receives payment. However, the DHCS continues to refund federal portion at 60 days due to extensive system changes required to refund at one year. When providers fail to repay overpayment debt before the federal portion is refunded, the state must borrow funds or redirect funds to repay CMS.

Since the state currently borrows at a rate that is higher than the rate charged to providers, the difference must come from funds that the DHCS could otherwise allocate to the provision of more services to the Medi-Cal population. The higher the state expenditures are, the more money the state must borrow. In instances where the state does borrow externally, interest rates have been up to 3 percent in recent years. This is much higher than the current SMIF rate.

Other TPLRD recovery programs, such as estate recovery and the collection of quality assurance fees, assess interest on unpaid recovery debt at a rate of seven percent per annum. The interest rate charged by Medicare for overpayments is 11.5 percent and has been above 10 percent since at least the year 2000.

Interest rates assessed on Medi-Cal provider overpayments are so low, they neither deter provider overbilling, nor do they encourage timely repayment of overpayments. Rather, the low interest rates actually cause a loss of General Fund revenue. These low interest rates afford providers little to no incentive to repay Medi-Cal overpayments promptly or to secure financing from an alternate source to repay the debt.

VOTE-ONLY ISSUE 9: ABOLISHMENT OF FOUR FUNDS

The budget proposes to add a sunset date of June 30, 2013 for the following special funds:

1. Emergency Services and Supplemental Payments Fund (0693);

2. Medi-Cal Medical Education Supplemental Payment Fund (0550);

3. Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund (0549); and,

4. Small and Rural Hospital Supplemental Payments Fund (0688)

The Emergency Services and Supplemental Payments Fund has a balance of $10,000 and the DHCS is working with the State Controller's Office to transfer this balance to the Distressed Hospital Fund (as allowed by state law).

The supplemental funds proposed to be discontinued were originally established to supply funds for the nonfederal share of supplemental payments to Disproportionate Share Hospitals.

The funding mechanism for the non-federal portion of these supplemental payments has changed since the establishment of the funds, most notably by SB 1100 (Chapter 560, Statutes of 2005). The intent of SB 1100 was to zero out the balances of the prior supplemental funds by transferring 20 percent of the money in the prior supplemental funds to the Distressed Hospital Fund each year over a five-year demonstration period.

Existing statute does not specify a sunset date for these funds, nor does it provide any other mechanism by which the funds can be abolished. Amending current law to provide a sunset date for the statutory references to these prior supplemental funds will avoid inaccurate and outdated fiscal records, inconsistencies with current law, and DHCS staff time to track the funds and provide reports.

VOTE-ONLY ISSUE 10: ROGER'S AMENDMENT SUNSET DATE

The budget proposes trailer bill language to extend the Rogers Amendment sunset date from January 1, 2013, to July 1, 2013, for capitation rates (known as Rogers Rates) paid to non-contract hospitals for emergency inpatient and post-stabilization services provided to Medi-Cal managed care plan (Plan) enrollees. The proposal would also allow DHCS to implement the Rogers rates methodology after June 30, 2012 via All Plan Letters (APL) or other similar instructions, rather than through the regulatory process.

Medi-Cal provides health care services to 7.65 million beneficiaries through two distinct health care delivery systems: the traditional fee-for-service (FFS) system and the managed care system. Approximately 4.3 million Medi-Cal beneficiaries receive health services by enrolling in contracted Medi-Cal managed care Plans in 30 counties. These Plans emphasize primary and preventative care and offer established networks of organized systems of care. Most health care plans contracting with the Medi-Cal program are licensed under the Knox-Keene Health Care Service Plan Act of 1975.

Section 6085 of the Federal Deficit Reduction Act of 2005 established an upper limit to the amount Medicaid health plans may pay to hospitals that are outside the Plans' provider networks (out-of-network hospitals). The federal law, known as the "Rogers Amendment," was in response to demands by out-of-network hospitals for payments that were above the established Medicaid rates normally paid by health plans across the nation for inpatient emergency services.

AB 1183 (Budget Committee), Chapter 758, Statutes of 2008, required DHCS to establish inpatient hospital rates as limits to the amounts that may be paid by Medi-Cal Plans to out-of-network hospitals. These rates are for both emergency inpatient bed days and for post-stabilization inpatient bed days.

The DHCS is also required to develop and implement a payment methodology based on diagnosis-related groups (DRGs). Statute requires implementation by July 1, 2012, or on a date when the DHCS Director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later. When implemented, these DRG rates will replace the existing Rogers Rates payment methodology.

Current statute provides for the Rogers Rates to sunset on January 1, 2013. Currently, the DRG methodology is expected to be implemented January 1, 2013. However, if there are delays past January 1, 2013, the DHCS will not have statutory authority to continue payments under the Rogers Rates methodology to out-of-contract hospitals providing emergency and post-stabilization services to Plan enrollees. DHCS requests that statute be amended to extend the sunset date to July 1, 2013. Once the DRG methodology is implemented, the Rogers Rates will no longer be used.

Additionally, the DHCS will need to establish a payment mechanism to cover the time period from the date of expiration of the California Medical Assistance Commission (CMAC) to the date the DRG methodology becomes effective. Existing law requires DHCS to carry out the Rogers Rates methodology through the regulatory process. This proposal would allow DHCS the ability to establish and implement the interim payment mechanism in a timely manner by granting the

DHCS the authority to extend the Rogers Rates methodology after June 30, 2012, when the CMAC methodology ends, via APLs or similar instruction.

Extending the sunset date for an additional six months would allow payments to continue under the Rogers Rates methodology if the DRG rate methodology is not implemented on January 1, 2013. It would also provide plans with a greater degree of program stability by providing more predictability in reimbursement rates.

VOTE-ONLY ISSUE 11: ALIGN MANAGED CARE POLICIES FOR RETROACTIVE COVERAGE

The Administration proposes to shift a County Organized Health System (COHS) health plan's responsibility for the retroactive period of Medi-Cal to the Fee-For- Service (FFS) system. This proposal would result in a one-time savings of $57 million General Fund in 2012-13.

Medi-Cal covers the costs of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. Currently, the COHS have been covering the cost of this retroactive time period. The DHCS is working with the COHS health plans to adjust their capitation rates to no longer account for the retroactive period (since these costs would now be paid under FFS).

Medi-Cal managed care is delivered through three models for its full-scope of services. These are:

- County Organized Health System**.** A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS model. (COHS counties are: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo).

- Two-Plan Model**.** Under the Two-Plan model, each designated county has two managed care plans: a local initiative and a commercial plan. (Two-Plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare).

- Geographic Managed Care**.** There are two Geographic Managed Care (GMC) counties in the state. In both counties (Sacramento and San Diego), the Department of Health Care Services (DHCS) contracts with several commercial plans to provide choices to the enrollees.

The three models of Medi-Cal managed care handle payment for retroactive periods differently. Currently COHS health plans receive an adjustment in their capitation rates for the cost of the retroactive period. In contrast, Two-Plan and Geographic Managed Care health plans do not receive an adjustment to their capitation rates for this cost. Instead, these costs are paid by the FFS system.

VOTE-ONLY ISSUE 12: OFFICE OF HIPAA COMPLIANCE RESOURCES REQUEST

The DHCS is requesting authority to convert 14.0 limited term positions to permanent positions in the Office of HIPAA Compliance at a cost of $723,000 (37%) General Fund and $1,228,000 (63%) federal funds.

In 1996, the federal government enacted the Health Insurance Portability and Accountability Act (HIPAA). The law established a process to achieve uniform national health data standards and health information privacy. The law requires all covered organization to standardize the way they transmit and code health information for billing and record keeping purposes, and to protect the privacy and security of that information.

New HIPAA regulations ("HIPAA-2") were released in January 2009 that established significant revisions to HIPAA. In addition to these changes, the Affordable Care Act (ACA) also includes considerable HIPAA-related changes, including: more frequent HIPAA updates, new operating rules, new transaction standards, new health plan certification requirements, and higher penalties for non-compliance. Further, HIPAA requirements continue to evolve and expand as a result of the push for use of electronic heath records and health information sharing. Since 2005, there has been a 600% increase in the number of incidents reported to the DHCS Privacy Office. The DHCS states that the additional privacy and security requirements and increased outreach efforts will likely double the number of reported incidents in upcoming years.

Failure to maintain or achieve HIPAA compliance by established federal deadlines has several implications for DHCS, including additional administrative burdens for Medi-Cal providers, increased risk of federal penalties, loss of support to HIPAA-implemented solutions, and additional breach reporting costs. According to the DHCS, permanent staffing of the Office of HIPAA compliance will reap several financial benefits for the Department.

VOTE-ONLY ISSUE 13: TRANSFER OF CMAC STAFF TO DHCS

The health budget trailer bill AB 102 (Budget Committee), Chapter 29, Statutes of 2011, approved the elimination of the California Medical Assistance Commission (CMAC) and the implementation of the Diagnosis-Related Group (DRG) hospital reimbursement system. In order to comply with the requirements of AB 102, the DHCS is requesting:

1. Approval of trailer bill for the transfer of 12.0 CMAC positions, effective July through December, 2012, to continue working on the Selective Provider Contracting Program until the DRG payment system is implemented January 1, 2013;

2. Authority to establish 12.0 permanent positions to administer and manage the new DRG payment system; and,

3. Authority to transfer $658,000 in current year General Fund authority from the CMAC to the DHCS to handle CMAC workload for the remainder of 2012.

The CMAC was established to negotiate contracts utilizing the SPCP on behalf of the DHCS. The MCAC contracts on a competitive basis with approximately 200 public and private hospitals that choose to provide inpatient services to Medi-Cal beneficiaries at a negotiated per diem rate. Hospitals that do not contract with the state through CMAC and the SPCP are reimbursed using a cost-based reimbursement methodology that uses interim per-diem rates.

Designated Public Hospitals are a separate category of hospitals that are owned by counties or the University of California and are reimbursed based on certified public expenditures (CPE). These hospitals will be exempt from the new DRG payment system given their CPE structure and the absence of State General Fund in their inpatient rates.

Utilized by Medicare, the new DRG system establishes rates based on average costs of groups of related diagnoses. The DHCS will be reimbursing approximately 350 fee-for-service hospitals using the new DRG methodology.

The CMAC staff, proposed for transfer to the DHCS, would address the following types of workload:

- The ongoing administration of the SPCP until the DRG system is implemented on January 1, 2013;
- Development, ongoing management and administration of the DRG system;
- Development of the State Plan Amendment and other documentation required by the federal government (CMS);
- Developing policy and processes, documenting program needs and acting as the liaison to all divisions of the DHCS related to the conversion to the DRG system;
- Policy development and implementation of the interim reconciliation process;
- Administration, monitoring and researching policy and fiscal issues of the DRG system; and,
- Performance of financial oversight, addressing policy changes and generally meeting the demands of the DRG system.

VOTE-ONLY ISSUE 14: INFORMATION PRIVACY AND SECURITY RESOURCES REQUEST

The DHCS is requesting to make permanent 10.0 existing limited term positions, at a cost of $1,388,000 ($585,000 General Fund, $803,000 federal funds), to perform the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, in compliance with requirements of the federal Social Security Administration (SSA). The positions expire on June 30, 2012.

The DHCS has entered into a data sharing agreement with the SSA and must comply with all of the requirements of this agreement. In 2007, the SSA identified a number of deficiencies in the areas of management and oversight, computer security safeguards and physical security. DHCS had to develop a comprehensive remediation plan to address SSA's concerns with security issues of the Medi-Cal eligibility Data System (MEDS). This plan addressed terminating direct access to the on-line MEDS for business partners who are not authorized to view the SSA data, enforcing county compliance with current security standards, and enhancing DHCS management oversight of SSA data. Additionally, the SSA recommends that DHCS perform regularly scheduled reviews of all 58 counties to monitor compliance with security safeguards. Thus far, the DHCS has completed 33 county reviews. In order for the DHCS to maintain access to SSA data, the DHCS must continually maintain contracts with all 58 counties, regularly assess county security compliance, maintain and renew interagency agreements allowing access for other state agencies and business partners, and track an analyze audit logs. The DHCS expects this workload to continue well past the current expiration date of the positions.

The DHCS periodically revises its agreements with counties and is currently working to include the new federal Health Information Technology for Economic and Clinical Health (HITECH) Act breach reporting requirements.

In 2008-09, the annual budget act provided resources for the DHCS to establish 16.0 limited-term positions to perform the activities necessary to maintain compliance with the SSA agreement. In 2009-10, these positions were extended to continue these activities.

The SSA conducted an onsite security review of DHCS on August 11, 2010 and identified a major finding: the DHCS unlawfully re-discloses citizenship and identity information via MEDS to agencies not covered by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. In response, the DHCS submitted a remediation plan, which called for a complex modification of MEDS. Over the past 6 months, the DHCS has worked to identify the correct program for over 40,000 MEDS users and modify MEDS accounts to reflect this new restricted level of access.

The DHCS also leads a Security Task Force to ensure compliance with all state and federal security requirements; this task force recently assisted San Francisco with a security breach. DHCS staff invested a substantial amount of time working closely with San Francisco sorting through data in order to report accurately to the SSA what information was lost.

VOTE-ONLY ISSUE 15: HOSPITALS QUALITY ASSURANCE FEE

In order to extend the Hospital Quality Assurance Fee (QAF) program through 2013, as required by SB 335 (Statutes of 2011), the DHCS requests authority to extend 9.5 positions, that are set to expire on June 20, 2012, until December 31, 2015 for a cost of $1 million ($471,000 from the Hospital Quality Assurance Revenue Fund and $562,000 in federal funds).

The DHCS is also requesting funding authority for contracts to calculate and validate capitation rates at a cost of $600,000 for 2011-12 and $100,000 for 2012-13 (funding for these contracts would be split equally between the Hospital Quality Assurance Revenue Fund and federal funds).

Estimated Revenue from Hospital QAF
(Dollars in millions)

Fiscal Year	2011-12	2012-13	2013-14 (6 months)
QAF Revenue	$2,637	$2,942.3	$1,533

Proposed QAF Payments
(Dollars in millions)

	2011-12	**2012-13**	**2013-14 (6 months)**
Direct Grants to Public Hospitals	$47	$68	$27
Hospital Payments (includes private and non-designated hospitals, managed care plans, and mental health plans)	$2,591	$7,018	$2,626
Children's Health	$255	$472	$193
DHCS Staff and Administration	$1	$1	$1
Total Payments	$2,894	$7,559	$2,846

Note: The estimated payments are presented on a cash basis. The DHCS Staff and Administration information for 2013-14 reflects the approximate budget authority for 12 months; the rest of the items in 2013-14 represent six-month estimates.

Each of the proposed expenditures identified in the table above is described below:

Direct State Grants to Public Hospitals. As contained in statute, Public Hospitals are to receive direct grants in support of health care expenditures. Public hospitals include both those operated by counties and by the University of California system. These grants are not considered Medi-Cal payments and cannot be matched with federal funds. This is because these hospitals are now paid at the maximum amount that qualifies for federal matching funds under the existing Hospital Financing Waiver.

***Hospital Payments*.** The reference in the table above broadly covers several areas:

- First, private hospitals (those paying the fee) will receive *supplemental* Medi-Cal payments for inpatient and outpatient hospital and subacute care services. These supplemental payments are in addition to existing Medi-Cal per diem payments.

- Second, the DHCS will increase Medi-Cal payment rates to Managed Care Plans (Plans) and require them to "pass-through" all of these funds to hospitals. The Plans will receive funds for those hospitals located in their service region as well as funds for hospitals in neighboring counties where there is no Medi-Cal Managed Care. The Plans will then pay *supplemental* payments to these hospitals as directed by the DHCS. The amount a hospital will receive will be based on the number of total Medi-Cal Managed Care days it provides.

- Third, the DHCS will provide payments to County Mental Health Plans to "pass-through" to hospitals providing Acute Psychiatric Services. This is a *supplemental* payment made in a similar manner as done with the Managed Care Plans.

- Fourth, non-designated hospitals (District Hospitals) will also receive *supplemental* Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals since non-designated hospitals are not paying the QAF.

***Children's Health*.** As contained in statute, funds are provided for health care coverage of children. The funds are an offset to General Fund support in the Medi-Cal Program for providing services to children. These funds will be matched with federal funds.

***Department of Health Care Services—9.5 State Staff*.** For 2012-13, DHCS requests to extend 9.5 positions to administer this program. The DHCS states the workload for these staff includes the following key items:

- Develop and secure federal approval for State Plan amendments, fee models.

- Monitor plans' contracts with hospitals to ensure compliance resulting in pass-through of appropriate funds.

- Reconcile QAF funds included in the capitation rates paid to managed care plans to actual amounts paid to hospitals.

- Respond to legal issues regarding the QAF program.

The enabling legislation specifies a three-tier QAF structure which is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Certain categories of hospitals, such as designated public, small and rural, most specialty care, and long-term care, are exempt from paying the fee.

Statute establishes a per diem fee assessed on every private acute care hospital for every acute, psychiatric, and rehabilitation inpatient day at the following:

- $86.40 per managed care day (other than Medi-Cal);
- $383.20 per Medi-Cal day;
- $48.38 per prepaid health plan hospital managed care day;
- $214.59 per prepaid health plan hospital Medi-Cal managed care (MCMC) day; and,
- $309.86 per Fee for Service (FFS) day (other than Medi-Cal).

The DHCS must obtain federal CMS approval for this program. The DHCS may alter the specified QAF amount in order to obtain federal CMS approval. Therefore, the above fee schedule may be altered. The DHCS anticipates receiving CMS approval for this QAF by the end of March or early April.

ITEMS TO BE HEARD

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: DEPARTMENT & BUDGET OVERVIEW

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

One of OSHPD's responsibilities is to implement the state's hospital seismic safety requirements. The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 established a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. Numerous pieces of legislation since then have amended the Alquist Act, by increasing OSHPD responsibilities and modifying seismic safety deadlines for hospitals. Most recently, SB 90 (Steinberg), Chapter 19, Statutes of 2011 sought to respond to the fiscal challenges facing many hospitals and the resulting difficulty for them to meet the current seismic deadline of 2013, thereby facing the real possibility of closure. Hence, SB 90 authorized OSHPD to grant hospitals an extension of up to seven years beyond the 2013 deadline if specific milestones and public safety conditions are met.

OSHPD Budget

The OSHPD's overall department budget is summarized in the table below. Overall expenditures are proposed to increase by $7,797,000, primarily due to an $11,459,000 increase in Mental Health Services Act (MHSA) funds (described below) and a decrease of $2,705,000 in expiring federal American Recovery and Reinvestment Act (ARRA) funds.

OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT					
Fund Source	**2010-11 Actual**	**2011-12 Projected**	**2012-13 Proposed**	**BY to CY Change**	**% Change**
General Fund	62,000	0	74,000	74,000	100
Federal Trust Fund	2,576,000	4,140,000	$1,435,000	(2,705,000)	(65)
Reimbursements	634,000	1,830,000	995,000	(835,000)	45
Special Funds	99,752,000	95,428,000	95,546,000	118,000	11
Mental Health Services Fund	5,681,000	6,993,000	18,452,000	11,459,000	164
Total Expenditures	**$108,705,000**	**$108,391,000**	**$116,502,000**	**$8,111,000**	**7.5**
Positions	**416.2**	**472.6**	**473.6**	**1**	**.2**

The increase in MHSA funds largely represents the proposed shift of the MHSA Workforce Education and Training ("WET") program from the Department of Mental Health (DMH) to the OSHPD, as part of the proposed elimination of the DMH. If approved, the WET program would shift 1.0 position and $12.3 million from the DMH to the OSHPD.

The Governor's Budget proposes $31,601,000 for operating expenses and equipment, a 5 percent decrease ($1,536,000) over the current year budget. The Governor's Budget proposes on-going Workforce Cap reductions of 3.8 PYs and $2,111,000 (various fund sources) per Control Section 3.90 of the 2010 Budget Act.

STAFF COMMENT / QUESTIONS

The Subcommittee staff has asked the OSHPD to provide an overview of the department, its budget, and significant workload changes and issues anticipated in the Budget Year.

PANEL

- Office of Statewide Health Planning & Development
- Department of Finance
- Legislative Analyst's Office

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: DEPARTMENT & BUDGET OVERVIEW

The mission of the Department of Managed Health Care (DMHC) is to help California consumers resolve problems with their Health Maintenance Organizations (HMOs) and to ensure a better, more solvent and stable managed health care system through:

- Administration and enforcement of California's HMO patient rights laws;
- Operating the 24-hour-a-day Help Center; and,
- Licensing and overseeing all HMOs in the state.

Proposed 2012-13 Budget

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

As summarized in the table below, the Governor's 2012-13 Budget proposes total funding of $53,097,000, a decrease of $3,115,000.

DEPARTMENT OF MANAGED HEALTH CARE					
Fund Source	**2010-11 Actual**	**2011-12 Projected**	**2012-13 Proposed**	**BY to CY Change**	**% Change**
General Fund	$0	$0	$0	$0	0
Federal Trust Fund	1,254,000	4,550,000	755,000	(3,795,000)	-83
Managed Care Fund	40,349,000	50,488,000	51,156,000	668,000	1.3
Reimbursements	276,000	1,174,000	1,186,000	12,000	1
Total Expenditures	**$41,879,000**	**$56,212,000**	**$53,097,000**	**(3,115)**	**-5.5**
Positions	**280.1**	**349.6**	**349.6**	**0**	**0**

The decrease in the department's overall funding is primarily attributable to the expiration of the federal Consumer Assistance Program Grant of $4.2 million originally awarded in 2010. The DMHC expended $3.9 million of this grant in 2011-12. The Consumer Assistance Program Grant funds are being used to update and enhance the Healthcare.ca.gov website and to promote a consumer education campaign, including translations of website content, recruitment of community based organizations to perform outreach efforts, and utilization of social networks to improve consumer education and outreach related to federal health care reform.

The Governor's Budget proposes $19,104,000 for operating expenses and equipment, a 2 percent decrease ($4,619,000) over the current year budget. The Governor's Budget also reflects on-going $1.3 million in savings from reducing the department's position authority by 5.0 temporary help positions in response to the Governor's Executive S-01-10 order on January 8, 2010 ordering all departments to cap the workforce by achieving 5 percent salary savings by July 1, 2010.

Bureau of State Audits 2011 Audit

A December 2011 report by the Bureau of State Audits (BSA) found that the DMHC: 1) has inconsistencies in the financial reviews it conducts of Medi-Cal managed care plans run by county entities under the two-plan model (local initiatives); 2) does not have an effective process to monitor local initiatives' response to corrective action plans that result from its financial examinations; and, 3) fails to conduct medical audits (intended to review aspects of the provision of health care). The DMHC concurred with most of the audit findings and recommendations. It is in the process of developing corrective actions, which are expected to be completed by October 31, 2012.

Recent press articles have outlined severe issues with Medi-Cal Dental Managed Care in Sacramento. The articles highlighted that children may be forced to wait months or even years before receiving needed dental treatment. Some of these concerns focus on DMHC's lack of enforcement to ensure timely access to dental care, an issue covered in more detail later in this agenda.

The DMHC is responsible for ensuring that managed health care plans, including local initiatives, are financially viable, and comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Act requires DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years. The survey is an evaluation of the plan's compliance with the law in the following areas: quality management, grievances and appeals (member complaints), access and availability, utilization management, and overall plan performance in meeting enrollees' health care needs.

The DMHC has indicated to staff that they are working closely with the Department of Finance on the development of increased staffing requests to be included in the Governor's 2013 proposed budget. These positions will support premium rate review activities as well as other aspects of ACA implementation.

STAFF COMMENT / QUESTIONS

The DMHC and the Department of Health Care Services (DHCS) share oversight responsibility for Medi-Cal managed care plans. The issues raised by the audit and the recent press articles raise concern as to whether or not the state is prepared to proceed with further Medi-Cal managed care expansions, as proposed in the budget.

The Subcommittee has requested DMHC to respond to the following questions:

1. Please discuss DMHC's role in monitoring Medi-Cal Managed Care plans and "specialty" plans such as dental and vision.

2. Please discuss how DMHC shares the information it receives regarding health plan complaints with the DHCS and how DMHC follows-up regarding these complaints.

3. Please discuss how DMHC and DHCS coordinate their oversight of Medi-Cal managed care plans and where there are opportunities for improvement.

PANEL

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT & BUDGET OVERVIEW

The California Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner.

Medi-Cal. The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 8.3 million qualified individuals, including low-income families, seniors, and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases or conditions.

Children's Medical Services (CMS). CMS coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and the Newborn Hearing Screening Program.

Primary and Rural Health. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations, and it includes the Indian Health Program, the Rural Health Services Development Program, the Seasonal Agricultural and Migratory Workers Program, the State Office of Rural Health (CalSORH), the Medicare Rural Hospital Flexibility Program (FLEX)/Critical Access Hospital (CAH) Program, the Small Rural Hospital Improvement Program (SHIP), and the J-1 Visa Waiver Program.

Mental Health & Substance Abuse. As adopted in the 2011 Budget Act, the DHCS is also coordinating and directing the delivery of community mental health services and substance use disorder services that are funded by Medi-Cal.

***New Programs*.** Finally, the Governor's January 2012 Budget proposes to transfer to DHCS:

- From DPH: The Every Woman Counts Program, the Family Planning Access Care and Treatment Program and the Prostate Cancer Treatment Program;
- From DADP: Various non-Medi-Cal programs associated with the proposed elimination of the DADP;
- From DMH: Various non-Medi-Cal mental health programs associated with the proposed elimination of the DMH; and,
- From MRMIB: All of the programs currently operated by the Managed Risk Medical Insurance Board (MRMIB), associated with the proposed elimination of the MRMIB.

DHCS Budget

For FY 2012-13, the Governor's Budget presents a total of $61.0 billion for the support of DHCS programs and services, as summarized in the chart below. Of the amount proposed, $506.1 million is for state operations and $60.4 billion is for local assistance. The $1.4 billion increase in MHSA funding represents the replacement of General Fund with MHSA funds, approved last year, coupled with the shift of Medi-Cal mental health programs from the DMH to the DHCS, also approved in the 2011 Budget Act. The $2.5 billion increase in the Hospital Quality Assurance Revenue Fund results from a timing issue that results in overlapping payments between 2011-12 and 2012-13.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Thousands)

Fund Source	2010-11 Actual	2011-12 Projected	2012-13 Proposed	BY to CY Change	% Change
General Fund	$12,570,630	$15,572,740	$15,398,789	($173,951)	(1.1)
Federal Trust Fund	29,145,101	29,775,070	33,770,967	3,995,897	13
Reimbursements	109,466	431,521	2,390,433	1,958,912	453
Mental Health Services Fund	1,107	863	1,407,803	1,406,940	163,000
Health Care Support Fund	1,104,209	1,709,156	1,027,830	(681,326)	(40)
Hospital Quality Assurance Revenue Fund	7,691,457	1,573,076	4,125,225	2,552,149	162
Other Funds	1,762,465	2,336,752	2,832,065	495,313	21
Total Expenditures	**$52,384,435**	**$51,399,178**	**$60,953,112**	**$9,553,934**	**183**
Positions	**2,665.3**	**3,017.9**	**3,380.8**	**362.9**	**12**

Overview of the Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 46-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, and people with disabilities. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match of the federal funds.

Medicaid is the single largest health care program in the United States. According to the Kaiser Family Foundation (KFF), in 2011 the average monthly enrollment was projected to exceed 55 million, and a projected 70 million people, roughly 20 percent of Americans were expected to be covered by the Medicaid program for one or more months during the year. In California, the estimated average monthly enrollment is eight million or roughly one seventh of the national total program enrollment. Approximately 29 percent of Californians are enrolled in Medi-Cal.

Beginning in 2014, the ACA will expand Medicaid coverage to nearly all non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 133 percent of the Federal Poverty Level. This is estimated to expand Medi-Cal by 1.4 million by 2019.

Funding for the Medi-Cal program is summarized in the table below. Medi-Cal costs have grown about six-percent annually, since 2006-07 due to a combination of health care cost inflation and caseload growth. The increase in "other funds" of over $5 billion represents approximately $2 billion in increased reimbursements and $2.5 billion in increased Hospital Quality Assurance Revenue (as discussed above).

Medi-Cal Funding Summary (000s)	2011-12 Revised	2012-13 Proposed	CY to BY $ Change	% Change
Benefits	46,929,547	54,416,224	7,486,677	16
County Administration (Eligibility)	2,913,699	3,015,544	101,845	3.5
Fiscal Intermediaries (Claims Processing)	389,502	302,969	(86,533)	(22)
Total Local Assistance	**$50,232,748**	**$57,734,737**	**$7,501,989**	**15**
General Fund	15,297,145	14,800,127	(497,018)	(3.2)
Federal Funds	31,414,356	34,271,710	2,857,354	9.1
Other Funds	3,521,247	8,662,900	5,141,653	146

Proposed 2012-13 Medi-Cal Budget

The Governor's proposed 2012-13 budget contains the following major cost-containment strategies within Medi-Cal, estimated to collectively result in $1,068.5 million in General Fund savings. The Coordinated Care Initiative was the subject of a joint hearing of this Subcommittee and the Assembly Committee on Aging and Long-Term Care on March 7, 2012, and the Healthy Families transition was discussed at the Subcommittee's hearing on April 9, 2012. All of the other proposals are issues to be covered by this hearing and are described in more detail below in this agenda. The major Medi-Cal proposals, and their projected Budget Year savings, are:

Coordinated Care Initiative - For General Fund savings of $621.7 million, significantly reorganizes the way care is delivered to both "dual-eligibles" (individuals eligible for Medi-Cal and Medicare) as well as all other seniors and persons with disabilities. Savings in the Budget Year is the result of a proposed managed care payment deferral.

Healthy Families Transition – For General Fund savings of $64.3 million, transitions all children in the Healthy Families Program to Medi-Cal.

Managed Care Expansion – For General Fund savings of $2.7 million, proposes to expand managed care to all 58 counties and is discussed in more detail later in this agenda.

Payment Reform for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) – For General Fund savings of $27.8 million, significantly reforms the payment system for FQHCs and RHCs and makes an overall ten percent reduction in payments to FQHCs and RHCs. Savings in the Budget Year is the result of a proposed managed care payment deferral.

Value Based Purchasing – For General Fund savings of $75 million, minimizes legislative oversight and regulatory requirements in order to afford the DHCS with increased flexibility in making changes to the Medi-Cal program.

Elimination of Sunset on Gross Premiums Tax – For General Fund savings of $161.8 million, proposes to eliminate the sunset on this tax on Medi-Cal managed care organizations that generates revenue to support children's health and Medi-Cal in general.

Means Test for the Medical Therapy Program – For General Fund savings of $9.1 million, proposes to means test the MTP, a small program under the CCS program, which provides unique occupational therapy services to school-aged children.

Hospital Stabilization Funds for General Fund Savings – For one-time General Fund savings of $42.8 million, supports the Medi-Cal program instead of being provided to specified hospitals.

Annual Open Enrollment – For General Fund savings of $3.5 million, limits Medi-Cal beneficiaries opportunity to change managed care plans to annually.

Managed Care Default Assignment – For General Fund savings of $2.4 million, requires that beneficiaries, in specified aid categories, who do not choose a plan be defaulted into a plan based on default ratios, which consider health plan cost in addition to quality of care and safety net population factors.

Alignment of Managed Care Policies – For one-time General Fund savings of $56.9 million, by covering the 90-day retroactive period of new enrollees through fee-for-service, rather than directly by the County Organized Health Systems.

Medi-Cal Savings Proposals *(Dollars in Thousands)*	GF Savings 2012-13	GF Savings 2013-14
Coordinated Care Initiative	**-$621,793**	**-$1,000,000**
Medicare Savings	-$42,125	
Long-Term Care Savings	$166,208	(one-time)
Payment Deferral	-$745,876	(one-time)
Value Based Purchasing	**-$75,000**	**-$75,000**
Managed Care Expansion	**-$2,680**	**-$8,800**
MC Expansion	$20,076	-$8,800
Payment Deferral	-$22,756	(one-time)
Healthy Families Program Transition to Medi-Cal	**-$64,377**	**-$91,500**
HFP Shift to Medi-Cal	$154,959	-$91,500
Savings in MRMIB (not in Medi-Cal estimate)	-$219,336	(one-time)
FQHC/RHC Payment Reform	**-$27,830**	**-$58,100**
Payment Reform	$15,796	-$58,100
Payment Deferral	-$43,626	(one-time)
Annual Open Enrollment	**-$3,568**	**-$6,000**
Annual Open Enrollment	-$4,014	-$6,000
Payment Deferral	$446	(one-time)
Managed Care Default Assignment	**-$2,409**	**-$5,800**
MC Default Assignment	-$2,628	-$5,800
Payment Deferral	$219	(one-time)
Gross Premiums Tax Sunset Elimination	**-$161,843**	**-$259,100**
CCS Medical Therapy Program Means Test	**-$9,123**	**-$10,900**
Hospital Stabilization Funds	**-$42,877**	(one-time)
Managed Care Policies Alignment	**-$56,984**	(one-time)
TOTAL	**-$1,068,484**	**-$1,515,200**

STAFF COMMENT / QUESTIONS

The Subcommittee staff has asked the DHCS to provide an overview of the department's proposed budget and the myriad of significant changes proposed for Medi-Cal and this department.

PANEL

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

ISSUE 2: PEDIATRIC DENTAL – SACRAMENTO GMC OVERSIGHT ISSUE

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

Structure of Existing Program

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

Initiated in 1994 as a pilot project, the DHCS contracts with five Geographic Managed Care (GMC) Dental Plans (Dental Plans) to provide Medi-Cal dental services in Sacramento. Each of these Dental Plans is licensed by the Department of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975. Presently, the five Dental Plans include Liberty Dental, Access Dental, Health Net, Western Dental Services, and Community Dental. Each Dental Plan receives a DHCS negotiated per member per month reimbursement rate (presently about $12) for each recipient enrolled in their plan. Due to the elimination of adult dental benefits in Medi-Cal, other than certain federally required services for adults, the program predominately provides services to children and adolescents (less than 21 years of age). There are about 110,000 children enrolled in the program.

Recipients are entitled to receive dental benefits from dentists within the Dental Plan's provider network. Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services are to include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days).

Dentists who wish to provide services under Geographic Managed Care must be a member of one of the Dental Plan's provider networks and must be enrolled in the Denti-Cal Fee-For-Service Program.

Summary of Key Concerns and Recent Local Actions.

In 2010, First 5 of Sacramento, chaired by Board of Supervisor Phillip Serna, commissioned the "Sacramento Deserves Better" report, which analyzed access, utilization, and quality of dental care under the GMC Dental Services model. Key findings from this report include the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service;

- Only 30 percent of children in GMC Dental Services received a dental service in 2010;

- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state;

- Dental plans have not complied with "first tooth/first birthday" recommendation for the initial dental visit;

- Inadequate prevention services were provided; and,

- The state provided minimal oversight of GMC Dental Services contracts.

Sacramento County formed a GMC Dental Subcommittee, consisting of numerous local stakeholders, to develop recommendations for the DHCS to improve the GMC Dental Services model. The GMC Dental Subcommittee is actively engaged with the DHCS to significantly revise the state's Request for Proposals (RFP) process used to contract with Dental Plans participating in the GMC Dental Services model. From this effort, the Subcommittee developed a comprehensive package of suggested contract changes in December 2011. Key recommendations from the GMC Dental Subcommittee include:

- Provide for "voluntary" enrollment in lieu of existing "mandatory" enrollment;

- Implement the Healthy Families Program utilization strategies and dental quality measures in Medi-Cal dental contracts;

- Allow families who choose a Federally Qualified Healthcare Center (FQHC) clinic as a dental home to maintain it;

- Develop comprehensive contracts with strong performance measures, including the ability to withhold payments if standards are not met, and the ability to provide incentives for outreach and performance;

- Improve state oversight, including data analysis, on-site visits and audit reviews of Dental Plan performance;

- Address the need for increased patient education and outreach strategies to support access to dental services and rights of Medi-Cal patients to services; and,

- Make improvements to the Medi-Cal Ombudsman process.

Summary of Recent Actions by DHCS

The DHCS recognizes the need for improvements to the GMC Dental Services model; recent actions have included the following:

- Met with the five Dental Plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children;
- Provided a letter to Dental Plans articulating expectations and necessary improvements; and,
- Convened a stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA), which, in its final form, will be used as the basis for contracting with Dental Plans.

Senate Action

At the request of Senate President Pro Tempore Steinberg, Senate Budget Subcommittee #3 on Health and Human Services recently adopted *placeholder* trailer bill language (attachment A) to improve dental services for children enrolled in Medi-Cal in Sacramento. This language includes the following key components:

- Provides enrollment on a "voluntary" basis in lieu of the existing "mandatory" enrollment;
- Requires the department to establish performance measures and benchmarks for dental health plans, and to post each plan's performance on the department's website at least twice annually;
- Requires the dental health plans to provide performance data to the department;
- Requires the department to utilize dental health plan performance data for contracting purposes, including for the establishment of contract incentives and disincentives;
- Requires the use of an independent External Quality Review Organization for dental health plans as is similarly done for Medi-Cal Managed Care health plans, and have this information posted on websites for public transparency;
- Requires the department to review and approve dental health plan marketing plans;
- Requires the department to review and approve member services procedures; and,
- Requires the Department of Managed Health Care to report to the Legislature regarding its surveys of the five dental plans participating in the Sacramento Geographic Managed Care Program.

Many of the components in the proposed language were included in the Administration's trailer bill language submitted to the Legislature in January as part of the Governor's proposed transition of the Healthy Families Program to improve and expand dental health plan services. However, the proposed trailer bill language adopted by the Senate does not address or include any aspects of the Healthy Families Program transition.

State Oversight of Managed Care

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

It appears that both departments have utilized these monitoring tools only on medical plans, and have ignored the operations of dental plans, despite dental plans also being licensed under Knox-Keene. According to the DMHC, dental plans are not required to submit the annual reports on timely access required of medical plans. The DMHC also indicates that their primary tool for becoming aware of problems with any managed care plan, of any type, is through their consumer complaint data. The DMHC states that they did not directly receive many complaints about pediatric dental care in Sacramento.

Managed Care: Medical vs. Dental

The delivery of medical care is substantially different than the delivery of dental care, and therefore managed care in the medical world is quite different from dental managed care. Specifically, physicians and other medical providers often work in groups, clinics, or other medical settings where the care and financial risk can be spread out among providers. Dentists, by and large, work as individual small businesses. When the state pays a managed care plan a capitated payment to provide medical care to a Medi-Cal beneficiary, the managed care plan seeks to provide comprehensive care in the most cost-effective manner possible.

When the state pays a dental plan a capitated payment, some dental plans simply take a significant portion of the payment and provide the remainder to dentists as a capitated payment. Other dental plans pay dentists on a fee-for-service basis. When dental plans pay dentists a capitated payment, the financial risk is shifted from the plans to the dentists who state that the payments are much too low for them to be able to manage the risk of this fairly high need, expensive population. In this scenario, the dental plan is not actually managing the care or managing utilization, and therefore it is unclear what exactly the state is buying from these dental plans.

The Medi-Cal program contracts with Delta Dental for all fee-for-service dental care. Delta Dental is a non-profit that acts as a fiscal intermediary, but also provides a managed care function by paying dentists for care on a fee-for-service basis.

The Healthy Families Program provides dental care through managed care contracts. Some of these plans pay dentists capitated payments and some pay them on a fee-for-service basis. Some stakeholders argue that the fee-for-service model is working much better than the capitated model. Overall, the Healthy Families Program has benefited from larger provider networks that are a result of higher reimbursement rates.

The DHCS explains that the two are so different that they cannot necessarily be compared. Nevertheless, the department remains convinced that managed care is superior to fee-for-service in both medical and dental care. Substantial evidence supports the contrary with regard to dental care.

Dental Coverage in California

In general, California has treated dental care, within the state's safety net, as a very low priority, as evidenced by the following:

- Adult dental benefits were eliminated from the Medi-Cal program in 2009;
- The state lacks a dental director or other identified state leader on oral health;
- Two state departments regulate and oversee managed care plans, but have had little focus on dental health plans;
- Low reimbursement rates have led to insufficient Medi-Cal participation by dentists;
- Excessive bureaucracy and application delays have discouraged many dentists from participating in Medi-Cal; and
- An inadequate investment has been made in oral health education.

Alameda County WIC Oral Health Program

With a federal grant, Alameda County implemented a pilot program that provided preventive dental services to low-income children ages 9 months through five years at WIC sites. The services included: 1) oral health education for parents; 2) prevention and screening; and, 3) case management. A UC Berkeley health economist conducted an evaluation of the program and found that:

- Program participants required approximately 42.4 percent less restorative and other corrective care than those not participating;
- The average cost savings per participant per year, relative to the average child on Denti-Cal in Alameda County, was 54 percent; and,
- The pilot project, which included 1,200 children, resulted in $107,280 in overall annual cost savings. If the project were extended to all children in the Denti-Cal program in Alameda County, the savings were estimated to be $913,757.

Potential Programmatic Changes:

In addition to the provisions included in the language approved by the Senate, some additional issues that the Legislature may want to consider include:

Rate Setting. Currently, the Medi-Cal program pays dental plans a per member per month capitated payment. The plans then set the rates for paying the dentists, outside of any statutory or regulatory requirements. It has been suggested that the state should explore utilizing the same rate setting methodology utilized in Medi-Cal's medical managed care whereby the state establishes actuarially sound rates.

Pediatric Dentists. Any child can receive dental care by either a pediatric dentist or a general dentist; however, pediatric dentists have completed 2-year residencies in pediatric care and have chosen to develop an expertise specifically in caring for children. As with any specialty, pediatric dentists devote significantly more time to caring for kids than do other dentists and therefore are able to provide superior care. This level of expertise and comfort with treating children becomes especially important in the context of caring for children who have significant dental care needs, as is the case with the Medi-Cal population in general. Nevertheless, dental plans view pediatric dentists as specialists only, rather than as primary care dentists. In order for a child to be referred to a pediatric dentist, the child must have experienced at least three failed treatment visits with a general dentist. This type of experience can be quite traumatizing for a child. Pediatric dentists, as with all medical specialists, command higher rates than primary care dentists, however the state and dental plans could develop a rate structure that provides equivalent rates for primary care and higher rates for specialist-required treatments, and incentivize pediatric dentists to participate in the program.

Medical Loss Ratio. Medical managed care plans are required to operate with a "Medical Loss Ratio," which dictates how much of their revenue can be spent on administrative overhead and how much must be spent on direct care. Dental plans have no such restrictions.

Excess Bureaucracy. The state should explore ways to simplify and decrease the time involved with applications and participation by dentists.

Health Education. The state should explore ways to expand programs like the Alameda County WIC program in order to reduce dental care needs and costs from the outset for this population.

STAFF COMMENT / QUESTIONS

The Subcommittee has asked the DHCS to respond to the following questions:

1. Please provide an overview of Sacramento's GMC dental care.

2. What evidence supports the continuation of GMC in Sacramento?

3. How is Delta Dental different than a dental health plan?

4. How long does it take DHCS to process an application from a dentist to become a Medi-Cal provider?

5. What does the state do to incentivize participation by pediatric dentists?

The Subcommittee has asked the DMHC to respond to the following questions:

1. Please explain the role and responsibilities that the DMHC has with regard to regulating dental managed care plans.

2. Please explain the reasons that the DMHC was unaware of the low utilization of care in Sacramento's GMC dental care program.

PANEL

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

PUBLIC COMMENT

ISSUE 3: CLINIC PAYMENT REFORM

Governor's Proposal

The DHCS proposes to reform the Medi-Cal payment system for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by integrating costs into managed care capitated rates. Under this proposal, payments made to FQHCs and RHCs (participating in Medi-Cal managed care contracts) would change from the current prospective payment system (PPS) system--a cost and volume-based payment--to a fixed capitated payment as described below.

Fiscal Estimate

The Governor's Budget assumes 2012-13 General Fund savings of $27.8 million and out-year savings of $58 million. In the long run, savings in this proposal result from a proposed ten percent reduction in overall payments to clinics, which the Administration states can be absorbed by clinics through operational efficiencies that would become possible in light of the reforms proposed by this proposal. These efficiency savings are described in more detail below. $58 million in savings represents a reduction to clinics of over $100 million due to the federal funding match in Medi-Cal.

In the budget year, this proposal, as with the Governor's proposal related to "dual-eligible" beneficiaries, would result in increased costs as a result of the overlap in payments that occurs whenever beneficiaries shift from fee-for-service to managed care, due to the time lag in the state receiving FFS claims overlapping with the beginning of managed care capitation payments. This proposal does not move individuals from FFS to managed care; however, it reforms the payment system from a FFS payment system to a capitated system for Medi-Cal beneficiaries already in managed care, thereby having the same effect on costs. Therefore, in order to achieve savings in the budget year, the Governor proposes to delay $43.6 million (General Fund) in managed care payments to FQHCs and RHCs into 2013-14. The net savings of this payment deferral, with increased costs, is $27.8 million.

BACKGROUND

Efficiency Savings & Operational Restrictions

As referenced above, the long-term savings from this proposal would result from a ten percent reduction to clinics, which the Administration states can be absorbed by clinics in the form of increased efficiencies, which become possible to achieve as a result of the proposed payment reforms. Currently, FQHCs operate under restrictions that inhibit the clinic's ability to provide efficient care. Restrictions include:

- Payments are limited to visits with certain provider types;
- Services are limited to those provided within the "four walls" of the clinic; and,
- Multiple payments for multiple services in the same day are prohibited.

These restrictions not only increase costs, but also reduce the quality of care that clinics are able to provide. Therefore, the Administration proposes to eliminate current operating restrictions that prevent best practices, such as group visits, tele-health, preforming multiple services on the same day, and telephonic disease management. According to the Administration, eliminating these operating constraints would create efficiencies, allow FQHCs and RHCs to institute best practices, and result in cost savings for the clinics, and therefore the state.

The State has the authority and ability to eliminate these operating restrictions now; however, the Administration explains that eliminating them without significant changes to the overall payment system would result in substantial increased costs for the state. The DHCS states that under the existing PPS payment system, the State has no way to reimburse clinics for these services except through additional "wrap-around" payments (described below), which are in effect costs/payments carved out of the overall PPS rate.

Proposed Rate Calculation

As proposed, the clinic-specific, capitated rate would be calculated using the historical per-beneficiary revenue that the clinic would have received under the PPS system as follows:

- Rate based on a facility's current average plan revenue Per Member Per Month (PMPM) (PPS rate X number of plan beneficiaries X average number of visits);
- Method to adjust plan funding quickly regarding shifts in FQHC utilization; and,
- An efficiency savings of ten percent would be removed from the funding provided to plans and the rate paid to FQHC/RHCs.

After the first year, subsequent capitated rate calculations would be developed based on experience and costs, risk mix, and performance and quality outcomes.

Clinics

FQHCs and RHCs are community-based centers that provide primary and preventative health care services to medically underserved populations or areas without regard to a patient's ability to pay. In addition to receiving grants from the federal government, these health centers are reimbursed for providing Medicare and Medi-Cal services. There are 681 FQHCs and 293 federally designated RHCs in California. In 2009-10, FQHCs and RHCs represented over 90 percent of Medi-Cal expenditures for clinic-based care. In 2009-10, about 1.6 million Medi-Cal beneficiaries made 6.8 million health center visits and nearly 400,000 beneficiaries made 2.1 million rural clinic visits. Also in 2010, 64 percent of primary care visits in the doctor's office or clinic setting were at FQHCs and RHCs.

In its "Management Brief: DHCS' Monitoring Plan and Initial Assessment of Healthcare Access for Medi-Cal Beneficiaries" completed in October 2011, the DHCS indicates that it found that FQHCs and RHCs treated a much higher average number of Medi-Cal beneficiaries during the year compared to physicians in solo practices and other organized outpatient clinics.

In 2014 under federal health care reform, it is projected that two to three million individuals will be eligible for Medi-Cal; thereby, further increasing the demand for health care services at these centers.

According to the mental health and substance use needs assessment conducted on DHCS' behalf as part of California's Section 1115 Bridge to Reform waiver approval, FQHCs and RHCs play an important role in the provision of mental health and substance use services in California, particularly for people living in rural areas and for underserved populations such as people experiencing homelessness. In the past, FQHCs were required to either provide mental health and substance use services, or have referral relationships with other agencies that could serve people with mental health and substance use treatment needs. However, all new FQHCs are now required to directly provide these services, making FQHC providers an even more valuable resource for ensuring access to mental health and substance use services. In 2010, 108,597 Californians received mental health services and 21,893 people received substance use services from FQHCs.

Prospective Payment System (PPS)

Federal law requires Medi-Cal to reimburse FQHCs and RHCs based on the PPS, which is considered to be the basis for determining reasonable costs. Under PPS, Medi-Cal generally reimburses centers a per-visit rate, which is a "global rate" reflecting all clinical and operational costs of the clinic. The PPS rate is adjusted annually to reflect the Medicare Economic Index. The Administration explains that the PPS rate was created in response to inadequate Medicaid rates, which resulted in clinics subsidizing Medicaid payments with federal grant funds that they receive to cover the costs of treating uninsured patients.

Managed Care and Clinics

Medi-Cal managed care plans commonly contract with FQHCs and RHCs as part of their provider networks and are required to reimburse FQHCs and RHCs in their networks for providing services to plan beneficiaries at rates that are, at a minimum, comparable to other providers of similar services in the same network. Federal law requires Medicaid programs to make up the difference between negotiated rates paid by managed care plans and a clinic's guaranteed PPS fee-for-service rate. An annual reconciliation determines the total difference between plan payments and PPS payments. These "wraparound" payments (or supplemental payments) paid by Medi-Cal to FQHCs and RHCs with managed care contracts totaled $229 million General Fund in 2009-10. The Governor's proposal would end these wrap-around payments, and instead require managed care plans to pay FQHCs and RHCs the full PPS rate. The Administration intends to implement this aspect of the proposal even if CMS denies California's request for a waiver to implement the full payment reform proposal.

Federal Waiver

Federal law requires state Medicaid programs to reimburse these clinics using a PPS. Therefore, the Administration is seeking a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to reform the payment methodology per this proposal. If CMS does not approve of the waiver request, under this proposal DHCS would continue forward with the proposal to eliminate the PPS "wrap-around" payments, thereby requiring plans to pay clinics the full PPS rates rather than the State filling in the gap. In the absence of a waiver, the operating restrictions discussed above would remain in place and plans would be required to pay FQHCs at PPS rates, to the extent that plans use these clinics for services.

Recent and Anticipated Increases and Decreases in Costs and Resources
FQHCs and RHCs generally have been protected from Medi-Cal rate reductions via federal law that requires the state to pay the established PPS rates. For example, they were exempt from the 10 percent provider rate reduction authorized in the 2011-12 budget. However, over the past few years, clinics also lost approximately $100 million in state funding as a result of the elimination of the adult dental benefit in Medi-Cal in 2009 and the elimination of the following programs in 2010: Expanded Access to Primary Care, Seasonal Agricultural Migratory Worker Program, Rural Health Services Development Program and Indian Health Program.

The Administration states that clinic resources will increase substantially with the implementation of the ACA, in that many currently uninsured individuals will become insured through either Medi-Cal or the Health Benefits Exchange, and many will receive primary care services through clinics.

Clinics and Other Stakeholders
In an effort to explore all potential means of reducing and controlling costs in the Medicaid program, as well as efforts to increase efficiencies and quality of care, the California Primary Care Association (CPCA) states that discussions are underway nationally on potential future reforms to the clinic payment system under Medicaid. Nevertheless, the Administration acknowledges developing this proposal without collaborating or consulting with clinics or any of the clinic associations. CPCA, other clinic associations, and many individual clinics are strongly opposed to this proposal, for this and other reasons.

Clinic opposition is primarily rooted in the proposed ten percent funding reduction, which they believe many clinics would be unable to sustain particularly in light of recent resource reductions and anticipated increased demand for clinic services. Clinics state that the proposed rate cut would likely force some FQHCs and RHCs to close and others to restrict hours and limit patient access at a time when the state needs to be developing methods to increase capacity and maximize the ability to provide more services. The California Association of Public Hospitals (CAPH) and the California Hospital Association (CHA) also oppose this proposal due to the proposed ten percent reduction. The CHA states that the reduction to clinics could impact access, particularly in rural areas where clinics operate on a very thin margin. Hospitals operate many FQHC clinics.

Regardless of the proposed funding reduction, this proposal represents a massive restructuring of the payment system, which could be expected to significantly change the way health care is delivered through clinics. For example, the proposed new payment system would apply only to clinic patients in managed care, and not those who receive services through fee-for-service Medi-Cal. It is possible that having different payment methodologies for these two separate populations would result in two different treatment models as well. While these changes might ultimately result in improvements to clinic care, the proposal contains complex policy changes that should be thoroughly vetted, such as through the legislative policy process, and in consultation with clinics.

STAFF COMMENT / QUESTIONS

This is a major policy proposal with a very aggressive time line. It would have a substantial impact on the community-based center delivery system. FQHCs and RHCs are critical to the existing Medi-Cal provider network and the future Medi-Cal expansions with federal health care reform.

The Subcommittee has asked the Administration to present this proposal and answer the following questions:

1. Has this new complex policy reform been fully vetted with stakeholders either in California or elsewhere in the country?

2. What evidence can you provide that clinics can sustain a ten percent payment reduction?

3. Would this payment system result in two different models of care, one for managed care patients, and a different one for fee-for-service?

PANEL

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

PUBLIC COMMENT

ISSUE 4: MANAGED CARE EXPANSION

Beginning in June 2013, the Administration proposes to expand Medi-Cal managed care into the 28 rural counties that are now Fee-For-Service (FFS) (see table below). This proposal would result in General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14 and approximately $30 million on-going.

BACKGROUND

This proposal is both a stand-alone proposal as well as a component of the Administration's "Coordinated Care Initiative" (discussed by this Subcommittee on March 7, 2012). Furthermore, it supports the Administration's proposal to transfer all children in the Healthy Families Program (HFP) to Medi-Cal, many of whom reside in fee-for-service counties, and therefore would transition from managed care in the HFP to fee-for-service Medi-Cal. In fact, it is possible that Medi-Cal managed care could be modeled on the HFP model of rural managed care, which occurs through an "Exclusive Provider Network," which involves a care coordinator who operates on a FFS basis.

As of July 2010, approximately 4 million (54 percent) of Medi-Cal beneficiaries were enrolled in managed care, while the remaining 3.4 million (64 percent) were in FFS. Currently, managed care for Medi-Cal operates in 30 counties in California, according to three different models of care:

1. County Organized Health Systems (14 counties) which utilizes one health plan run by a public agency;

2. Geographic Managed Care (2 counties: Sacramento & San Diego), which allows beneficiaries to choose one of several commercial plans; and,

3. Two-Plan Model (14 counties) which consists of one locally developed and operated plan and a second commercial plan.

The 28 counties that remain FFS are listed in the table below:

Current Medi-Cal Fee-For-Service Counties			
County	Number of Medi-Cal Eligibles	County	Number of Medi-Cal Eligibles
Alpine	204	Modoc	1,866
Amador	4,095	Mono	1,143
Butte	47,834	Nevada	10,452
Calaveras	6,106	Placer	28,269
Colusa	4,271	Plumas	2,971
Del Norte	7,706	San Benito	9,334
El Dorado	17,216	Shasta	38,039
Glenn	6,610	Sierra	458
Humboldt	25,208	Siskiyou	9,759
Imperial	54,563	Sutter	21,724
Inyo	3,213	Tehama	16,049
Lassen	4,544	Trinity	2,628
Lake	16,556	Tuolumne	7,511
Mariposa	2,599	Yuba	18,857
		Total	**369,785**

Request for Information

On March 30, 2012, DHCS released a Request for Interest (RFI) in providing Medi-Cal managed care services in the 28 FFS-only counties. In the RFI, DHCS is requesting managed care health plans to express their interest in providing Medi-Cal covered services (with a complete provider network) in five ways: 1) in the 26 contiguous county region; 2) in a combination other than in all 26 contiguous counties; 3) in three regions (Northern, Central, and Border); 4) in San Benito and/or Imperial counties; and, 5) in an alternate proposal. Responses to this RFI were required to be submitted by April 23, 2012. The Administration states that managed care in rural counties might be structured differently in different counties or parts of the state.

Previous Geographic Managed Care Expansions

The Budget Act of 2005 authorized the DHCS to expand the Medi-Cal managed care program to 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura. Expansion to all of these counties has not yet occurred and in some of the cases where it did occur, it took three years longer to implement. For example, Ventura County's original implementation date was April 1, 2008; however, the implementation did not occur until July 1, 2011. Expansion has not occurred in Imperial, San Benito, and El Dorado Counties based on consultation with the counties' local stakeholders, nor has it occurred in Placer County because two of the three interested health plans were unable to participate. The Administration points out that there is a much larger membership base available to managed care companies now, with the transition of seniors and people with disabilities, than there used to be with only families and children.

STAFF COMMENT / QUESTIONS

Discussions continue between the Administration and stakeholders on the feasibility of expanding managed care throughout the state. Given the past difficulties in expanding managed care into rural counties, it is unclear how the Administration's proposal is feasible. Furthermore, provider shortages are pervasive in rural counties. As seen with Sacramento's pediatric dental managed care program, a Medi-Cal beneficiary does not gain access to providers just because the state has paid a managed care company a capitation payment for that beneficiary.

The Subcommittee has requested the Administration to present this proposal and respond to the following questions:

1. What is the proposed timeline to implement this proposal?

2. Has the Department received any responses to the RFI (which were due April 23, 2012) and what has been the nature of the responses?

3. What lessons did the Department learn from prior geographic managed care expansions?

4. What assurances can the Administration provide that, should managed care be expanded, the state won't simply be paying capitation rates while beneficiaries lack access to providers and care?

5. How will the Administration work with stakeholders on the implementation of a managed care expansion?

PANEL

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

PUBLIC COMMENT

ISSUE 5: ANNUAL OPEN ENROLLMENT (LOCK-IN)

The DHCS is proposing trailer bill language that would change the enrollment model for Medi-Cal managed care beneficiaries who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; an enrollee could only change plans once a year as compared to monthly which is currently allowed.

Beneficiaries would receive written notice 60 days prior to the end of an enrollment year, allowing them to change plans during this 60-day period. If the beneficiary does not elect to change plans, he or she would be required to remain in their plan for one year until the next open enrollment period. Under this proposal, a beneficiary would have the option to change to an alternate plan within the first 90 days following initial enrollment into a managed care plan.

Annual enrollment is expected to reduce the number of initial health assessments and mailings performed by plans, thereby resulting in cost savings projected to be $3.6 million General Fund in 2012-13 and total savings of $11.9 million in 2013-14. This proposal would be implemented October 1, 2012, and cover the nine remaining months of the first fiscal year and each year thereafter. This proposal requires an amendment to California's 1115 Medicaid Waiver.

BACKGROUND

Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month. Approximately 16,687 enrollees (combined for Two Plan Model and Geographic Managed Care) currently switch plans each month, which totals 200,240 changes per year. This represents 5.6 percent of projected mandatory enrollment.

Commercial health plans, Medicare Advantage and Part D Plans, and the Healthy Families Program all have annual open enrollment periods.

The DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies since enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Improvement in the monitoring of clinical measures used to assess quality of care, such as, HEDIS® (Healthcare Effectiveness Data and Information System);
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using their Health Plan; and,
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution).

Mandatory Enrollment of SPDs into Managed Care

In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from CMS authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011 and will take twelve months to complete. Concerns have been raised regarding the low percentage of enrollees actively selecting their managed care plan versus being defaulted into a plan. About 60 percent of this population has been defaulted into a managed care plan and often do not realize that a change to their health coverage was made. Additionally, there have been challenges regarding an enrollee's ability to continue care with a provider. Guidance provided during the SPD transition to managed care states that enrollees would be able to change plans at any time of the year, as needed.

STAFF COMMENT / QUESTIONS

This proposal was included in the Governor's proposed 2011 budget and was denied by the Legislature.

The Subcommittee has requested the DHCS to present this proposal.

PANEL

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

PUBLIC COMMENT

ISSUE 6: DEFAULT MANAGED CARE PLAN ASSIGNMENTS

In order to achieve General Fund savings of $2.4 million in 2012-13 and $5.8 million in 2013-14, the Administration proposes to change how it selects a default managed care plan when a Medi-Cal enrollee does not make a health plan selection. The Administration proposes to consider health plan cost in addition to quality of care and safety net population factors as part of the default algorithm. Specifically, the default algorithm would be adjusted to increase defaults to low cost plans by 5 percent. Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the existing default ratios to lower cost plans.

This default algorithm would be implemented for Geographic Managed Care (GMC) and Two-Plan counties with the exception of Kings and Madera counties; managed care is new in these counties and consequently, plans in these counties are currently paid the same capitation rate since health plan quality data is not yet available. It is anticipated that beginning on January 1, 2013, plans in these two counties would use the proposed default algorithm (as health plan quality data would become available).

BACKGROUND

When a Medi-Cal enrollee does not select a Medi-Cal managed care plan, a default health plan is assigned. Currently, the default algorithm defaults beneficiaries into a plan based on health plan quality (6/8 of the weighting, using six HEDIS measures) and safety net population factors (2/8 of the weighting). This algorithm is based on Family and Seniors and Persons with Disabilities (SPD) aid categories. The DHCS has regulatory authority to determine how assignments of default beneficiaries are to be made. In 2011, 40 percent of new Medi-Cal managed care enrollees were defaulted into a health plan.

AB 2002 (Cedillo) has been introduced as well seeking to change the nature of this default algorithm. Specifically, AB 2002 defines "safety net provider" for the purpose of determining which Medi-Cal managed care (MCMC) plan a beneficiary will be assigned to if they do not choose a plan.

STAFF COMMENT / QUESTIONS

The Subcommittee has requested the Administration present this proposal.

PANEL

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

PUBLIC COMMENT

ISSUE 7: COMMUNITY-BASED ADULT SERVICES (ADULT DAY HEALTH CARE) PROGRAM

The Administration proposes $289.1 million ($144.6 million General Fund) for the transition of Adult Day Health Care (ADHC) benefits in 2011-12 and $166.3 million ($83.1 million General Fund) in 2012-13. The current year estimate accounts for continuing ADHC benefits until March 1, 2012.

BACKGROUND

AB 97 (Statutes of 2011) eliminated ADHC as an optional Medi-Cal benefit to provide for an estimated $170 million in General Fund savings in 2011-12. The 2011 budget provided $85 million (General Fund) to provide for a temporary transition program for existing ADHC enrollees to other Medi-Cal appropriate services. As part of this transition, the Legislature provided for the development of policy legislation to create a federal Waiver program, but the Governor vetoed this budget bill language and subsequent policy bill, AB 96.

Settlement Agreement

Consequently, through the summer and fall of 2011, the Administration developed a transition plan for existing ADHC beneficiaries. However, as part of the settlement of a lawsuit that challenged the elimination of the ADHC benefit, based on insufficient alternative community-based services, an agreement was reached between the state and the plaintiffs to phase out the ADHC program and replace with a new program called the Community-Based Adult Services (CBAS) that will provide necessary medical and social services to those with the greatest need. CBAS will be provided as a Medi-Cal managed care benefit.

CBAS Eligibility

At the time of the settlement, the DHCS had estimated that roughly half of the "settlement class" (approximately 40,000 individuals who received ADHC services on or since July 1, 2011 through February 29, 2011) would qualify for CBAS; however, it is now estimated that approximately 80 percent of the class would be eligible.

Eligibility to participate in CBAS will be determined by state medical professionals on the basis of medical need, and the benefits provided will be coordinated by managed care plans. The CBAS program was originally expected to be implemented on March 1, 2012, but was not implemented until April 1, 2012, because of delays in getting federal CMS approval.

CBAS Providers

As part of the settlement, the DHCS will primarily use non-profit providers for CBAS services. CBAS Standards of Participation require, after July 1, 2012, a CBAS provider to convert to a non-profit entity unless it meets one of the following exceptions:

1. The for-profit CBAS provider offers program specialization that meets the specific health needs of CBAS-eligible participants not otherwise met by any other CBAS provider in the participants' geographic area.

2. The for-profit CBAS provider's operation is necessary to preserve an adequate number of CBAS providers for CBAS-eligible participants to transition without interruption in services due to wait lists.

3. DHCS determines that a provider needs additional time beyond July 1, 2012, to complete its conversion to non-profit status.

After July 1, 2012, the DHCS retains the discretion to reexamine whether one of the above-listed exceptions for a for-profit CBAS provider still applies to that CBAS provider, and in doing so, DHCS may withdraw the exception as needed.

With the CMS delay of the state's waiver approval by one month, the DHCS delayed advising CBAS centers on specific criteria related to the non-profit exceptions until April. The DHCS has started conversations with provider representatives and will release additional information about these requirements to providers/stakeholders in the coming weeks.

The DHCS has received 275 CBAS provider applications. Of these, 268 have been approved, 3 have been denied, and 4 have been withdrawn. As of April 16, 2012, there are 260 open CBAS centers in the state. In December 2011, there were 271 ADHC centers in the state. Of the 268 approved centers, 193 are for-profit CBAS providers and 75 are non-profit CBAS providers.

Contempt Motion

In March 2012, Disability Rights California (DRC) filed a contempt motion stating that the DHCS had not been following the terms of the settlement agreement. Since then, DRC and the DHCS have come to agreement on the following:

- Both sides agree that the DHCS will not be required to conduct further presumptive eligibility reviews;

- Both sides agree that a denial of presumptive eligibility is not appealable at a fair hearing;

- Both sides agree that the 37,000 people with disabilities and seniors who are part of the settlement class and were determined ineligible for the new CBAS program prior to April 1, 2012, who were not eligible to receive CBAS-pending, but who prevail at their respective fair hearings, will be deemed eligible CBAS retroactive to the date of CBAS implementation, April 1, 2012; and,

- The DHCS will coordinate with DRC and the California Department of Social Services State Hearings Division to offer optional telephonic hearings for the settlement class.

The other issue discussed in the contempt motion is the quality assurance process for the more than 315 eligibility determinations from 13 ADHC centers. A workgroup from the DHCS and ADHC representatives have met to work towards an agreement. If an agreement was not reached, a court hearing was scheduled for April 27, 2012.

STAFF COMMENT / QUESTIONS

As discussed above, there was a one-month delay in the implementation of CBAS and 80 percent (rather than 50 percent) of those who received ADHC services are estimated to be eligible for CBAS. As a result, the estimates for the transition period will be updated by DHCS at May Revise.

The Subcommittee has requested the Administration respond to the following questions:

1. Please provide a brief overview of the transition of ADHC to CBAS.

2. Please provide an update regarding the contempt motion and the outstanding issue to be resolved.

PANEL

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

PUBLIC COMMENT

ISSUE 8: FAMILY HEALTH PROGRAMS

a. Genetically Handicapped Persons Program (GHPP)

The budget proposes total expenditures of $97.3 million ($63.3 million General Fund, $25.5 million federal funds, $8 million Rebate Fund, $436,000 Enrollment Fees). This reflects technical fiscal adjustments and caseload only. The proposed 12-13 budget includes a $40 million increase in General Fund, reflecting a decrease of $29.3 million in federal funds. The decrease in federal funds reflects the use of certified public expenditures (CPE) in this program.

BACKGROUND

The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. The GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for the GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

This estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. The DHCS indicates that it will update this estimate in the May Revise.

b. Child Health and Disability Prevention (CHDP) Program

The budget proposes total expenditures of $2.4 million ($2.3 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds). This reflects technical fiscal adjustments and caseload only.

BACKGROUND

The CHDP provides pediatric prevention health care services to: 1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty; and 2) children and adolescents who are eligible for Medi-Cal services up to age 21. CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent. This program serves as a principle provider of vaccinations and facilitates enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

As with the GHPP, this estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and

would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. The DHCS indicates that it will update this estimate in the May Revise.

c. California Children's Services (CCS) Program Estimate

For the "state-only" portion of the CCS program, the budget proposes total expenditures of $236.9 million ($68.2 million General Fund), a $25.6 million reduction from the 2011-12 budget (November 2011 estimate). Despite the overall decrease, the proposed 2012-13 budget reflects a General Fund increase of $45.7 million.

BACKGROUND

The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children and young adults, aged 21 years and under, with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

State law establishes a family income ceiling of $40,000 per year adjusted gross income (AGI) or estimated annual CCS related medical expenses in excess of 20 percent of family AGI in order for a child to be financially eligible for CCS diagnosis and treatment services.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists, and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: 1) CCS-only (not eligible for Medi-Cal or the Healthy Families Program); 2) CCS and Medi-Cal eligible; and 3) CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

STAFF COMMENT / QUESTIONS

The Subcommittee staff has asked the department to provide an overview of the family health programs and their proposed budgets.

PANEL

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

PUBLIC COMMENT

ISSUE 9: MEDICAL THERAPY PROGRAM MEANS TEST

The DHCS proposes trailer bill language to apply the existing CCS financial eligibility requirements to the Medical Therapy Program (MTP), which is currently not means-tested.

The CCS financial eligibility requirements that would be applied to the MTP are:

- A family income ceiling of $40,000 per year adjusted gross income (AGI); or,
- An estimated annual CCS related medical expenses in excess of 20 percent of family AGI.

The proposal would result in annual savings of $21.9 million ($9.1 million General Fund in 2012-13, and $10.9 million General Fund, and $11 million county funds on-going) as a result of 4,779 of 24,433 children, currently receiving CCS MTP, no longer qualifying under the proposed financial eligibility requirements.

BACKGROUND

The CCS MTP provides physical therapy, occupational therapy, medical therapy, and conferencing services to children who have CCS-eligible conditions, such as neurological or musculoskeletal disorders. These services are provided in an outpatient clinic setting known as the Medical Therapy Unit (MTU) that is located on a public school site. Currently, 24,433 CCS children are served by 125 school based MTUs operated by county CCS programs. Therapists at these sites are employed by the county.

Of these children, 14,273 have an Individual Education Program (IEP) under the provisions of the federal Individuals with Disabilities Education Act (IDEA). Schools are responsible for *educationally* necessary therapy services covered by a child's IEP, and the CCS MTP is responsible for *medically* necessary therapy services covered by a child's IEP. The MTP assists children with adapting their disabilities to their school settings and provides other types of therapies that will help them succeed academically.

Historically, this program has not been means-tested in light of the federal guarantee to a free and appropriate education for children with disabilities. Federal law requires children with disabilities to be provided with special education and supportive services without charge to the family. Should this proposal be approved, and therefore the MTP becomes a means-tested program, 4,779 children would no longer qualify for state funding for MTP. For the approximately half or more of these children who likely have an IEP, the schools would be obligated to cover the MTP services. For these children, this proposal represents a cost shift from the CCS program to schools. For the other approximately half of these children, they would either lose MTP services altogether, pay for the services out of pocket or through private insurance (though currently there is no mechanism to do this), or seek to obtain an IEP, in order to secure school funding for the services.

STAFF COMMENT / QUESTIONS

The state cannot afford to provide services on a non-means tested basis. However, with regard to school-based services, several issues must be considered:

- Instituting a means test might accomplish little more than shifting costs to schools;
- Regardless of federal mandates and students' needs, some school may lack the resources, expertise, or will to adequately provide these services to students; and,
- The MTP offers a unique set of services that are critical to some children being able to access education and succeed academically; these services are not available elsewhere and the program lacks a private payment mechanism. Therefore, currently this program is the only way to access these services, even for students from families with greater means.

The Subcommittee has requested the DHCS to present this proposal and respond to the following questions:

1. Would these costs shift to school or regional centers?
2. Would all of the children currently in the MTP program continue to have access to MTP services, but with an alternative payment source?
3. Could these children seek full-scope Medi-Cal through "institutional deeming?"
4. How long have the CCS financial eligibility criteria been in law? Are they potentially out of date?

PANEL

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

PUBLIC COMMENT

ISSUE 10: SKILLED NURSING FACILITIES (AB 1629) QUALITY ASSURANCE FEE

The DHCS proposes to eliminate the sunset date for the nursing home quality assurance fee (QAF) program and the rate-setting methodology established under AB 1629 (Statutes of 2004) and thereby, make this program permanent. The QAF program sunsets on July 31, 2013.

If the QAF program and rate-setting methodology sunset dates are not extended, the department will no longer be authorized to assess and collect the QAF and continue paying facility-specific rates to nursing homes. Maintaining the QAF collection offsets General Fund expenditures and can fund rate increases to the skilled nursing facilities. According to the DHCS, if the QAF sunsets, over $400 million in General Fund support could be at risk.

BACKGROUND

AB 1629 (2004) imposes a QAF on skilled nursing facilities and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to certain nursing facilities that support improvement efforts. The Legislature's goal with AB 1629 and the new reimbursement system was that it would result in improvements in individual access to appropriate long-term care services, quality resident care, wages and benefits for nursing home workers, a stable workforce, and provider compliance with all applicable state and federal requirements. Use of QAF revenue has enabled California to provide reimbursement increases to nursing homes with *no* added General Fund support.

Legislative Actions Contained in SB 69 Budget Bill

Both the SB 69 Budget Bill and AB 97, Statutes of 2011 (Health Trailer Bill) conformed to the Governor's January budget to reduce payments by 10 percent to AB 1629 Nursing Facilities effective June 1, 2011.

In addition, this conforming action reduces Pediatric Subacute Care Facilities to 2008-09 levels then further reduces payments by 10 percent effective June 1, 2011.

Summary of the Budget Act of 2010 Actions

Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following *key* components:

- *Rate Adjustments*. Provided for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.

- *Quality & Accountability.* Began to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information. A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be $50.9 million (total funds).

- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of $15,000. This increases to $30,000 for those who are non-compliant from 50 percent or more of audited days.

- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.

- *Expanded the Quality. Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

The administration states that repeated sunsets since the inception of the QAF in 2004 have failed to produce meaningful improvements to the program and therefore it is not necessary to continue to have a sunset. However, the nursing home industry's cooperation and support of this program is integral to its success, and they believe a reasonable sunset ensures them critical opportunities to negotiate changes and improvements to the program. Similarly, in discussions on sunset extensions, consumer advocates have provided substantial contributions on patient safety and quality of care. Currently, discussions are underway between the Administration and stakeholders on the specifics of trailer bill language for moving this program beyond 2013.

STAFF COMMENT / QUESTIONS

The Subcommittee staff has requested the Department to present this proposal and provide an update on discussions with the nursing home industry and other stakeholders on this proposal.

PANEL

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

PUBLIC COMMENT

ISSUE 11: HOSPITAL STABILIZATION FUNDING

The DHCS proposes to redirect $42.8 million in unpaid private and nondesignated public hospitals' stabilization funding for fiscal years 2005-06 through 2009-10 (including the extension period of the Medi-Cal Hospital/Uninsured Demonstration through October 31, 2010) for purposes of General Fund savings.

Additionally, the DHCS proposes to provide the Director of DHCS the authority to utilize a portion of the redirected funding to make payments to hospitals that received Disproportionate Share Hospital (DSH) Replacement underpayments in 2005-06 and 2006-07, if a determination is made that such underpayments occurred.

Finally, the DHCS proposes to continue to exercise its powers received from the California Medical Assistance Commission's (CMAC) dissolution for the years that have not yet been finalized even though the Diagnosis Related Group (DRG) system will be implemented.

BACKGROUND

SB 1100 (Statutes of 2005) established the Medi-Cal Hospital/Uninsured Care Demonstration Project Act which set forth a methodology for distributing the funding made available under the Demonstration. Under SB 1100, additional funding termed "stabilization funding" may be available to private DSH and non-designated public hospitals for the period of the Demonstration Project.

Stabilization payments (STB) cannot be paid out until the DHCS completes the final reconciliation of the hospital workbooks. The reconciliation for 2005-06 is scheduled to be finished in 2011-12 and the reconciliations for 2006-07 and 2007-08 are scheduled to be completed in 2012-13.

Under the 2005 Demonstration Project, private DSH and nondesignated public hospitals were permitted to receive stabilization funding as determined under specific formulas. Most of this funding has not been paid out for the entire Demonstration Period. In December 2009, upon request by private hospitals, an interim STB payment for 2005-06 ($25.5 million) was made to relieve private hospitals' cash crisis.

Hospital Quality Assurance Fee

In 2009, AB 1383 (Statutes of 2009) established the Hospital Quality Assurance Fee (QAF) program and included supplemental payments to all private and nondesignated hospitals up to the available Upper Price Limit (UPL) and provided significant supplemental payments under Medi-Cal managed care. Subsequently, SB 90 (Statutes of 2011) continued the Hospital Quality Assurance Fee program and associated supplemental payments for private hospitals, and AB 113 (Statutes of 2011) instituted an intergovernmental transfer (IGT) program, which funded supplemental payments for nondesignated public hospitals.

These programs have resulted in billions of additional revenue being provided to these hospitals. Given the significant additional funding provided under these QAF and IGT programs, the DHCS believes that redirecting the unpaid stabilization funding is appropriate to achieve General Fund savings without having a significant impact on beneficiary access or on the financial status of the hospitals.

This proposal provides the DHCS the authority to correct underpayments to hospitals, if necessary, without an impact on the General Fund. This proposal is also necessary to allow DHCS to retain the power to finalize payments made with the authority granted to fulfill the responsibilities transferred from the CMAC after the implementation of the DRG system. Without this change, the DHCS would be unable to finalize payments previously handled by the CMAC.

The hospital quality assurance fee and the intergovernmental transfer program have resulted in billions of additional revenue being provided to these hospitals. Please see the table below for the Administration's estimates of the net benefits of these programs in comparison to the proposed loss in stabilization funding.

	4/2009-12/2010	1/2011-6/2011	7/2011-12/2013	Total Net Benefit of QAF and IGT	Proposed Loss in Stabilization Funding
Private Disproportionate Share Hospitals					
Hospital Quality Assurance Fee Net Benefit	$1.3 billion	$600 million	$3.2 billion	$5.1 billion	$107 million
Non-Designated Public Hospitals (District)					
Hospital QAF Net Benefit	$60 million		$46.5 million	$198 million	$2 million
Intergovernmental Transfer (IGT) Program Benefit		$17 million	$75 million		

STAFF COMMENT / QUESTIONS

The Subcommittee staff has asked the Administration to present this proposal.

PANEL

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

PUBLIC COMMENT

ISSUE 12: LEA BILLING OPTION PROPOSED TRAILER BILL

The DHCS proposes trailer bill to: 1) delete the current program sunset date of January 1, 2013, for the program enhancement contracts program under the Local Educational Agency (LEA) Medi-Cal Billing Option (LBO) program; 2) eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs; and 3) remove the maximum annual funding amount of $1.5 million for contractor costs, and instead makes the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee.

The DHCS finds that:

- Eliminating the sunset date clause would reduce the administrative requirements and costs to develop, track, and submit proposed legislation to extend the sunset date.

- Eliminating the baseline requirement prior to funding LBO contract costs would allow DHCS to reduce federal Medicaid payments to fund contractor costs without delay. Not acting could potentially restrict the DHCS from generating sufficient funds to cover all necessary contractor costs. The DHCS must monitor reimbursements to the LEAs to ensure the baseline requirement is met prior to funding contractor costs required for the LBO program.

- Eliminating the maximum annual funding amount of $1.5 million for contractor costs and making the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee would allow sufficient flexibility to accommodate reasonable cost increases associated with contract services. The current cap of $1.5 million has remained static since 2001.

BACKGROUND

California established the LBO program in 1993 to allow school districts to claim federal reimbursement by matching local education dollars already being spent on health services for Medi-Cal children. The DHCS and the California Department of Education (CDE), along with a consortium of private foundations, collaborated to develop the LBO program, which allows LEAs to generate more funds for services provided to California's children.

The DHCS works directly with the LEA Ad Hoc Workgroup Advisory Committee that was organized in 2001 to identify barriers for existing and potential LEA providers and to recommend new LBO program services. Committee members represent urban, rural, large and small school districts, county offices of education, the local education consortium, local educational agencies, and CDE.

In April 2000, the United States Government Accountability Office ranked California in the bottom quartile among states that have school-based Medicaid programs with respect to the amount of its LEA claims per Medicaid-eligible child. In October 2001, SB 231 (Ortiz, Chapter 655, Statutes of 2001) created methods to increase the per-student amount of Medicaid reimbursements received by the State of California through enhancement contracts. According to the DHCS, our federal claiming has doubled since 2001.

The state has maintained one sole-source contract to perform the necessary enhancements that have led to a substantial increase in federal claiming. The contract is for the full $1.5 million and the DHCS states that the contract will be up for renewal in 2012, and the contractor is seeking an increase in the contract amount.

AB 2608 (Bonilla), sponsored by the Los Angeles Unified School District, addresses many of these same issues and is currently awaiting action by the Assembly Appropriations Committee. Specifically, AB 2608:

1) Requires the Department of Health Care Services (DHCS) to amend the Medicaid state plan and regulatory requirements pertaining to the provision of medical transportation services by LEAs to be no more restrictive than federal requirements.

2) Codifies and categorizes funding that can be withheld for administrative, auditing, and contractor costs, requires DHCS to withhold funds proportionately from participating LEAs, and requires DHCS to provide an accounting of funds withheld in an annual report.

3) Requires DHCS to collaborate with the California Department of Education (CDE) to help ensure LEA compliance with state and federal Medicaid requirements.

STAFF COMMENT / QUESTIONS

The Subcommittee has requested DHCS to present this proposal and respond to the following questions:

1. Has DHCS engaged with the LEA Ad Hoc Workgroup Advisory Committee regarding this proposal?

PANEL

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

PUBLIC COMMENT

ISSUE 13: GROSS PREMIUMS TAX ON MANAGED CARE ORGANIZATIONS

The Administration proposes trailer bill language that eliminates the sunset date for the existing gross premiums tax (GPT) imposed on Medi-Cal managed care plans. The Administration estimates that this will generate $161.8 million in General Fund savings in 2012-13 and $259.1 million in General Funds savings in 2013-14. The GPT is expected to generate $352 million in overall revenue, half of which, or about $176 million, will be matched with federal funds to provide for an increase in capitation payments to Medi-Cal managed care plans.

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. The GPT was extended through July 1, 2011 by SB 853 (Statutes of 2010). Subsequently, ABX1 21 (Statutes of 2011) extended the sunset date to July 1, 2012, and included provisions that make 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 are 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 in the Healthy Families Program (serves as a backfill to the General Fund).

AB 1422 requires the State to allocate 38.41 percent of the tax revenue to the DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenues go 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 include: 1) Two Plan Model (Local Initiatives); 2) County Organized Health Systems (COHS); 3) Geographic Managed Care; 4) AIDS Healthcare; and 5) SCAN.

The revenue under the GPT can be expected to increase in 2012-13 and 2013-14 with the transition of Seniors and Persons with Disabilities into managed care, the proposed integration of long term care benefits into managed care, the proposed transition of Healthy Families Children into Medi-Cal, the proposed integration of Federally Qualified Health Center (FQHC) payments into managed care and the expansion of Medi-Cal to childless adults in 2014 (as required by federal health care reform). SB 335 (Statutes of 2011) implemented a new hospital quality assurance fee (QAF) program on hospitals from July 2011 to December 2013. The new QAF program provides for increased payments to managed health care plans, which will increase the total operating revenue of the Medi-Cal managed care plans as well.

The GPT provides a funding source for the Healthy Families Program (HFP) by adding managed care plans to the list of insurers subject to California's GPT of 2.35 percent. The GPT enables the state to draw down federal moneys, allocated according to the federal medical assistance percentage (FMAP), to fund children's health services under the HFP.

STAFF COMMENT / QUESTIONS

The Subcommittee has requested the Administration present this proposal.

PANEL

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

PUBLIC COMMENT

ISSUE 14: VALUE-BASED PURCHASING

The DHCS is proposing trailer bill to establish a process for Value-Based Purchasing in the Medi-Cal fee-for-service (FFS) system. This proposal is estimated to save $75 million General Fund in 2012-13 and annually thereafter. Of the $75 million, $26.6 million is attributable to the savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions (for Medi-Cal managed care), as required by the Affordable Care Act (ACA) (effective July 1, 2012).

BACKGROUND

Currently, the DHCS must use regulations or statute to add, modify, limit, or eliminate reimbursement and services in the Medi-Cal program. For example, the DHCS uses the Medi-Cal Manual of Criteria to define services associated with covered benefits, which is embedded in the California Code of Regulations (CCR). According to DHCS, the regulatory process is time-consuming and ineffective, often taking a year or more for completion. During this processing time, the Medi-Cal program continues to pay for services and utilize payment methodologies that may be ineffective and inefficient. According to the DHCS, due to the intensive staff effort required to promulgate regulations, the last formal regulatory update to the Manual of Criteria was on December 6, 2007.

Value-Based Purchasing is an approach that is commonly used in the private sector by large, self-insured companies, major public entities responsible for health care purchasing, and by purchasing coalitions such as the Pacific Business Group on Health. As such, this proposal seeks to align DHCS with other major health care purchasers. The DHCS states that the Medicare program utilizes a process that encompasses the same key principles as proposed here for Medi-Cal.

Proposal

Under this proposal, the DHCS would implement value-based service design to ensure beneficiary access to necessary health care services by adding services or by identifying and reducing services that do not improve health outcomes, may cause harm to patients, or that are overused and should be provided only under limited conditions. Although this process would allow DHCS to change the way in which providers may deliver services, it would not change the benefits covered under the State Plan.

The proposed value-based service design process encompasses the following:

- Evidence review, which shall include systematic reviews and individual studies published in peer-reviewed literature or evidence-based treatment guidelines issued by organizations whose primary mission is to conduct objective analyses of the effectiveness of medical or evidence-based clinical practice guidelines.

- Determination of fiscal effect by analyzing proposals for the costs and savings associated with adding, modifying, limiting, or eliminating services.

- Feasibility analyses to consider administrative and process issues related to the addition, modification, limitation, or elimination of services, such as the cost and timeframe for computer system changes, the staffing and expertise needed to craft utilization policies that limit inappropriate use of a service without interfering with appropriate use of that same service, and the ability to use utilization management.

Stakeholder Input

Under this proposal, DHCS would inform and consult with stakeholders, including health professionals, Medi-Cal providers, and consumer advocacy organizations for input prior to implementing changes pursuant to the Value-Based Purchasing process. The DHCS would notify stakeholders of proposed changes to targeted services, rate methodologies, and payment policies by regularly updating the Medi-Cal website. Stakeholders would have 30 days to provide written input regarding changes proposed through the Value-Based Purchasing process and, upon request; the DHCS would provide a public meeting to hear their comments. DHCS would respond to stakeholder comments. Implementation of proposed changes would occur no sooner than 30 days from the date the department notifies stakeholders of the proposed changes or 30 days from the date, a public meeting is held.

Outcome Review

DHCS would monitor policy and program changes to ensure that the department obtains the intended results for achieving value regarding clinical quality outcomes, access, and cost effectiveness. Where ongoing monitoring indicates results are not as expected or negative, DHCS would modify the intervention accordingly.

Federal Approval

DHCS states it would not implement changes pursuant to the Value-Based Purchasing process until it obtains any necessary federal approvals. DHCS would implement changes in the development of rate methodologies and payment policies only if they comply with applicable federal Medicaid requirements and if federal financial participation is available.

The DHCS indicates that producing new regulations can take up to 18 months, and in some situations, the department will delay or choose not to start the process due to the time-consuming and resource-intensive nature of it. This proposal would enable the department, per the process described above, to remove coverage of specific procedures without issuing regulations, and make changes to Medi-Cal rates without obtaining statutory authority.

STAFF COMMENT / QUESTIONS

Health care spending continues to increase at a significant rate, but the increased cost is not always accompanied by an increase in the quality of care or value to the consumer. For example, experts estimate that Medicare wastes 20 to 30 percent of its $500 billion in annual expenditures on treatments and procedures that have minimal or no benefit to the patients.

How this process would ensure an appropriate level of input from stakeholders and accountability to the public and Legislature is unclear. Discussions on striking a balance between the ability to be able to respond rapidly to the changing field of health care and the engagement of stakeholders need to continue.

The Subcommittee staff has asked the Department to present this proposal.

PANEL

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

PUBLIC COMMENT