AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY WEBER, CHAIR

MONDAY, FEBRUARY 24, 2014

4:00 P.M. - STATE CAPITOL ROOM 126

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW

Department of Health Care Services (DHCS) Budget

For Fiscal Year 2014-15, the Governor's Budget proposes $76 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, $556 million is budgeted for state operations, while the remaining $75.5 billion is for local assistance. The proposed budget reflects a 4 percent increase over the current year budget.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Thousands)

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
General Fund	**$15,117,724**	**$16,480,591**	**$17,212,283**	**$731,692**	**4.4%**
Federal Fund	27,186,874	42,405,766	45,111,444	2,705,678	6.4
Special Funds &Reimbursements	9,642,847	13,366,133	13,810,225	444,092	3.3
Total Expenditures	**$51,947,445**	**$72,252,490**	**$76,133,952**	**$3,881,462**	**5.4%**
Positions	3,028.0	3,550.2	3,693.3	143.1	4.0

BACKGROUND

The 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. DHCS programs include:

- ***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, low income people with specific diseases, and, as of this year, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level.

- ***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 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: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Us Disorder Services***. As adopted in the 2011 through 2013 Budget Acts, the DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*****.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program and the Prostate Cancer Treatment Program.

DHCS Expansion

Over the past few years, DHCS has undergone a substantial transformation into a much larger department. DHCS has undertaken a massive increase in authority and responsibility in terms of both programs that have been transferred from other departments to DHCS as well as significant new Medi-Cal initiatives, including the following:

- ***Affordable Care Act Implementation***. DHCS is responsible for an array of activities, responsibilities, and functions related to the full implementation of the ACA, the most significant of which is the expansion of the Medi-Cal Program.

- ***Healthy Families Transition***. In 2012 the Governor proposed and the Legislature approved of the transition of all children in the Healthy Families Program to Medi-Cal. Approximately 760,000 children transitioned from Healthy Families to Medi-Cal in 2013. This transition is complete.

- ***Coordinated Care Initiative (CCI)***. In 2012, the Governor proposed and the Legislature approved of the CCI to integrate care for "dual eligibles" (in Medicare and Medi-Cal), involving the creation of an entirely new way to provide care to this population. DHCS has begun implementing the CCI, and dual-eligibles can begin being enrolled no sooner than April 1, 2014.

- **Seniors & Persons with Disabilities**. In 2011-12, DHCS transitioned 350,000 seniors and persons with disabilities into managed care, from fee-for-service Medi-Cal.

- ***Rural Managed Care***. In 2012, the Governor proposed and the Legislature approved of providing DHCS authority to seek out and establish contracts with managed care organizations to serve Medi-Cal beneficiaries in California's still-fee-for-service, primarily rural counties. DHCS selected Anthem Blue Cross, California Health and Wellness Plan, and Partnership Health Plan of California to serve these rural counties.

- ***Community Mental Health Care***. The 2011-12 budget package moved Medi-Cal mental health programs, and the 2012-13 budget package moved several non-Medi-Cal community mental health programs, from the former Department of Mental Health to DHCS.

- ***Substance Use Disorder Treatment Services***. The 2011-12 budget package moved Drug Medi-Cal from the Department of Alcohol and Drug Programs (DADP) to DHCS, and the 2013 budget approved of the transition of the remaining non-Medi-Cal DADP programs to DHCS.

- ***Direct Services from the Department of Public Health (DPH)***. The 2012 budget approved of the Governor's proposal to move the Every Woman Counts, Family Planning Access Care and Treatment, and Prostate Cancer Treatment Programs from DPH to DHCS.

The DHCS has included many resource requests in the proposed 2014-15 budget, several of which are covered later in this agenda. Altogether, the DHCS proposals would add approximately 170.5 positions, the most significant of which are for implementation of the county true-up mechanism for capturing county ACA-related savings, modernization of the Medi-Cal Eligibility Data System (MEDS), ACA enrollment and recertification of Medi-Cal drug treatment providers, and implementation of enhanced mental health and drug treatment services. These 170.5 positions are comprised of new permanent positions, new limited-term positions, extensions of existing limited-term positions, and conversions from contracted or limited-term positions to permanent positions.

Fiscal Crisis Reductions

Since 2008, approximately $7.2 billion in cuts to the Medi-Cal program were approved through the state budgets, as shown in the following table:

Fiscal Year	Approved Reduction to Medi-Cal
2008-09	$737,000,000
2009-10	$1,977,000,000
2010-11	$1,112,000,000
2011-12	$1,932,000,000
2012-13	$1,472,000,000
TOTAL	**$7,230,000,000**

STAFF COMMENTS/QUESTIONS

DHCS has experienced enormous growth and change over the past few years, coupled with significant funding reductions and constraints. The Subcommittee would like DHCS to respond to the following:

1. Please provide an overview of the department, its various programs and functions, its basic organization, and the proposed budget for the department.

2. Please describe the reductions that were taken out of necessity during the state's most recent fiscal crisis.

3. Please explain how the Medi-Cal program has absorbed an approximately $7 billion reduction since 2008. In what ways has the program suffered, and are there ways in which it has improved?

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

ISSUE 2: FAMILY HEALTH ESTIMATE

The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Children's Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts. The costs of these programs specific to Medi-Cal enrollees are captured in the Medi-Cal estimate. As described below, the Administration is not proposing any substantial policy or fiscal changes to these four programs, although a substantial reduction in CCS reflects the transition of children from Healthy Families to Medi-Cal.

The overall Family Health Estimate shows a projected 3.7 percent decrease in funding in the proposed budget year, compared to the estimate for the current year. This decrease results from a decrease in costs in the CCS program, which reflects the transition of children from Healthy Families to Medi-Cal.

Family Health Estimate
2013-14 and 2014-15

Program	Budget Act 2013-14	Projected 2013-14	Proposed 2014-15	CY to BY $ Change	CY to BY % Change
CCS	$118,910,000	$131,966,000	$93,874,000	($38,092,000)	(29%)
CHDP	1,795,000	1,767,000	1,811,000	44,000	2.5%
GHPP	110,741,000	101,497,000	122,333,000	20,836,000	20.5%
EWC	52,619,000	52,696,000	59,142,000	6,446,000	12.2%
TOTAL	**$284,065,000**	**$287,926,000**	**$277,160,000**	**($10,766,000)**	**(3.7%)**

Many state programs, such as these, are likely to experience declining enrollment as a result of full implementation of the Affordable Care Act, with increasing numbers of individuals gaining comprehensive coverage through either Medi-Cal or the Exchange. Nevertheless, the Family Health Estimate does not account for this expected decline in caseload. The administration explains that there is still insufficient data to be able to accurately predict future caseload shifts and declines in many state programs, and therefore plans to analyze such data in the fall of 2014 and include such estimates in the November 2014 budget estimates.

BACKGROUND

California Children's Services (CCS)

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who

are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate. Therefore, a reduction in costs associated with the decreasing number of children in the Healthy Families Program can be seen as an equivalent increase in CCS costs within the Medi-Cal budget.

The CCS program is administered as a partnership between county health departments and the DHCS. Historically, approximately 70 percent of CCS-eligible children were Medi-Cal eligible; their care is paid for with state-federal matching Medicaid funds. The cost of care for the other 30 percent of children had been split equally between "CCS Only" and "CCS Healthy Families." The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

CCS Budget

Excluding Medi-Cal costs, the proposed 2014-15 CCS budget includes total funds (TF) of $93.9 million (including $17 million GF), as compared to the current year (2013-14) estimate of $132 million TF ($12.4 million GF). This $38 million reduction primarily reflects the transition of approximately 760,000 children from Healthy Families to Medi-Cal. Therefore, this is not a savings for the state, but rather a cost shift from the CCS Healthy Families program to CCS Medi-Cal. Therefore, the Medi-Cal estimate includes an equivalent increase in cost (as the state continues to receive 65 percent FFP and 17.5 percent county funding for this population).

Non-Medi-Cal CCS Budget		
	2013-14	**2014-15**
CCS Only	$90,022,000	$92,916,000
CCS Healthy Families	$41,944,000	$958,000
TOTAL	**$131,966,000**	**$93,874,000**
Federal Funds	$119,594,000	$76,860,400
General Fund	$12,371,000	$17,013,600
Non Medi-Cal Caseload	20,271	19,754
Medi-Cal Caseload	159,922	163,115

2013-14 CCS Estimate Adjustments:

- The November 2013 estimate for the current fiscal year assumes lower expenditures due to: 1) An inpatient reimbursement methodology change has been incorporated into the CCS Treatment Base expenditures; and 2) base expenditures have been lower than previously estimated.

- The November 2013 estimate reflects an additional two months of expenditures due to a two-month delay in the Healthy Families Transition to Medi-Cal.

2014-15 CCS Estimate Adjustments

- The November 2013 estimate for 2014-15 assumes that all Healthy Families children will have been transitioned to Medi-Cal, and only residual expenditures are to be paid in the budget year.

- Due to a reduction of General Fund in the program, a corresponding reduction of $11.7 million federal matching funds is assumed.

CCS Carve Out

For many years, the CCS program has operated as a managed care "carve out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve out was approved through AB 301 (Pan) Chapter 460, Statutes of 2011, which extended the sunset on the carve out until January 1, 2016. DHCS indicates that although the administration did not include a specific proposal in this year's budget, they believe that the program would greatly benefit from various reforms. DHCS states that these reforms would not necessarily transition the program to a managed care benefit, however the program would be operated within the framework of an "organized delivery system." DHCS states that a great deal of confusion results from the current program organization, given that children must leave their managed care networks in order to receive CCS services and it becomes somewhat unclear if the state or the managed care organization holds fiscal responsibility for these services.

Children's Health & Disability Program (CHDP)

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

CHDP Budget

The proposed CHDP budget includes $1,800,000 total funds ($1.8 million General Fund), as compared to the current year estimate of $1.76 million ($1.75 million General Fund). The program also receives $11,000 in Childhood Lead Poisoning Prevention Funds to cover the cost of blood tests for lead.

Genetically Handicapped Person's Program (GHPP)

SB 2265 (Statutes of 1975) established the GHPP to provide medical care for individuals with specific genetically handicapping conditions. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP
Average Monthly Caseload

	2013-14	2014-15
GHPP State Only	967	987
GHPP Medi-Cal	723	755
TOTAL	**1,690**	**1,742**

GHPP Budget

The proposed 2014-15 GHPP budget includes total funds of $122.3 million ($63.6 million General Fund), compared to the 2013-14 estimate of $101.5 million ($17.3 million General Fund). This $20.8 million (20.5 percent) increase reflects the following estimate adjustments:

2013-14 GHPP Estimate Adjustments:

- The 2013-14 appropriation included one-time funding from the balance of the Special Rebate Funds; however the November 2013 estimate anticipates $5.2 million of this amount will not be received in time to offset General Fund in the program.

- As anticipated, restitution of $10.4 million was received from the USA v. Bio-Med lawsuit, offsetting General Fund.

2014-15 GHPP Estimate Adjustments:

- GHPP base treatment costs are expected to increase by $10.98 million General Fund due to growth in expenditures.

- The 2013-14 appropriation included a one-time fund shift of a balance of $26.98 million in Special Rebate Funds to provide General Fund relief. The 2014-15 estimate assumes the rebates will return to the normal annual level.

- The 2013-14 budget included restitution of $10.4 million from the UA v. Bio-Med Lawsuit, which provided a one-time General Fund relief.

Every Woman Counts (EWC)

The EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage. The EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC Budget

The proposed 2014-15 budget includes $59.1 million total funds ($21.4 million General Fund) for EWC, a $6.4 million (12%) increase over the 2013-14 estimate of $52.7 million ($18 million General Fund), which primarily reflects a full year of digital Mammography costs, as compared to only a half year in 2013-14.

2013-14 EWC Estimate Adjustments:

- Base costs are expected to grow by $77,000.

2014-15 EWC Estimate Adjustments:

- Base costs are expected to increase by $2.25 million General Fund due to growth in expenditures.

- Digital Mammography reimbursement became effective January 1, 2014, thereby increasing costs for half of the current fiscal year and the full budget year.

STAFF COMMENTS/QUESTIONS

The Subcommittee would like DHCS to respond to the following:

1. Please provide a brief overview of the Family Health Estimate and each of its programs.

2. Please describe the department's plans for reforming the CCS program. Specifically, please explain the need to reform or reorganize the program.

Staff Recommendation: This item should be held open pending updates and changes at May Revise.

ISSUE 3: EVERY WOMAN COUNTS CONTRACT STAFF CONVERSION (BD14-01) BCP

DHCS requests 4.0 2-year limited-term positions to replace existing contract staff in the Every Woman Counts (EWC) Program in order to comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants. DHCS expects this proposal to result in savings of $143,000 federal funds.

BACKGROUND

The EWC is funded through a combination of tobacco tax revenue, General Fund, and federal Centers for Disease Control (CDC) grant. The CDC grant requires the program to monitor the quality of screening procedures, and therefore the program collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal. This recipient data is then reported to CDC biannually and assessed for outcomes to determine if outcomes meet performance indicators, such as the number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment.

The existing contract positions are responsible for performing core program performance activities associated with the federal grant deliverables and data analyses to support the development and completion of the Annual report to the Legislature required under the Revenue and Tax Code 3046.6(f). These positions provide semi-annual estimates, quarterly reports on caseload, program expenditures and program monitoring, as required by SB 853 (Committee on Budget & Fiscal Review), Chapter 717, Statutes of 2010. Currently, DHCS contracts with the University of California, Davis, to provide contract staff to perform these federally mandated data collection and reporting activities.

DHCS proposes to acquire the following positions for this purpose:

- Associate Governmental Program Analysts (2.0)
- Associate Information Systems Analyst (1.0)
- Research Scientist Supervisor II (1.0)

To fill these positions, DHCS intends to hire the same individuals who currently are employed as the contracted staff to do this work, thereby ensuring the availability of qualified individuals to fill these positions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to please briefly present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.

ISSUE 4: MEDI-CAL ESTIMATE

Proposed 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 proposed 2014-15 Medi-Cal local assistance budget is about 5 percent greater than the estimated 2013-14 budget.

Medi-Cal Funding Summary *(Dollars In Millions)*	2013-14 Estimate	2014-15 Proposed	BY to CY $ Change	% Change
General Fund	**$16,229.9**	**$16,899.5**	**$669.6**	**4.1%**
Federal Funds	43,631.3	45,752.5	2,121.3	4.9
Other Funds	9,816.7	10,854.5	1,037.8	10.6
Total Local Assistance	**$69,677.7**	**$73,506.4**	**$3,828.7**	**5.5%**
Medical Care Services	65,641.0	69,725.3	4,084.3	6.2
County Administration (Eligibility)	3,622.5	3,361.9	(260.6)	(7.2)
Fiscal Intermediary (Claims Processing)	414.3	419.3	5.0	1.2

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 48-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. 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 for 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 this year, the federal Affordable Care Act (ACA) will support the expansion of 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 138 percent of the Federal Poverty Level. This expansion is estimated to increase Medi-Cal enrollment by 1.4 million Californians by 2019.

Significant Estimate Adjustments

The major budget adjustments include the following:

2013-14 Medi-Cal Estimate Adjustments:

The November 2013 Estimate for the current year (2013-14) is $136.2 million General Fund greater than the 2013-14 Budget due to all of the following:

- Affordable Care Act (ACA) Expansion
- Other ACA Items
- Managed Care Model
- Coordinated Care Initiative
- Managed Care Organization Tax
- 1% FMAP Increase for Preventive Services
- Provider Rate Reductions
- Hospital Quality Assurance Fee
- Retroactive Managed Care Rate Adjustments
- Restoration of Selected Adult Dental Benefits
- Drug Rebates
- General Fund Reimbursement from Designated Public Hospitals
- County Administration
- Enhanced Federal Funding for County Administration
- Payment to Primary Care Physicians
- Drug Medi-Cal
- Women's Health Services
- Managed Care Expansion to Rural Counties
- Mental Health Services Expansion

2014-15 Estimate Adjustments:

The 2014-15 budget proposes General Fund costs that are $669.6 million (4 percent) greater than for 2013-14, due to the following:

- Health Insurer Fee
- County Administration
- MCO Supplemental Drug Rebates

Medi-Cal Caseload

DHCS estimates baseline caseload to be approximately 7.7 million average monthly enrollees in 2013-14 and 7.8 million in 2014-15, a one percent increase.

Reflecting implementation of the ACA, DHCS estimates a nearly 1.5 million increase in average monthly enrollees in 2014-15.

LAO Concerns:

The LAO raises concerns about just one aspect of the caseload estimate, which is specific to the Targeted Low Income Children's Program (TLICP), a new program created to receive the children transitioning into Medi-Cal from the former Healthy Families Program (HFP). Most recently, and for several years, the HFP had a caseload of approximately 850,000. All of the caseload has been transitioned to Medi-Cal, however the administration reported recently that only approximately 760,000 formerly HFP children are now enrolled in Medi-Cal, and it remains unclear what has happened to approximately 90,000 children. In contrast, the estimate projects 995,000 in the TLICP, which is the source of LAO's concern. This represents a nearly 17 percent increase in caseload over a two-year period. LAO states that the administration attributes this increase to the improving economy, resulting in family incomes rising and leading to children moving from the main Medi-Cal program into this higher income program. LAO questions this reasoning and raises doubts that the economic recovery would have this effect.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes in 2014-15.

The Subcommittee requests DHCS to explain the TLICP caseload projections, and respond to the LAO's concerns. Related to this issue, please explain what happened to 90,000 HFP children who did not transition to Medi-Cal.

Staff Recommendation: This item should be held open pending updates and changes at May Revise.

ISSUE 5: MEDI-CAL PROVIDER RATES

AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, requires DHCS to implement a 10 percent Medi-Cal provider payment reduction starting June 1, 2011. The Governor's budget continues these payment reductions and recognizes $489 million ($244.5 million General Fund) in ongoing annual savings and $76.6 million ($38.3 million General Fund) in savings from the recoupment of certain retroactive reductions (that are not forgiven, as discussed below) in 2014-15.

January Budget Proposal

The proposed budget forgives certain retroactive provider payment reductions for physicians/clinics, specialty drugs, dental, intermediate care facilities for the developmentally disabled (ICF/DDs), and medical transportation.

This results in an $11.6 million ($5.8 million General Fund) increase in 2013-14 and a $72.6 million ($36.3 million General Fund) increase in 2014-15. The total cost of these recoupments is $434.2 million ($217.1 million General Fund), which will be forgiven over the next several years. The Administration finds that implementation of both the retrospective and prospective reduction for these provider types would have a negative impact on access to these services for Medi-Cal enrollees. See table below for a summary.

The Administration indicates that federal CMS has no concerns with the proposal to forgive retroactive obligations and has provided guidance on the ability to draw down federal funds to help pay (based on a 50:50 split) for this proposal. Previously, the Administration indicated the federal funds would not be available to address retroactive reductions and consequently would have been all General Fund.

Managed Care Rates – The 2013 budget included $267.5 million ($133.8 million General Fund) in ongoing annual savings from this rate reduction on managed care rates. The Governor's 2014-15 budget only includes $134.2 million ($67.1 million General Fund) in ongoing annual savings from implementation of this reduction on managed care plans.

PANEL 1

- Debbie Toth, Chief Executive Officer, Rehabilitation Services of Northern California
- Linda Trowbridge, Chief Executive Officer, Center for Elders Independence
- Nathan Allen, M.D., California Medical Association, Network of Ethnic Physician Organizations
- John L. Blake, DDS, Executive Director/Dental Director, Children's Dental Health Clinic
- Linda Mefford, Senior Administrator Director, Bruceville Terrace, Methodist Hospital, Dignity Health, on behalf of California Hospital Association
- Eammon Casey, Regional Vice President, Numotion

PANEL 2

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

BACKGROUND

AB 97 Rate Reductions

As a result of the state's fiscal crisis, AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, requires DHCS to implement a 10 percent Medi-Cal provider payment reduction starting June 1, 2011. This 10 percent rate reduction applies to nearly all providers with certain exemptions. The providers and services exempted by AB 97, or by DHCS due to access concerns, include: distinct part adult subacute, distinct part pediatric subacute, hospital inpatient, hospital outpatient, critical access hospitals, federal rural referral centers, federally qualified health centers, rural health clinics, services provided by the Breast and Cervical Cancer Treatment program, Family Planning, Access, Care, and Treatment program, hospice services, payments funded by intergovernmental transfers and certified public expenditures, In-Home Supportive Services, and Pediatric day health centers. Other provider types have a varied implementation of the 10 percent rate reduction. For example, not all Intermediate Care Facility/Developmentally Disabled (ICF/DD) providers receive a 10 percent rate reduction, reflecting the fact that a calculation based on cost data is performed each year to determine which ICF/DD facilities receive the reduction. AB 97 also requires the 10 percent rate reduction for distinct part skilled nursing facilities to apply to the rates that were in effect in 2008-09 and freezes rates for rural swing beds to the 2008-09 level.

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

Court Injunctions. After CMS approval of the rate reductions, a U.S. District Court issued preliminary injunctions preventing DHCS from implementing most of the provider payment reductions. On December 13, 2012, a Ninth Circuit Court of Appeals panel reversed the district court's decisions, thereby allowing the rate reductions to proceed.

Retroactive Savings. Federal approval of the AB 97 rate reductions was obtained in October 2011; however, since the state had been prevented from implementing most of these rate reductions due to court injunctions, there is a retroactive period of savings (generally from June 1, 2011 to present) in addition to the ongoing out-year savings achieved by these rate reductions. The total amount of fee-for-service savings projected to be recouped in 2013 was $998.6 million from the retroactive period. Last year, DHCS explained that federal CMS regulations require that the state pay providers "using rates determined in accordance with the methods and standards specified in an approved State plan" (42 C.F.R. §447.253(i)) and since this reduction is specified in the approved State plan, the state is obligated to pay this rate or would have to use state funds to make up the difference. Generally, DHCS has proposed to recoup the retroactive savings over a 24-month period.

Key Changes in 2013. In August 2013, DHCS released an AB 97 implementation plan and timeline, which announced the following three exemptions:

- Distinct Part Nursing Facilities (DP/NFs) – On a prospective basis, DHCS exempted rural DP/NFs as of September 1, 2013 based on access and SB 239 (Hernandez and Steinberg), Chapter 657, Statues of 2013 exempted all DP/NFs from these prospective reductions as of October 1, 2013. The 2013 budget included $38.2 million ($19.1 million General Fund) in ongoing annual savings from this reduction. The proposed budget does not include any ongoing savings from DP/NFs.

- Pediatric Dental Surgery Centers (for profit and nonprofit) – DHCS exempted most nonprofit dental pediatric surgery centers effective September 1, 2013; and most for-profit dental pediatric surgery centers effective December 1, 2013.

- Certain Prescription Drugs – The budget includes the implementation of the exemption of certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions. The 2013 budget included $271.9 million ($135.9 million General Fund) in ongoing annual savings from pharmacy, whereas, the proposed budget only includes $113.7 million ($56.8 million General Fund) in ongoing annual savings from the implementation of this reduction. On March 30, 2012, DHCS submitted a State Plan Amendment to the federal CMS for this change and it is still pending CMS approval.

AB 97 Payment Reductions
(Total Fund)

Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-Going Annual Savings	Nov. 2013 Estimated Savings from AB 97 Reduction (1) (2)			
				FY 2013-14		FY 2014-15	
				On Going	Retro	On Going	Retro
Nursing Facilities - Level A	6/1/11-6/30/12	$245,754	$253,544	$253,544	$122,877	$253,544	$20,480
ICF/DDs	8/1/12-10/31/13	$0	$17,404,975	$11,603,317	$0	$17,404,975	$0
ICF/DD-Habilitative	8/1/12-10/31/13						
ICF/DD-Nursing	8/1/12-10/31/13						
FS Pediatric Subacute	Exempt						
AB 1629 Facilities (3)	N/A						
DP/NF-B	6/1/11-9/30/13	$83,437,273					$15,170,413
Phase 1 Providers (4)	6/1/11-12/20/11	$28,753,171	$61,951,000	$55,208,892	$14,376,585	$56,136,663	$0
Physician 21 yrs+	6/1/11-1/9/14	$0	$49,746,144	$24,873,072	$0	$49,746,144	$0
Medical Transportation	6/1/11-9/4/13	$0	$14,461,310	$12,051,092	$0	$14,461,310	$0
Medical Supplies and DME	6/1/11-10/23/13	$39,427,840	$17,393,988	$11,595,992	$1,251,677	$17,393,988	$7,510,065
Dental	6/1/11-9/4/13	$0	$64,733,864	$35,451,470	$0	$64,733,864	$0
Clinics	6/1/11-1/9/14	$0	$18,511,701	$9,255,850	$0	$18,511,701	$0
Pharmacy	6/1/11-2/6/14	$296,621,286	$113,717,663	$47,382,359	$0	$113,717,663	$53,931,143
Phase 3 Providers	6/1/11-10/31/13	$0	$2,414,050	$1,609,367	$0	$2,414,050	$0
Managed Care			$134,234,574	$100,675,930	$0	$134,234,574	$0
Grand Total		**$448,485,324**		**$309,960,885**	**$15,751,139**	**$489,008,476**	**$76,632,101**

STAFF COMMENTS/QUESTIONS

Medi-Cal rates, and the corresponding issue of sufficient access to services, are of great concern to a great number of providers, stakeholders, and advocates. The administration has provided various exemptions to specific providers or services, stating that they have reason to believe that access may be unreasonably compromised for these specific providers. However, there is widespread concern that access throughout the Medi-Cal program is inadequate, or at least could be much improved. There are also considerable concerns and doubts about the validity of the administrations access monitoring process.

The Subcommittee requests DHCS to respond to the following:

1. Please provide a comparison of Medi-Cal's rates to those of other states (particularly larger and higher-cost states).

2. Please describe the department's access monitoring process, and evidence of its accuracy. What definition does the department use for sufficient access?

3. Would the federal government allow California to forgive more components of the retroactive reductions than what is included in the Governor's budget?

Staff Recommendation: Staff recommends holding this item open pending further discussions with the administration and stakeholders.

ISSUE 6: PEDIATRIC DENTAL OUTREACH

The proposed 2014-15 budget includes $17.5 million (Proposition 10 funds provided by the California Children and Families Commission) to increase dental care outreach activities for children ages zero to three years. Specifically, DHCS proposes to identify beneficiaries who are ages 0-3, during their birth months, that have not had a dental visit during the past 12 months, and mail parents/legal guardians a letter that: 1) encourages them to take their children to see a dental provider; and 2) provides educational information about the importance of early dental visits.

BACKGROUND

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 managed care for dental services. Los Angeles County utilizes both fee-for-service and managed care for the provision of dental services; however, enrollment in managed care is done on a voluntary basis, and about 15 percent of Medi-Cal recipients in Los Angeles enroll in a dental managed care plan.

Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services 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).

State Oversight of Dental Managed Care

The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) share oversight of managed care plans in the state. Both departments have the statutory authority to conduct quality reviews. 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, 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.

Historically, both departments have utilized these monitoring tools only on medical plans, by and large ignoring the operations of dental plans, despite dental plans also being licensed under Knox-Keene. Dental plans were not required to submit annual reports on timely access as required of medical plans. DMHC indicated in the past that their primary tool for becoming aware of problems with any managed care plan, of any type, was through their consumer complaint data.

First 5 Report on Sacramento's Geographic Managed Care

In 2010, First 5 of Sacramento commissioned the "Sacramento Deserves Better" report, produced by Barbara Aved Associates, which analyzed access, utilization, and quality of dental care under Sacramento's Geographic Managed Care (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 a "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.

Early in 2012, through a series of articles and editorials, the *Sacramento Bee* brought attention to the dire conditions of Sacramento County's pediatric dental managed care program. The *Bee* coverage focused on the findings of the report commissioned by First 5 of Sacramento, which revealed shockingly low utilization rates and highlighted a series of examples of specific children who had been in desperate need of dental care, yet unable to access the care they needed without significant delays, worsening conditions, prolonged pain, and a significant amount of fear, frustration, and relentless advocacy on the part of their parents.

DHCS Response and Action

In response, the DHCS has undertaken a substantial corrective action plan for dental managed care, with a focus on Sacramento's GMC. The DHCS actions in 2012 included:

- 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 immediate expectations and necessary improvements;

- Convened a stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA), which is used as the basis for contracting with Dental Plans;

- Communicated with beneficiaries by: 1) letter on the importance of dental care as well as on how to access care; and, 2) by phone with beneficiaries who have not accessed care in the past 12 months;

- Began collecting utilization data from plans which the department shares with the stakeholder group;

- Increased monitoring of plans and providers based on data that indicates low utilization rates;

- Implemented a beneficiary dental exception process, per 2012 budget trailer bill (summarized below); and,

- Implemented changes to all dental plan contracts, including adoption of all Healthy Families Program HEDIS measures.

2012 Budget Trailer Bill

Also in response to the First 5 report, subsequent press coverage, legislative hearings and stakeholder input, provisions to address the shortcomings of dental managed care were included in AB 1467 (Committee on Budget) Chapter 23, Statutes of 2012, budget. This bill includes the following key provisions:

- *Sacramento Stakeholder Advisory Committee*. The bill allows Sacramento County to establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care. It authorizes the advisory committee to provide input to the DHCS and to the Sacramento County Board of Supervisors. Requires DHCS and the Sacramento County Department of Health and Human Services advisory committee to meet with this advisory committee.

- *Beneficiary Dental Exception*. The bill authorizes the Director of DHCS to establish a beneficiary dental exception (BDE) process in which Medi-Cal beneficiaries who are mandatorily enrolled in dental health plans in Sacramento County can move to fee-for-service Denti-Cal. The BDE is to be available to beneficiaries in Sacramento who are unable to secure access to services through their managed care plan, within time-frames established within state contracts and state law.

- *Dental Plan Performance Measures*. The bill requires DHCS to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

The bill also requires DHCS to designate an external quality review organization to conduct external quality reviews for all dental health plan contracting.

- *Dental Plan Marketing and Information*. The bill requires each dental plan to submit its marketing plan; member services procedures, beneficiary informational materials, and provider compensation agreements to DHCS for review and approval.

- *Annual Reports*. The bill requires DHCS to submit annual reports to the Legislature, beginning March 15, 2013, on dental managed care in Sacramento and Los Angeles, including changes and improvements implemented to increase Medi-Cal beneficiary access to dental care. The bill also requires the DMHC to provide the Legislature, by January 1, 2013, its final report on surveys conducted and contractual requirements for the dental plans participating in Sacramento.

- *Amendments to Contracts*. Requires DHCS to amend contracts, upon enactment of the statute, with dental health plans to reflect and meet the requirements of this new statute.

Study on Fee-for-Service

In 2012, dental health plans contracted with Barbara Aved Associates (the author of the managed care study) to conduct research on Medi-Cal's fee-for-service dental care. The study found, in part, that: 1) 97 percent of non-participating dentists cited low reimbursement rates as the reason for not participating; 2) 90 percent of general dentists said it was somewhat or very difficult to find a pediatric dentists accepting Medi-Cal referrals; and, 3) 38 percent of general dentists and 69 percent of pediatric dentists who take Medi-Cal have 15 percent or less of their patient population in Medi-Cal. The author concludes that children in Medi-Cal are getting inadequate dental care, largely due to insufficient provider participation, reflecting low reimbursement rates. The author recommends: 1) streamlining the provider enrollment process; 2) increasing rates; 3) adopting more quality measures; 4) increasing monitoring of utilization data; and, 5) increasing public oral health education to families.

DHCS March 2013 Report

On April 5, 2013, DHCS submitted a follow-up report to the Legislature on their efforts to improve the Dental Managed Care program. The report cites a substantial increase in dental care utilization rates in the program, from 2011 to 2012. Specifically, DHCS finds an "Increase of plans' utilization rates in Sacramento County from 32.3 percent in 2011, to 43.7 percent in 2012, and in Los Angeles County from 24.6 percent in 2011, to 36.8 percent in 2012." The report lists the following actions that DHCS has taken over the past approximately two years to improve dental managed care:

- DHCS implemented the Immediate Action Expectations (IAE), which has resulted in the submission of monthly reporting to DHCS to compile and publish reports to the public.

- Implementation of the Beneficiary Dental Exemption (BDE) process, has allowed the staff to assist and manage these special needs cases until the rendering provider completes the necessary services.

- Conducting stakeholder and all plan meetings, to collaborate on dental issues, have become a component in improving the program.

- Assembly Bill 1467 (Committee on Budget), Chapter 23, Statutes of 2012 was enacted July 1, 2012, to improve requirements of DMC and amend Welfare and Institutions (W&I) Codes.

- Since IAE was implemented in March and April of 2012, the dental plans have realized higher utilization increases in the second half of the year. Utilization is expected to continue to increase in 2013.

- The DMC Contract procurement process was changed from a Request for Application to a Request for Proposal, which allowed DHCS to award contracts to plans demonstrating an ability to meet DHCS' goals and objectives, resulting in improved delivery of services in DMC.

- DMHC in conjunction with DHCS conducted non-routine surveys on most of the Sacramento County dental plans, and noted Knox-Keene deficiencies and contract findings

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the following:

1. Please provide an update on improvements to pediatric dental care, both managed care and fee-for-services.

2. Please provide the most up-to-date utilization numbers, statewide, for both managed care and fee-for-service.

3. Please present this proposal and describe any evidence that the proposed letters to families would be an effective health education tool.

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.

ISSUE 7: SUBSTANCE USE DISORDER SERVICES

The Drug Medi-Cal (DMC) program, which provides substance use disorder treatment services to individuals enrolled in Medi-Cal, was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS in 2011. The proposed 2014-15 budget reflects a $134.3 million (52 percent) increase over the current year budget with total funds of $392 million as compared to the current year total funds of $258 million. This substantial increase reflects the increased costs of the enhanced benefits that were adopted as a component of the ACA implementation legislation in 2013. As described in more detail below, the Administration is proposing the following two significant policy changes specific to DMC:

1. Increased staffing for recertifying providers in response to provider fraud; and

2. DHCS's intent to propose a waiver in order to operate the program differently.

BACKGROUND

DADP contracts with counties and direct service providers for the provision of DMC. County participation in DMC is optional, and counties may elect to provide services directly or to subcontract with providers for these services. All but approximately 15 California counties currently maintain a program. If a county chooses to not participate in DMC and a certified provider within that county indicates a desire to provide these services, DADP currently executes a service contract with the county and provider for the provision of these services. The DMC covers the following services:

- **Day Care Rehabilitation Treatment** - Minimum of three hours per day, three days per week, for EPSDT-eligible beneficiaries and pregnant and postpartum women only.

- **Outpatient Drug Free Services** – Individual counseling for 50-minute minimum or group counseling for 90-minute sessions.

- **Perinatal Residential Substance Abuse Treatment** – 24-hour structured environment, excluding room and board, for pregnant and postpartum women.

- **Naltrexone Treatment Services** – Face-to-face contact per calendar day for counseling and/or medication services.

- **Narcotic Treatment Services** – Core services (intake assessment, treatment planning, physical evaluation, drug screening, and physician supervision), laboratory work (tuberculin and syphilis tests, monthly drug screening, and pregnancy tests for certain patients), and dosing (ingredients and dosing for methadone and other patients).

Medi-Cal Managed Care plans exclude from their contracts all services available under the DMC Program as well as outpatient drug therapies that are listed in the Medi-Cal Provider Manual as alcohol and substance abuse treatment drugs and that are reimbursed through the Medi-Cal fee-for-service program.

DMC Budget

As stated above, the proposed 2014-15 budget reflects a significant increase from the current year budget with total funds of $392,202,000 as compared to the current year total funds of $257,814,000. This increase represents the increased costs, from a half year to a full year, of the enhanced benefits that were approved through implementation of the ACA in 2013.

Drug Medi-Cal Budget
(Dollars In Thousands)

	2013-14 Estimate	2014-15 Proposed	CY to BY $ Change	CY to BY % Change	2014-15 Caseload
Narcotic Treatment Program	$110,381	$112,301	$1,920	1.7%	80,792
Residential Substance Abuse Services	55,039	131,111	76,072	138%	25,461
Outpatient Drug Free Treatment Services	73,036	81,250	8,214	11%	83,794
Intensive Outpatient Services	44,979	76,065	31,086	69%	46,010
Provider Fraud Impact	(29,300)	(29,300)	0	0%	--
Cost Settlement	3,429	3,429	0	0%	--
Annual Rate Adjustment	--	(5,033)	(5,033)	--	--
County Administration	--	22,129	22,129	--	--
3rd Party Validation of Certified Providers	250	250	0	0%	--
TOTAL	**$257,814**	**$392,202**	**$134,388**	**52%**	**236,057**

Provider Fraud

In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. The investigative report alleged that, over the past two fiscal years, the DMC program paid $94 million to 56 drug and alcohol rehabilitation clinics in Southern California that have shown signs of deceptive or questionable billing. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services. The allegations included the following:

- Busing of teenagers without drug problems from group homes;
- Fabricating patient treatment documents;
- Paying clients amounts between $5 and $40 for showing up to counseling;
- Counselors leaving in mid-session and allowing clients to spend counseling time chatting amongst themselves;
- Billing for patients who were incarcerated or dead;

- Billing for group counseling for dozens of clients on a day when clinic staff told reporters that no group counseling was offered;
- Billing for counseling 179 clients on a day when reporters staked out the clinic and documented fewer than 30 people entering and leaving;
- Billing for patients who did not show up to counseling sessions;
- Billing for pizza parties and basketball games as though they were counseling sessions;
- Billing for sessions when counselors were off work or at lunch; and,
- Filling out records of counseling sessions before they occur.

The reports suggested that the state's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

In July and August 2013, the DHCS ordered temporary suspensions against 48 alcohol and drug treatment programs at 132 sites where DHCS established credible allegations of fraud. According to the DHCS, these actions were the first phase of an ongoing review of the DMC program by the department's Audits and Investigations (A&I) Division. Since then, the DHCS has implemented a process requiring all DMC providers to become recertified in order to continue to participate in the program. Thus far, 68 providers, operating over 200 clinics, have been suspended and referred to the Department of Justice. In phase three of the recertifications, 196 providers have been decertified for failing to submit all of the required paperwork. DHCS states that 100 percent of the applications were incomplete in some way, and the department will be offering webinars and other types of assistance to providers in order to help them achieve recertification. The DHCS also will be conducting field reviews of all facilities in March and April.

The DHCS also conducted a "Limited Scope Review" to examine the operations of the program in detail, and developed 32 recommendations on needed changes to the program. The DHCS believes that they have made good progress and explains that these recommendations are in varying stages of implementation.

The Assembly Health and Accountability & Administrative Review Committees held a joint oversight hearing on September 26, 2013.

Proposed Waiver

As announced in the January budget package, DHCS intends to seek a waiver from the federal Centers for Medicare and Medicaid Services (CMS) in order to operate the Drug Medi-Cal Program "as an organized delivery system." Funding for DMC was realigned to counties in 2011 as a component of the 2011 Public Safety Realignment, however this was a fiscal realignment and not a programmatic realignment. DHCS describes the goal of the waiver to be a means to realigning DMC to counties programmatically. DHCS also cites the following issues they hope to address through the waiver:

- Integration through coordination – integration and coordination of substance use disorder treatment with county mental health services, public safety systems, and

primary care. DHCS notes that in 54 of 58 counties, substance use disorder and mental health services are in the same county department.

- Building upon the mental health system – building upon the success of the county-operated Medi-Cal Specialty Mental Health program.

- Medi-Cal eligibility and benefit expansion – significant increase in caseload anticipated in light of the expansion to Medi-Cal eligibility and the increased coverage for enhanced substance use services, both of which were adopted as components of the Affordable Care Act.

- Improving DMC – recent investigations and evidence of substantial provider fraud that calls for improvements to the operation of the program.

DHCS describes a variety of goals of the waiver, such as improving care, increasing access to services, strengthening county oversight of network adequacy, and standardizing provider selection practices. They also cite the following two primary goals:

- Elimination of unscrupulous providers – Currently, the state is required to contract with any provider who fails to acquire a contract with their county, which DHCS believes results in a greater number of fraudulent providers participating in the program; and

- Creation of a single point of entry – Currently, a Medi-Cal beneficiary seeking substance use disorder treatment services can seek and receive those services from any provider anywhere in the state. There is no organized system to determine if that person is receiving duplicate services or the most appropriate services. DHCS hopes to create a no-wrong-door approach wherein beneficiaries seek many different types of services through counties, and counties would be responsible for conducting medical necessity assessments and providing appropriate, effective referrals.

Role of Counties

DHCS proposes that this new organized delivery system would be voluntary for counties, and any county choosing to opt in would be required to:

1. Implement selective provider contracting
2. Provide or arrange for all DMC benefits
3. Monitor providers based on performance criteria
4. Assure beneficiary access to DMC service providers
5. Use a single-point of access for beneficiary assessment
6. Collect and maintain data
7. Ensure timely termination of contracts
8. Partner with DHCS on provider licensing and certification
9. Maintain a collaborative relationship with DHCS

Waiver Timeline
DHCS indicates their desire to complete the process of developing, requesting, and securing approval for this waiver within approximately a year, however the department also states that their stakeholder process, and receipt and integration of stakeholder input, is a high priority, and therefore they are not wedded to specific deadlines.

Stakeholder Participation
DHCS has begun, and intends to continue, facilitating a process for stakeholder input on the development of this waiver. Specifically, the stakeholder process will include: conference calls, workgroup meetings, post-workgroup progress updates, and webinars, and includes both substance abuse disorder and mental health stakeholders.

Concerns Raised by California Opioid Maintenance Providers (COMP)
COMP has significant concerns with DHCS's intent to purse a waiver under which to operate DMC, primarily based on the notion that a Medicaid waiver, by design, waives federal law, and therefore would remove the entitlement protections that federal law guarantees to virtually all aspects of the Medi-Cal program. COMP argues that operating DMC under a waiver would enable counties (as proposed by DHCS) to limit access to services, something counties would have a significant financial incentive to do. Moreover, limiting access would also violate the Sobky v. Smoley legal settlement.

In 1992 Drug Medi-Cal patient beneficiaries and methadone providers went to federal district court in Sacramento to challenge the counties' role in administration and distribution of federal/state Drug Medi-Cal funds for narcotic treatment programs. See Sobky v. Smoley, 855 F.Supp. 1123 (E.D. Cal. 1994). At that time, counties were either refusing to enter into Drug Medi-Cal contracts at all, or limiting the number of "slots" available for Drug Medi-Cal patients. This resulted in waiting lists for methadone maintenance treatment despite the fact that it was medically necessary for patients who qualified for Medi-Cal and methadone maintenance treatment. Some Medi-Cal beneficiaries paid for services out of pocket and many others did not receive treatment at all.

In 1994 the United States district court issued a permanent injunction against the director of the Department of Alcohol and Drug Programs, the secretary of the Health and Welfare Agency, and the director of the Department of Health Services, their successors, agents, and all persons working in concert and participation with them, including all 58 California counties. The injunction expressly prohibits limiting the availability of methadone maintenance services due to budgetary constraints.

COMP also disagrees with DHCS's assertion that the Specialty Mental Health waiver can serve as an appropriate model for substance use disorder services due to the fact that although there is significant overlap in the population of patients needing substance use disorder treatment and mental health care, they are nevertheless very different systems of care. Furthermore, substance use disorder treatment continues to suffer from significant stigmatization, thereby making it especially vulnerable in the context of being operated by 58 different counties with 58 unique political and cultural

environments. Even today, some counties choose not to participate in DMC, and various participating counties choose not to contract with various types of drug treatment providers, thereby requiring the state to fill in the gaps and ensure access for all Californians to these services.

COMP points out that there are many changes to DMC that are warranted, both in terms of weeding out provider fraud as well as to improve the program generally, however they argue that these changes can and should be made through state statutory changes and do not require or justify a federal waiver.

Recommendations of the California Association of Alcohol and Drug Program Executives (CAADPE)

Related to DMC generally, CAADPE submitted the following recommendations to the committee and other members of the Legislature:

1. Fund detoxification services and residential care services until there is some resolution on the Institute for Mental Disease exclusion at the federal level;

2. Establish specialized health homes for parolees as part of the state's demonstration project/waiver under AB 361 enacted in 2013 along with the state 1115 waiver; and

3. Reclaim state authority for testing, certifying, and disciplining of substance use disorder professionals.

STAFF COMMENTS/QUESTIONS

A critical component of federal Medicaid law is its protection of the entitlement aspect of the Medicaid program. Anyone who meets eligibility criteria for the program is guaranteed access to services. Generally, federal waivers remove this guarantee, giving the state additional flexibility and control to operate a particular program or category of services (within Medi-Cal) differently and often with greater restrictions. DHCS has provided both written and verbal descriptions of the need for this waiver, yet it remains unclear what justifies this waiver, and how these services would be protected.

The provider fraud scandal last year clearly served as a call to action in terms of program reforms and increased accountability. Nevertheless, a waiver may swing the pendulum too far in the other direction, thereby unnecessarily limiting access to these critical services, particularly at a time when over-dose deaths are on the rise. The Subcommittee may want to urge DHCS to abandon the waiver proposal and instead work closely with stakeholders to develop a legislative proposal to reform the program to meet various worthy goals: reduce fraud, increase accountability and transparency, increase access, and improve the quality of care.

The Subcommittee requests DHCS to respond to the following:

1. Please provide an overview of: 1) the DMC budget; 2) the department's response to the allegations of provider fraud; and 3) the waiver proposal.

2. Please describe the different types of programs and providers within Drug Medi-Cal, the various types of licenses and certifications different types of providers are required to have, and what patterns of fraud have been uncovered related to these different categories of providers. I.e., is there evidence that most of the provider fraud is occurring within one (or more than one) category of providers (or type of treatment)?

3. Please describe the connection, if any, between provider fraud and the department's intent to pursue a waiver.

4. Please explain in detail what problems exist in the program today that will be addressed by a waiver.

5. Please explain how the state can guarantee statewide access to substance use disorder treatment services, as an entitlement, while operating the program under a federal waiver.

6. What specific reforms require a federal waiver, and can't be implemented through state statutory changes?

7. Providers report a long history of county restrictions on the DMC NTP program and lack of availability of these services in 50% of the counties due to opposition to Medically Assisted Treatment, despite the strong medical research support for this program. Given this history and recent reports of county efforts to limit enrollment, why would the state wish to waive federal law when more patients are expected to come into the system under the expansion due to the ACA? What will the state do to guarantee access?

8. Under the new realigned systems, are most of the new departments of behavioral health led by drug treatment directors or by mental health directors? It appears that most professionals in these practices believe that the one does not necessarily understand the treatment systems of the other. How is DHCS accommodating the different cultures and protecting against bias for one treatment system over the other?

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 8: DRUG MEDI-CAL PROVIDER RECERTIFICATIONS (PED14-01 / 016) BCP

DHCS is requesting $2,180,000 ($1,090,000 GF, $1,090,000 FF) for 21.0 1-year limited-term positions to recertify all Drug Medi-Cal program providers, in an effort to decertify fraudulent providers.

BACKGROUND

The Drug Medi-Cal (DMC) program, formerly operated by the former Department of Alcohol and Drug Programs was the subject of a major fraud investigation conducted by the Center for Investigative Reporting and CNN during the fall of 2013 (as described above). As a result of this investigation and resulting allegations of significant provider fraud in the program, DHCS began a review of the program. As of August 16, the review had resulted in the suspension of 42 DMC clinics at 116 locations, and dozens of referrals to the Department of Justice for criminal investigation and prosecution. Moreover, DHCS is undertaking the recertification of all DMC providers with the hopes of decertifying all unscrupulous, fraudulent providers.

DHCS requests the following positions:

- Associate Governmental Program Analysts -- to process applications (10.0)
- Associate Governmental Program Analysts -- to ensure quality control of applications and training (2.0)
- Associate Governmental Program Analysts -- for policy development (4.0)
- Office Assistants (2.0)
- Program Technician II (1.0)
- Staff Services Manager I -- for oversight of policy staff (1.0)
- Staff Services Manager III -- for full management and supervisory responsibilities (1.0)

The DHCS states that these positions have been redirected from within the department, and that the most experienced staff have been moved into the positions.

STAFF COMMENTS/QUESTIONS

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

1. Please clarify the total number of providers and what percentage the department expects to decertify.

2. Given that 100 percent of the providers in phase three failed to submit all of the required paperwork, could the paperwork be overly onerous?

3. How can the Medi-Cal program guarantee access to these services if the department decertifies a large number of providers?

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 9: RESIDENTIAL & OUTPATIENT PROGRAMS (SUDS14-01 / 017) BCP

DHCS is requesting $739,000 (Residential & Outpatient Program Licensing Fund) and 6.0 3-year limited-term positions to investigate substance use disorder counselor and facility complaints. Funding is contingent on legislative approval of a fee increase for licensed and certified facilities.

BACKGROUND

DHCS licenses and certifies facilities that provide 24-hour, non-medical residential and outpatient alcohol and other drug (AOD) detoxification, treatment, or recovery services to adults. DHCS also determines the appropriate skills and qualifications of providers in these facilities, narcotic treatment facilities, programs certified to receive Medi-Cal reimbursement and driving under the influence programs. AOD providers/counselors in any of these facilities must be registered, certified, or licensed.

DHCS charges fees for licensure and certification of all residential AOD recovery and treatment facilities and of all outpatient AOD programs. The revenues collected are used to provide oversight of these facilities. These fees have not been increased since 2007. DHCS states that there is a growing number of counselor and facility complaints requiring administrative action.

DHCS is responsible for investigating facility and counselor complaints, unlicensed facilities and death reports. According to DHCS, over the past five years, the state has experienced an increase in non-medical AOD facilities providing medical services and/or operating outside the scope of their licensure.

DHCS also states that the goal of this request is to address a backlog of 500 complaints. Complaint investigation time requirements are in law for complaints about providers (i.e., counselors), however not for complaints about facilities.

STAFF COMMENTS/QUESTIONS

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

1. Please describe the fee increase that is being proposed. How much is the fee now and how much of an increase is proposed?

2. Would DHCS support creating complaint investigation time requirements in law for facility-related complaints?

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 10: DUI PROGRAM EVALUATION (SUDS14-03 / 018) BCP

DHCS requests $96,000 (DUI Program Licensing Trust Fund) to renew a contract, until 2016 to continue evaluating data of the Driving-Under-the-Influence (DUI) Programs licensed and monitored by the state. DHCS states that the purpose of continuing this contract is to act upon specific recommendations provided in the previous and existing evaluation.

BACKGROUND

Since 1978, individuals convicted of a DUI have been mandated by the court to attend DUI programs, which are regulated and licensed by the state. Licensing and monitoring of DUI programs had been done by the former-Department of Alcohol and Drug Programs (DADP), until that department was eliminated in 2013, and the program was transferred to DHCS.

The DHCS Substance Use Disorder Compliance Division licenses and monitors all DUI programs statewide, which seek to reduce the number of repeat DUI offenses and address drivers' substance use disorders. DHCS licenses 492 DUI programs throughout California that offer programs for first-offenders, multiple-offenders, and 30-month services.

The DUI Program Licensing Trust Fund receives licensing fees, enrollment fees, fines and penalties collected from DUI programs, and these revenues are used to offset costs incurred by DHCS in administering the program. DUI programs pay a one-time $400 licensing fee, and each enrollee pays $10 which is then paid to DHCS.

The 2008 Budget Act appropriated $96,000 (DUI Trust Fund) to DADP for two years to review the DUI program structure at both the state and provider levels, and develop recommendations in order to improve service delivery. DADP contracted with San Diego State University (SDSU) to conduct the review. DHCS states that "this study was exploratory in nature and has laid the groundwork for future evaluations to identify and promote the effective components of DUI programs."

Accordingly, DHCS expects this request to do all of the following:

1. Continue an in-depth analysis of the system improvements recommended in the first DUI descriptive study.

2. Provide continued systematic assessment of DUI program providers,

3. Reveal best practices in program processes, data collection and monitoring

4. Establish program benchmarks, performance measures and outcomes.

5. Revisit recommendations provided in the descriptive study to determine which have and have not been addressed by the state.

6. Provide DHCS with future direction on how to best collect participant data, determine and develop program performance benchmarks, and develop outcome measures needed to measure DUI program success.

7. Identify what is working in the first and multiple offender programs in order to develop a statewide, standardized curriculum for FUI participants that takes in account variables such as culture, gender and age.

8. Establish critically needed program benchmarks and performance measures, outcomes, and suggested recommendations for related regulations.

STAFF COMMENTS/QUESTIONS

The request is fairly unclear about how this "extended evaluation" relates to the original evaluation. It is also unclear what has been the results of the original evaluation, and appears that DHCS is requesting this contract extension and additional funding simply to understand the original evaluation.

The Subcommittee may wish to ask DHCS for a clearer, simpler explanation of the overall timeline and progression of these various evaluations prior to approving of additional funding.

The Subcommittee requests DHCS to present this proposal and to clarify the relationships between the various evaluations that are described in the proposal.

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 11: CAREGIVER RESOURCE CENTERS

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

Prior to the budget reductions:

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

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

The following summary describes how the cuts affect services:

Total of 11 CRC's

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

STAFF COMMENTS/QUESTIONS

These services are a valuable piece of our overall safety net that allows caregivers to continue providing care, thereby enabling many disabled Californians to continue living in the community rather than in institutions. Keeping people at home leads to substantial savings for the state in reduced institutional care costs. States that have prioritized and invested in community-based care, as a preferred alternative to nursing homes and other institutional care settings, generally support these types of services.

Staff Recommendation: Staff recommends holding this item open and consider opportunities to augment funding for CRCs, when possible, in the coming months or years.

ISSUE 12: SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

California school districts receive matching federal Medicaid funds for administrative services they provide to identify and enroll students into Medi-Cal. This funding has helped schools develop Family Resource Centers, and outreach and enrollment programs. On June 26, 2012, the federal government informed DHCS that the SMAA program was put on deferral due to deficiencies in DHCS' claiming plan. DHCS has not yet received approval from the federal government for a revised claiming plan and school districts have not been reimbursed for their expenses since July 1, 2012, and are owed over $600 million dollars. In the meantime, school districts have been forced to reduce or eliminate their programs due to lack of funds.

BACKGROUND

Currently, the DHCS is the state agency responsible for the School Based Medi-Cal Administrative Activities (SMAA) program that reimburses school districts for a range of Medi-Cal outreach, referral, translation, program development an policy planning activities. Local Education Agencies (LEAs) providing these activities receive federal reimbursement upon the submission of invoices; the reimbursement rate is 50 percent of their allowable costs.

The DHCS has delegated the day-to-day administration of the SMAA program to Local Government Agencies (LGA), where these programs are administered, and eleven Local Education Consortiums (LECs). LEAs may contract with their regional LEC or their county LGA- if one is available, to participate in the SMAA program. About 8 LGAs contract with LEAs for the SMAA program. The LECs and LGAs are responsible for overseeing the LEAs' SMAA programs. They must ensure the accuracy of review the quarterly invoices prepared by the LEAs before submitting them to DHCS. The DHCS has final oversight, and are responsible for reviewing the accuracy of the claims before sending them to CMS for reimbursement.

In June of 2012, the federal Center for Medicare and Medicaid Services (CMS) notified DHCS that all LEA claims would be put in deferral status until improvements were made to the program. A subsequent CMS financial review and preliminary findings from an audit by the Office of the Inspector General identified problems with invoices, lack of compliance with federal regulations, and lack of oversight at all levels of the program. The only exception was Los Angeles Unified School District, which had adopted their methodology used for claiming to a Random Moment Time Survey (RMTS) in FY11, and the Santa Barbara County Office of Education, whose documentation was reviewed by CMS and found to be in good order. Santa Barbara's claims covered special education services while LAUSD covered a broader range of services.

All other districts in the State currently use what is known as a worker day log methodology to determine the amount of time (and related cost) that can be federally reimbursed. CMS has asked California to adopt an RMTS methodology to improve the accuracy of time reporting, and this request is supported by the LEAs.

To resolve the issues identified in the deferral, CMS required that DHCS submit a new plan for its SMAA program by September 2012. DHCS complied with this request. However, according to school districts, the plan DHCS originally submitted had insufficient input from the LEAs. The districts argue that DHCS developed the plan with significant input only from the LECs.

The LEAs have serious concerns that the plan, as written, will have grave consequences for the districts. They state that the program will be driven by the LECs and LGAs, whereas currently it is driven by the districts. As designed, the plan is likely to reduce claiming by 20-50%. This will be the result of placing districts in claiming units not of their choice, favoring activities related to special education students rather than on districts where outreach and enrollment in Medi-Cal is a priority. They state further that it will take all control of the program away from the districts and transfer it to the LECs and LGAs, but will leave the financial liability with the LEAs. Additionally, the plan permits the LECs and LGAs to operate the program and also to self-monitor their programs. This contradicts a major finding in the April 2012 CMS report citing a lack of "internal controls" over the program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the following:

1. Please provide the department's perspective on what led to the federal payment deferral to school districts.

2. What has the state's response been to date?

3. How is the state working with all stakeholders (including school districts) to resolve this issue?

4. What is a realistic date that school districts can expect to be reimbursed for services already provided?

Staff Recommendation: Staff recommends holding this item open in order to continue this conversation with the administration and stakeholders.

ISSUE 13: GROUND EMERGENCY MEDICAL TRANSPORTATION (AI14-01 / 007) BCP

DHCS requests $1,013,000 ($507,000 FF, $506,000 reimbursements) and 5.5 permanent & 3.0 3-year limited-term positions to perform audits on approximately 160 local fire districts and ground emergency medical transportation (GEMT) providers that will receive supplemental payments for services authorized by AB 678 (Pan), Chapter 397, Statutes of 2011. Reimbursements are to be provided by entities receiving supplemental payments as required by state law.

BACKGROUND

GEMT providers are required by law to respond to every emergency call regardless of one's ability to pay, and current Medi-Cal reimbursements cover only a portion of the actual cost, according to DHCS.

In order to bridge the gap between the Medi-Cal reimbursement rate and the actual allowable cost for providing this service, AB 678 gave state and local entities the option to claim federal financial participation (FFP) by allowing eligible public entities to certify their certified public expenditures for supplemental reimbursements for GEMT services. The intent of AB 678 was to relieve the financial burden on these public entities by providing a supplemental reimbursement at no cost to the state.

DHCS estimates the total supplemental reimbursement to be approximately $300 million based on 160 participating providers. AB 678 authorizes supplemental payments retroactive to January 2010, using cost reports. DHCS explains that the retroactive payments will create an immediate backlog of approximately 800 cost reports, and estimates 160 cost reports annually thereafter.

DHCS requests these positions to audit the public entities participating in this program, per requirements of the federal Centers for Medicare and Medicaid Management (CMS).

This request is consistent with the intent of AB 678, to hold the state harmless financially, by covering state staffing and other administrative costs with reimbursement from the Sacramento Metropolitan Fire District (Sac Metro), which will contract with other eligible providers which will reimburse a fair share back to Sac Metro.

The 4.0 permanent and 3.0 limited-term positions being requested will constitute an entire production unit designated to the GEMT audit activity. This unit will review approximately 275 cost reports annually for the first five years in order to reduce the backlog. Subsequently, the unit will review approximately 225 cost reports annually for three to four years, until the inventory has been reduced to just one fiscal year's volume of cost reports, approximately 160.

A 0.5 position will be responsible for developing, implementing and maintaining the entire GEMT Services Program. Another 1.0 position will administer the informal and formal appeal process.

STAFF COMMENTS/QUESTIONS

While apparently the federal government (CMS) requires these audits, it seems unfortunate that GEMT providers will have to pay for these audits as a condition of implementing a program that's entire goal is to create financial supplements to make up for inadequate Medi-Cal reimbursements.

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

1. Does CMS clearly require these audits?

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 14: MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) MODERNIZATION (ITSD14-03) BCP

DHCS requests $3,480,000 ($528,000 GF, $2,952,000 FF) and 16.0 2-year limited-term positions to modernize the Medi-Cal Eligibility Data System (MEDS).

BACKGROUND

MEDS is a centralized database that stores information on individuals receiving public benefits from the Medi-Cal and other health-related programs. It also performs a variety of eligibility, enrollment and reporting functions. One of the critical functions of MEDS is to centralize beneficiary eligibility information, which each of the 58 county welfare departments collects. MEDS contains data that originates in all 58 counties, state and federal agencies, health plans, and Covered California (California's health benefits exchange under the Affordable Care Act (ACA)). MEDS was originally envisioned to store information for approximately 3 million individuals. Currently, MEDS contains records for approximately 8 million beneficiaries, and needs to accommodate information for approximately 2 million more beneficiaries, as a result of the ACA.

MEDS serves as the system of record for numerous programs, including: Medi-Cal, CalWORKS, Cancer Detection Programs, Every Woman Counts, Child Health and Disability Prevention Program, Breast and Cervical Cancer Treatment Program, Supplemental Nutritional Assistance Program, and the Family Planning Access Care and Treatment Program.

DHCS contracted with a vendor in 2004 to assess MEDS and make recommendations to DHCS about its technical, data and application architectures, its engineering standards, application development languages and tools, database management and human resources. According to DHCS, this MEDS Assessment Report states that MEDS employs an obsolete application architecture, and provides strategies for modernizing MEDS, including a proposed schedule, associated resource requirements, and cost estimates. DHCS states that since 2004, the resources have not been available to modernize MEDS, particularly given the fiscal crisis and many other priorities.

IN April 2011, CMS issued a new Medicaid Rule that provided enhanced federal funding (FFP), at 75 percent, for operation of eligibility determination systems that meet the standards and conditions of the Medicaid Information Technology Architecture (MITA) initiative by December 31, 2015. The new Rule also provides 90 percent FFP for the design, development, installation, or enhancement of Medicaid Eligibility determination systems that meet CMS requirements until December 31, 2015.

In 2012, DHCS contracted with a vendor to develop an Advanced Planning Document (APD), which was scheduled for submission to CMS in January 2014.

DHCS states that MEDS is outdated technology that is becoming increasingly unable to meet the Departments' and other entities' data and functionality demands in a timely

and cost-efficient manner. Moreover, MEDS does not meet CMS's seven MITA conditions and standards required for enhanced 75% FFP.

DHCS identifies the following three primary goals of this project:
1. Enable MEDS to more fully meet the business needs of DHCS and its key stakeholders;
2. Reduce unnecessary redundancy within MEDS subsystems and with other external systems; and
3. Support CMS' future vision and goals for IT systems that support the Medicaid program.

DHCS states that the project will be complete in June 2020, and anticipates submitting additional proposals to address the resource needs for the remainder of the project.

Resources Request
DHCS is requesting resources for this purpose as follows:

Information Technology Services Division (ITSD) – 13.0 two-year limited-term positions. Specifically:
- Data Processing Manager IV (1.0)
- Data Processing Manager III (1.0)
- Senior Information Systems Analyst II (1.0)
- Systems Software Specialist II (2.0)
- Senior Information Systems Analyst Specialist (6.0)
- Senior Programmer Analyst Specialist (1.0)
- Systems Software Specialist III (1.0)

Medi-Cal Eligibility Division (MCED) – 3.0 two-year limited-term positions. Specifically:
- Health Programs Specialist II (1.0)
- Associate Governmental Program Analysts (2.0)

LAO Concerns
LAO agrees with the need to modernize MEDS, noting the antiquated nature of the existing technology, the increasing difficulty to maintain the system, the difficulties in accessing information, particularly in real time, and data security concerns. LAO also confirms that failure to modernize MEDS could jeopardize continued enhanced federal funding.

LAO points out that typically departments absorb the cost of planning a project, and subsequently submit only the completed plan to the Legislature for review and approval of funds, however LAO believes that this new approach by DHCS - requesting resources for the planning phase- has merit.

LAO recommends approval of this request, and also recommends that the Legislature direct DHCS to report to the Legislature at 2015-16 budget hearings on the status of information found through the planning phase, including details on the project's scope, timeline and costs.

STAFF COMMENTS/QUESTIONS

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

1. Was the Advanced Planning Document completed and submitted to CMS?

2. Please explain the reasons this project will take six years to complete, and how the new technology won't be outdated, or even obsolete, six years from now?

3. Please respond to the LAO's observation that this request for planning resources is somewhat out of the ordinary for state IT projects.

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 15: BREAST & CERVICAL CANCER TREATMENT PROGRAM BACKLOG (MCED14-01 / 011) BCP

DHCS requests $301,000 ($151,000 GF, $150,000 FF) for 2014-15 and authority to extend 6.0 limited-term positions from December 31, 2014, until June 30, 2016, to address a backlog of annual redeterminations, initial eligibility determinations, and the processing of requests by applicants for retroactive coverage in the Breast and Cervical Cancer Treatment Program (BCCTP). This request assumes total costs in 2015-16 of $603,000 ($302,000 GF, 301,000 FF).

BACKGROUND

The BCCTP provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer, who otherwise would not qualify for other Medi-Cal programs. The BCCTP is comprised of both federal-state funded and state-only funded program components. As of July 1, 2013, the BCCTP covered 14,248 individuals.

Federal Program

- Federal funds for the BCCTP cover full-scope Medi-Cal benefits for women requiring breast or cervical cancer treatment.

- Eligibility is restricted to women screened and diagnosed with breast or cervical cancer through state screening programs who are uninsured or under-insured, under 65 years of age, and meet citizenship or other immigration requirements.

State Program

- AB 430 (Statutes of 2001) established a state-only program for both women and men who do not meet the federal eligibility criteria.

- The state program limits treatment to 18 months for breast cancer and 24 months for cervical cancer.

Annually, approximately 4,350 new BCCTP cases are received, requiring an initial eligibility determination, with 94 percent of the cases requiring an annual redetermination thereafter. The total ongoing federal and state caseload, as of June 30, 2013, was 14,248, which consisted of:

- 10,007 new and ongoing federal full scope Medi-Cal cases requiring an initial determination and annual redeterminations thereafter;

- 3,000 ongoing federal restricted scope Medi-Cal cases requiring an initial determination and annual redeterminations thereafter;

- 714 state-only cases requiring an initial determination only; and

- 575 federal full-scope and restricted Medi-Cal cases, no longer eligible for coverage waiting for a county determination of eligibility under all other Medi-Cal programs.

DHCS attributes the backlog primarily to the following three circumstances:

1. Budget reductions in 2008 and 2009 resulted in the elimination of a total of six positions within the BCCTP. Moreover, in 2010 and 2011, the BCCTP experienced staff retirements while the hiring freeze was in place.

2. Implementation of the Deficit Reduction Act citizenship and identity requirements in 2008 significantly increased the time required for the initial case review; and

3. The recession and loss of employer-covered insurance resulted in an increase in caseload.

In 2011-12, DHCS conducted an analysis of the redetermination process and strategies were developed to improve the process and reduce the backlog, primarily transitioning from an "individual caseload" concept to a "caseload bank" structure. The program also transitioned to a paperless data management and processing system.

The following table shows the projected workload outcomes associated with reducing the backlog, per approval of this request:

BCCTP Projected Workload to Address Backlog				
Workload Measure	**2012-13**	**2013-14**	**2-014-15**	**2015-16**
Applications Received	4,970	4,320	3,760	3,270
Active Case Load	14,248	12,389	10,773	9,367
Completed Annual Redetermination	5,760	6,410	6,970	7,460
Backlog Annual Redetermination	7,144	4,268	3,803	1,907

According to DHCS, beneficiaries continue to receive treatment while their applications for eligibility or redetermination are pending final review and approval.

DHCS acknowledges that caseload can be expected to decrease, beginning this year (2014), with the implementation of the ACA, however precise numbers associated with this decline remain unknown.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.

ISSUE 16: HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) (OHC14-01 / 015) BCP

DHCS requests $1,907,000 ($320,000 GF, $1,587,000 FF) and authority to convert 7.0 limited-term positions to permanent and to extend 6.0 limited-term positions for 2 years, to maintain efforts on existing workload on current federal and state Health Insurance Portability and Accountability Act (HIPAA) rules, and address new workload associated with new HIPAA rules.

BACKGROUND

Since the beginning of HIPAA, and the release of the earliest federal HIPAA guidelines, DHCS has maintained only limited-term staffing. However, DHCS now states that HIPAA has evolved into a permanent undertaking requiring permanent staff to address both existing and future workload.

Existing Workload

DHCS describes a continuously increasing need for effective privacy and security systems. Specifically, the Information Protection Unit responded to 694 security breaches in 2012-13 as compared to only 23 in 2008-09. In response to recent security activity, DHCS contracted with The Garner Group to complete an assessment of security and risk management in IT, resulting in a comprehensive security improvement roadmap. DHCS explains that implementation of this roadmap requires additional staff.

To address this existing workload, DHCS is requesting the extension of 6.0 limited-term positions, including:

- Data Processing Manager II (1.0)
- Senior Information Systems Analyst (3.0)
- Associate Information Systems Analyst (1.0)
- Staff Information System Analyst (1.0)

New Workload

DHCS expects an increasing workload primarily as a result of the Affordable Care Act (ACA) which contains significant new HIPAA-related changes and new requirements. Specifically, the ACA includes: 1) Requirement for more frequent HIPAA updates; 2) new operating rules; 3) new transaction standards; and 4) new privacy and security requirements.

To address this new workload, DHCS is requesting 7.5 permanent positions, including:

- Nurse Consultant III (1.0)
- Senior Information Systems Analyst (1.0)
- System Software Specialist II (2.0)
- Staff Information Systems Analyst (2.0)
- Associate Governmental Program Analyst (1.5)

DHCS states that failure to achieve HIPAA compliance by statutory or regulatory deadlines could result in:

1. Additional administrative burdens for providers;

2. Jeopardizing of patient access, as a result of providers choosing not to participate due to the administrative burden;

3. Federal, civil, and monetary penalties for DHCS, including the loss, or withholding, of federal funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for more time for review and public input.