AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 13, 2017

2:30 P.M. - STATE CAPITOL ROOM 447

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LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW

PANEL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: MEDI-CAL ESTIMATE OVERVIEW

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: COUNTY ELIGIBILITY ADMINISTRATION FUNDING, BUDGETING METHODOLOGY BUDGET CHANGE PROPOSAL, AND COLA TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: DIABETES HEALTH CARE COSTS AND PREVENTION

PANELISTS

- **Harold Goldstein**, DrPH, Executive Director, Public Health Advocates
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 5: MEDI-CAL PROVIDER RATES, ALTERNATIVE BIRTHING CENTER RATES TRAILER BILL, AND STAKEHOLDER PROPOSALS ON RATES

PANELISTS – ADMINISTRATION & LEGISLATIVE ANALYST

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

PANELISTS - MEMBER AND STAKEHOLDERS

- **Assemblymember Brian Maienschein**
  Home Nurse Payments Proposal
- **Mark R. Klaus**, President & CEO, Home of Guiding Hands
  ICF-DD Proposal
- **Craig Pulsipher**, MPP, MSW, State Affairs Specialist, Government Affairs, APLA Health AIDS Waiver Proposal
- **Bob Acherman**, Executive Director, California Association of Medical Products Suppliers DME Proposal
- **Stuart Thompson**, Associate Director, Government Relations, California Medical Association California Medical Association Proposal

Public Comment

ISSUE 6: COORDINATED CARE INITIATIVE PROPOSAL AND TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Susan DeMarois**, State Policy Director, Alzheimer’s Association

Public Comment

ISSUE 7: GROUND EMERGENCY MEDICAL TRANSPORTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 8: PUBLIC CLINIC SUPPLEMENTAL REIMBURSEMENT (AB 959) BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 9: MEDI-CAL MANAGED CARE OMBUDSMAN STAFFING BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 10: USE OF CALWORKS ELIGIBILITY TO DETERMINE MEDI-CAL ELIGIBILITY TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW

PANEL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

Department of Health Care Services (DHCS) Budget
For 2017-18, the Governor's Budget proposes $105.3 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, approximately $629.1 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects nearly a 2.3 percent ($2.4 billion) increase from the current year budget. The vast majority of DHCS's budget is for the Medi-Cal Program, for which the January budget proposes $102.6 billion ($19.1 billion General Fund), a $2.4 billion (2.3%) increase from the current year. Given the size of the Medi-Cal program, the significant changes in the budget occur within the Medi-Cal estimate which is described in more detail in the next issue in this agenda.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Thousands)

Fund Source	2015-16 Actual	2016-17 Estimated	2017-18 Proposed	CY to BY Change	% Change
General Fund	**$18,093,676**	**$20,142,758**	**$19,613,704**	**-$529,054**	**-2.6%**
Federal Fund	55,295,755	$67,508,369	$67,443,202	-$65,167	-0.1%
Special Funds/ Reimburse-ments	$10,320,244	$15,222,963	$18,208,259	$2,985,296	19.6%
Total Expenditures	**83,709,675**	**$102,874,090**	**$105,265,165**	**$2,391,075**	**2.3%**
Positions	3,518.2	3,388.9	3,399.9	11	0.3%

As shown in the chart above, there was a very significant (18.7 percent) increase in the overall budget from 2015-16 to 2016-17 ($19.2 billion). This increase occurred in the Medi-Cal program and DHCS explains that it can be attributed to several factors, including the following:

- Estimate errors resulting in a $3-4 billion (total funds) shortfall (described in detail under Issue 2);
- Timing of the new Hospital Quality Assurance Fee;
- Timing of managed care payments; and
- General fluctuations in timing of various costs due to the nature of the Medi-Cal program operating on a cash budget (as compared to accrual).

Resources Requests

DHCS is requesting approximately $25 million ($6.9 million General Fund), 35 new positions, the conversion of 18 existing limited-term positions to permanent, and the limited-term extension of 186.5 existing limited-term positions to support workload associated with, among other activities, all of the following:

- Supplemental payments for ground emergency medical transportation (Issue 7);
- Supplemental payments for clinics (AB 959) (Issue 8);
- Implementation of the new 1115 Waiver;
- Medi-Cal managed care ombudsman (Issue 9);
- Development of a new county administration budgeting methodology (Issue 3);
- Expanded substance use disorder services;
- Implementation of new federal managed care regulations; and
- Replacement of the Medi-Cal Eligibility Data System.

These proposals will be covered in detail under various issues in this and future Subcommittee agendas.

BACKGROUND

DHCS's 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 14.3 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 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 through the following programs: 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 Use Disorder Services***. DHCS oversees the delivery of community mental health and substance use disorder services.

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

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the department, its various programs and functions, its basic organization, and the proposed budget for the department, and to respond to the following:

1. Please explain the nearly 20 percent increase in the Medi-Cal budget in under two years.

2. Given the state's annual budget cycle, please explain how the state accounts for savings in the future (out-years) resulting from actions taken, or investments, in this year's budget.

3. What metrics should the Legislature use to evaluate the performance and effectiveness of this department? I.e., what performance measures can DHCS point to as appropriate to determine how well DHCS is doing in meeting its mission effectively from year to year.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 2: MEDI-CAL ESTIMATE OVERVIEW

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $102.6 billion ($19 billion General Fund). The proposed 2017-18 Medi-Cal local assistance budget is approximately 2.5 percent more than the estimated 2016-17 budget.

Medi-Cal Funding Summary *(Dollars In Millions)*	2016-17 Estimate	2017-18 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$19,560.0**	**$19,130.0**	**-$430.0**	**-2.2%**
Federal Funds	$66,808.5	$66,750.1	-$58.4	-0.1%
Other Funds	$13,693.5	$16,704.8	$3,011.3	22.0%
Total Local Assistance	**$100,062.0**	**$102,585.0**	**$2,523.0**	**2.5%**
Medical Care Services	$95,375.8	$97,788.2	$2,412.4	2.5%
County Administration	$4,268.9	$4,372.7	$103.8	2.4%
Fiscal Intermediary	$417.3	$424.1	$6.8	1.6%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 52-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 within requirements of federal law. State Medicaid spending is "matched" by the federal government, historically 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. Approximately 37 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to 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.

Medi-Cal Caseload

The Medi-Cal estimate assumes caseload to be approximately 14.3 million average monthly enrollees in 2017-18, a 1.8 percent increase over the 2016-17 caseload projections, primarily reflecting increasing enrollment into the Affordable Care Act (ACA) "optional expansion."

	2015-16	2016-17	2017-18	CY to BY Change	CY to BY % Change
Medi-Cal Caseload	13,416,400	14,025,500	14,281,900	256,400	1.8%

Significant Medi-Cal Estimate Adjustments

The most significant adjustments to the November 2016 Medi-Cal estimate include the following the estimate:

- Assumes costs of $20.1 billion ($888 million General Fund) in 2016-17 and $18.9 billion ($1.6 billion General Fund) in 2017-18 for the 4.1 million Californians in the optional Medi-Cal expansion authorized through the ACA.

- Reflects a current year shortfall of $1.8 billion General Fund primarily due to a one-time retroactive payment of drug rebates to the federal government and a miscalculation of costs associated with the Coordinated Care Initiative (CCI).

- Assumes Managed Care Organization Tax funding for Medi-Cal of $1.1 billion in 2016-17 and $1.6 billion in 2017-18.

- Maintains an augmentation to counties for Medi-Cal eligibility administration of $655.3 million ($217.1 million General Fund) in 2017-18. Maintains $1.5 million ($731,000 General Fund) to develop a new budgeting methodology for counties' eligibility administration costs.

- Includes $279.5 million General Fund to provide full-scope benefits to 185,000 children who are gaining coverage regardless of their legal status.

- Assumes over $1 billion in General Fund savings in 2017-18 from the extension of the Hospital Quality Assurance Fee.

- Proposes to cease operation of significant components of the CCI for General Fund savings of $626.2 million in 2017-18 (described in detail in Issue 6).

- Allocates $1,237,400,000 of Proposition 56 (2016 tobacco tax) revenue to cover growth costs in Medi-Cal, estimated to be 82 percent of the tax revenue per the Act's requirements.

- Assumes more than $48 million (updated estimate forthcoming) in General Fund savings by transitioning coverage for all newly qualified immigrant eligible adults from Medi-Cal to a Health Benefits Exchange plan.

- Abolishes the Major Risk Medical Insurance Fund (MRMIF) and transfers the fund balance of approximately $65 million to a new Health Care Services Plans Fines and Penalties Fund to support remaining participants in the Major Risk Medical Insurance Program as well as Medi-Cal costs.

- Anticipates increased substance use disorder treatment services via participation of 6 counties in 2016-17 and an additional 10 counties in 2017-18 in the Drug Medi-Cal Organized Delivery System Pilot, at a cost of $19.9 million ($3.1 million General Fund) in 2016-17 and $661.9 million ($141.6 million General Fund) in 2017-18.

- Increases General Fund costs by $536.1 million to reflect the assumption that the Children's Health Insurance Program (CHIP) will be reauthorized by Congress, effective October 1, 2017, however at the non-enhanced, federal-matching percentage of 65 percent, rather than the enhanced rate of 88 percent authorized by the ACA.

The Shortfall

As stated above, the January budget reflects a $1.8 billion General Fund shortfall in the Current Fiscal Year (2016-17) that has resulted from the following:

Drug Rebates: $487 million

The state receives pharmaceutical rebates for the drugs that are provided to Medi-Cal beneficiaries. Normally, the state shares the rebate (approximately 50:50) with the federal government since most of the Medi-Cal program costs are shared 50:50 between the state and federal government. However, with the ACA Medi-Cal expansion population, the federal government has been covering 100 percent of the costs of that program (population), and therefore the state should have provided 100 percent of the drug rebates, specific to just that population, to the federal government. Instead, due to delayed automation updates, the state had been sending only half of the rebates to the federal government, per the state's usual process. Therefore, this is the other half of the drug rebates that should have gone to the federal government sooner, but was delayed and then not accounted for in the current year budget.

Coordinated Care Initiative (CCI): $1.43 billion

The May 2016 Medi-Cal estimate included two errors specifically within the CCI program that resulted from:

1. Double counting $857 million in savings as a result of using a very complex formula to calculate the savings resulting from transitioning individuals from fee-for-service into managed care, and continuing to count those savings for a longer period time than was accurate; and

2. Failing to account for the CCI costs in two County Organized Health System counties, amounting to $573 million, by overestimating how much cost was accounted for in the base estimate and underestimating how much was in the policy change.

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 proposed for 2016-17 and 2017-18, and to respond to the following:

1. Please explain the $1.8 billion General Fund shortfall and what the administration proposes to do to prevent shortfalls of this magnitude in the future.

2. When does DHCS expect to have a final savings estimate on its Newly Qualified Immigrant proposal?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 3: COUNTY ELIGIBILITY ADMINISTRATION FUNDING, BUDGETING METHODOLOGY BUDGET CHANGE PROPOSAL, AND COLA TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The proposed budget maintains an augmentation to counties for Medi-Cal eligibility administration of $655.3 million ($217.1 million General Fund) in 2017-18, and maintains $1.5 million ($731,000 General Fund) to develop a new budgeting methodology for counties' eligibility administration costs.

DHCS requests an extension of limited-term resources and expenditure authority for the Medi-Cal Eligibility Division (MCED), County Administration Unit to implement the provisions of SB 28 (Hernández, Chapter 442, Statutes of 2013). SB 28 directs DHCS, in consultation with the counties, to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act (ACA) on county administrative work and to present that methodology to the Legislature. Specifically, DHCS requests:

- Three-years for equivalent positions: $244,000 ($122,000 General Fund and $122,000 Federal Fund), and

- Two-years for contract costs: $1,217,000 ($608,000 General Fund and $609,000 Federal Fund)

The Administration also proposes trailer bill to suspend the annual county COLA for one year (2017-18).

BACKGROUND

County Funding
The following table shows the budget for county eligibility administration within Medi-Cal for the current year and budget year.

County Medi-Cal Administration Funding (Dollars in Millions)			
	2016-17 Estimate	**2017-18 Proposed**	**CY to BY Change**
General Fund	$859.2	$858.8	-$0.4 (0%)
Federal Funds	$3,397.7	$3,502.1	$104.4 (3.1%)
Total Funds	**$4,268.9**	**$4,372.7**	**$103.8 (2.4%)**

Budgeting Methodology Budget Change Proposal
Currently, counties are budgeted for their activities based upon claimed expenditures from prior years. The DHCS County Administration Unit provides the funding for counties to determine eligibility for the Medi-Cal program. A beneficiary's eligibility is reviewed whenever the county is notified of a change in status, and at designated times, such as at annual redetermination. The responsibility to run these processes is placed with each of the State's 58 counties who use state and federal guidelines and statutes to determine eligibility and perform case maintenance activities for California's Medi-Cal population. Currently, the base estimate for county administration consists of three parts, the costs identified as: 1) staff costs; 2) support costs; and 3) staff development costs. The base has been static since FY 2009-10, and has not been adjusted to include recent workload data, verified recent county expenditure data, or other county-submitted information in order to make appropriate adjustments to the base. The ACA has changed verification requirements and expanded the role and responsibilities of DHCS and county workload as Medi-Cal continues to expand to cover a greater number of individuals and families, which has directly affected the caseload and work carried out by the eligibility workers and staff at the counties.

The passage of SB 28 required DHCS to develop and implement a new budgeting methodology for county administration of the Medi-Cal program. This new methodology is to be developed in consultation with county staff and fiscal representatives, and to reflect the changes in county operation as a result of implementation of the ACA in 2014. In FY 2014-15, in an attempt to handle the additional workload associated with this effort, DHCS received two limited-term positions as well as funding to hire a contractor to perform advanced research activities and data verification. DHCS hired two staff who have been engaged in efforts to learn current county processes and spending patterns, research prior efforts to create a new budgeting methodology, and prepare documents required to engage the services of a contractor. In addition, the two staff began the work needed to convene a joint state and county workgroup that would help create the new budgeting methodology.

However, actual workgroup meetings were placed on hold because County Welfare Director's Association (CWDA) and DHCS agreed that there were too many ongoing changes to county business processes and eligibility systems during the two years after

implementation of the ACA. Data necessary to develop the new budgeting methodology would be too unstable and unreliable.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. DHCS has entered into a contract with an entity that will conduct this time study, create an ongoing monitoring plan and train Audits and Investigations staff on monitoring and evaluation of time studies. DHCS explains that the time study and development of the new methodology have been delayed due to the volatility in enrollment resulting from the ACA as well as due to delays in the full operation of CalHEERs, the eligibility and enrollment system for Covered California.

COLA Suspension Trailer Bill

DHCS reimburses counties for the costs they incur by performing administrative activities associated with the Medi-Cal eligibility process. Existing Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with a COLA annually. Nevertheless, the COLA has been suspended each fiscal year since 2009-10.

The administration indicates that it is the administration's policy and practice to end all automatic annual COLAs, consistent with Government Code Section 11019.10. Consistent with this policy, AB 8 X4, (Evans), Chapter 8, Statutes of 2009-10, Fourth Extraordinary Session, eliminates the automatic annual COLA for the State Supplemental Payment (SSP) program and for the CalWORKS program. The administration also points out that it has proposed to provide the counties with substantial increases in funding to address the substantial increase in ACA-driven workload, this year and over the past few years; hence, counties are being funded at a level higher than if they were just provided a COLA. Nevertheless, the Legislature has been unsupportive of eliminating the COLA entirely prior to development of the new budgeting methodology, and this proposed trailer bill simply suspends the COLA for another year.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the proposed county funding, the Budget Change proposal, and the proposed trailer bill.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 4: DIABETES HEALTH CARE COSTS AND PREVENTION

PANELISTS

- **Harold Goldstein**, DrPH, Executive Director, Public Health Advocates
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

BACKGROUND

Diabetes - a chronic disease affecting one in ten adults in California - is a growing epidemic that affects the health and economic wellbeing of families, employers, and communities. Diabetes is a serious health condition in which the body has a shortage of insulin, a decreased ability to use insulin, or both. It is a major risk factor for heart disease and stroke. Uncontrolled diabetes can also lead to significant disability, including blindness, amputations, and kidney failure. The number of adults in California with diabetes has risen dramatically since 1990, and continues to increase.

The UCLA Center for Health Policy Research reports, in their March 2016 policy brief, *Prediabetes in California: Nearly Half of California Adults on Path to Diabetes*:

> "In California, more than 13 million adults (46 percent of all adults in the state) are estimated to have prediabetes or undiagnosed diabetes. An additional 2.5 million adults have diagnosed diabetes. Altogether, 15.5 million adults (55 percent of all California adults) have prediabetes or diabetes. Although rates of prediabetes increase with age, rates are also high among young adults, with one-third of those ages 18-39 having prediabetes. In addition, rates of prediabetes are disproportionately high among young adults of color, with more than one-third of Latino, Pacific Islander, American Indian, African-American, and multiracial Californians ages 18-39 estimated to have prediabetes. Policy efforts should focus on reducing the burden of prediabetes and diabetes through support for prevention and treatment."

Public Health Advocates provides the following statistics that should set off alarms for the State of California, particularly from a budgetary perspective:

- 125 amputations per week are done in California;
- 55% of California adults have been *diagnosed* with either diabetes or pre-diabetes (some additional percentage remain undiagnosed);
- 1/3 of all children born in the year 2000 will become diabetic;
- ½ of all children of color born in the year 2000 will become diabetic;

- $15 billion is the annual health care costs of diabetes in California.

Although $15 billion is the amount of all healthcare costs, not just Medi-Cal, it is important to note that diabetes rates are highest in low-income populations, and therefore it can be assumed that over half of all Californians with diabetes are enrolled in Medi-Cal and therefore the Medi-Cal program likely bears more than half of the cost.

The Federal Centers for Medicare and Medicaid Services (CMS) provides the following information on diabetes costs in Medicare:

> "Diabetes affects more than 25 percent of Americans aged 65 or older and its prevalence is projected to increase approximately 2 fold for all U.S. adults (ages 18-79) by 2050 if current trends continue. CMS estimates that Medicare will spend $42 billion more in the single year of 2016 on fee-for-service, non-dual eligible, over age 65 beneficiaries with diabetes than it would spend if those beneficiaries did not have diabetes -- $20 billion more for Part A, $17 billion more for Part B, and $5 billion more for Part D. On a per-beneficiary basis, this disparity is just as clear. In 2016 alone, Medicare will spend an estimated $1,500 more on Part D prescription drugs, $3,100 more for hospital and facility services, and $2,700 more in physician and other clinical services for those with diabetes than those without diabetes. Fortunately, type 2 diabetes is typically preventable with appropriate lifestyle changes."

In response to these costs, Medicare covers a program called the Diabetes Prevention Program and CMS describes it as follows:

> "The Diabetes Prevention Program is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of 16 intensive “core” sessions of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the 16 core sessions, less intensive monthly follow-up meetings help ensure that the participants maintain healthy behaviors. The primary goal of the intervention is at least 5 percent average weight loss among participants.
>
> In March 2016, Department of Health and Human Services (HHS) announced that the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) certified the pilot Diabetes Prevention Program (DPP) model as a cost savings program that reduced net Medicare spending. The Secretary then determined that the program demonstrated the ability to improve the quality of patient care without limiting coverage or benefits. Together, these determinations fulfilled the expansion requirements of Section 1115A of the Social Security Act making DPP the first ever preventive service model certified for expansion from the CMS Innovation Center."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Public Health Advocates to make a presentation on the diabetes epidemics and its impacts on health care costs.

The Subcommittee also requests DHCS to share its thinking on how to prevent diabetes through Medi-Cal, how to manage the likely future costs of treating diabetes in Medi-Cal, and to respond to the following:

1. How much does diabetes care cost in Medi-Cal?
2. How much do amputations, resulting from diabetes, cost in Medi-Cal?
3. How much would it cost to cover the Diabetes Prevention Program within Medi-Cal?
4. Would covering the Diabetes Prevention Program in Medi-Cal be cost-effective in this fiscal year or in future fiscal years?
5. What will the increased costs of diabetes be should the state do nothing more than it is currently doing on diabetes prevention?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 5: MEDI-CAL PROVIDER RATES, ALTERNATIVE BIRTHING CENTER RATES TRAILER BILL, AND STAKEHOLDER PROPOSALS ON RATES

PANELISTS – ADMINISTRATION & LEGISLATIVE ANALYST

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

PANELISTS – MEMBER AND STAKEHOLDERS

- **Assemblymember Brian Maienschein**
  Pediatric Home Nurse Rates Proposal
- **Mark R. Klaus**, President & CEO, Home of Guiding Hands
  ICF-DD Rates Proposal
- **Craig Pulsipher**, MPP, MSW, State Affairs Specialist, Government Affairs, APLA Health -- AIDS Waiver Rates Proposal
- **Bob Acherman**, Executive Director, California Association of Medical Products Suppliers -- Durable Medical Equipment Rates Proposal
- **Kristian Foy**, Legislative Advocate, California Clinical Laboratory Association
  Clinical Laboratory Rates Proposal
- **Stuart Thompson**, Associate Director, Government Relations, California Medical Association -- Medical and Dental Providers Rates Proposal

Public Comment

PROPOSAL

This section of the agenda covers several issues related to Medi-Cal provider rates, as follows:

1. The Governor's budget proposes to use $1.2 billion in anticipated new revenue from Proposition 56 (tobacco tax) to pay for growing costs in Medi-Cal, and not for rate increases, as many believe was the intent of Proposition 56;

2. The Governor's budget proposes to change the rate setting methodology for Alternative Birthing Centers; and

3. Several stakeholders have submitted requests to the Subcommittee to raise Medi-Cal provider rates.

BACKGROUND

Proposition 56 (2016 Tobacco Tax)

Proposition 56 includes the following language that explains the intended purpose of the revenue that is specifically designated for the Medi-Cal Program:

> To the extent possible given the limits of funding under this article, payments and support for the nonfederal share of payments for healthcare, services, and treatment shall be increased based on criteria developed and periodically updated as part of the annual state budget process, provided that these funds shall not be used to supplant existing state general funds for these same purposes (Section 30130.55, paragraph a).

AB 97 (2011) Reductions

As a result of the state's fiscal crisis, AB 97 required DHCS to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

On October 27, 2011, the federal Centers for Medicare and Medicaid (CMS) approved California's proposal to reduce Medi-Cal provider reimbursement rates. As part of this approval, CMS required DHCS to: 1) provide data and metrics that demonstrated that beneficiary access to these services would not be impacted; and 2) develop and implement an ongoing healthcare access monitoring system.

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider ten percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

Managed Care and Actuarial Soundness of Rates

About 80 percent of Medi-Cal enrollees are enrolled in Medi-Cal managed care. The remaining 20 percent receive Medi-Cal through fee-for-service. Generally, those in FFS are persons with limited-scope aid codes, dual eligibles in the non-Coordinated Care Initiative counties, and persons who are exempt from managed care because of a medical exemption request. Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Health plans must meet access standards *and* a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services).

The following table shows the most recent estimate of the on-going and retroactive costs (revenue) associated with continued implementation of the AB 97 reductions:

November 2016 Estimate
AB 97 Payment Reductions

(Dollars in Thousands)

	FY 2016-17			FY 2017-18			Remaining Recoupment		
	TF	GF	FF	TF	GF	FF	TF	GF	FF
On Going	$ 550,481	$ 178,195	$ 372,286	$ 540,712	$ 178,769	$ 361,943	$ -	$ -	$ -
Retro	$ 20,277	$ 10,115	$ 10,162	$ 24,658	$ 12,301	$ 12,357	$ 41,492	$ 20,699	$ 20,793
Total	$ 570,758	$ 188,310	$ 382,448	$ 565,370	$ 191,070	$ 374,300	$ 41,492	$ 20,699	$ 20,793

Note. The AB 97 payment reduction amounts include adjustments for the applicable ACA Optional Expansion and Title XXI Federal Medical Assistance Percentages (FMAPs) during each fiscal year.

LAO Findings and Recommendations

In 2015, the LAO reviewed DHCS's baseline access analyses and quarterly monitoring reports and came away with numerous concerns about the quality of the data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on access. In the LAO's view, these concerns are sufficient to render the Administration's public reporting of very limited value for the purpose of understanding beneficiary access in the fee-for-service (FFS) system. The LAO also found that much of the debate regarding the Medi-Cal provider payment reductions has focused mainly on FFS while access issues in managed care are gaining more importance (as a majority of Medi-Cal enrollees are in managed care). The LAO recommended the Legislature create meaningful standards for monitoring Denti-Cal (FFS) access and also recommended future oversight focus on monitoring the managed care system.

ALTERNATIVE BIRTH CENTERS TRAILER BILL PROPOSAL

Proposal

DHCS proposes trailer bill in order to revise the current Alternative Birth Centers (ABC) rate-setting methodology to 80 percent of the Diagnosis Related Group (DRG) Level-1 in order for DHCS:

- To be in compliance with existing law;
- To change the reimbursement methodology to "statewide all-inclusive rates per deliveries;"
- To codify the use of licensed midwives to be utilized at ABC facilities consistent with the California State Plan; and
- To remove or amend certain "provider-oriented" and "departmental-oriented" reporting and certification requirements to reflect updates in the administration of ABCs and align policies with other areas of law.

Background

Existing law defines an ABC as a clinic that is not part of a hospital, and that provides comprehensive perinatal services and delivery care to pregnant women who remain in the facility for less than 24 hours (Health and Safety (H&S) Code Section 1204 (b)(4)).

Existing law outlines the Medi-Cal Fee-For-Service (FFS) rate-setting methodology for ABCs, and requires that the Department of Health Care Services (DHCS) provide Medi-Cal reimbursement to ABCs for facility-related delivery costs at a statewide all-inclusive rate per delivery (Welfare and Institutions (W&I) Code Section 14148.8). The statewide all-inclusive rate per delivery cannot exceed 80 percent of the average Medi-Cal reimbursement to General Acute Care (GAC) hospitals with Medi-Cal contracts, and is based on an average hospital length of stay of 1.7 days.

The ABC providers bill for the all-inclusive delivery service using the local procedure code Z7516. The reimbursement rate methodology for this code is 80 percent of the average contracted rate for GAC hospitals with Medi-Cal contracts, as identified in the California Medical Assistance Commission (CMAC) annual legislative report. The all-inclusive rate per delivery was last adjusted in June 2015 with rates effective July 1, 2014.

Current law requires for the contract between the CMAC and the DHCS be dissolved, effective July 1, 2012, and transfers the CMAC rate-setting responsibilities to DHCS. Assembly Bill 102 (Committee on Budget, Chapter 29, Statutes 2011) also requires that DHCS develop and implement a payment methodology that is based on the Diagnosis-Related Groups (DRG) as specified in W&I Code Section 14105.28. Existing law requires DHCS to provide Medi-Cal reimbursement to ABCs for facility-related delivery costs at a statewide all-inclusive rate per delivery that does not exceed 80 percent of the average Medi-Cal reimbursement rate for all-inclusive deliveries to GAC hospitals with Medi-Cal contracts.

The ABCs are currently a mandated provider type that provides low-risk birthing services to Medi-Cal beneficiaries. On average, there are approximately 200 FFS all-inclusive births within an ABC each year. Along with providing pregnant mothers an alternative to traditional low-risk hospital births, ABCs provide cost-effective birthing services and help to reduce high overall medical costs as compared to low-risk hospitals births.

MEMBER AND STAKEHOLDER PROPOSALS

Pediatric Home Health Nurse Incentive Payments

Assemblymember Maienschein requests $20 million for DHCS to provide incentive-based supplemental payments for providers of in-home care for pediatric patients in Medi-Cal. This funding would support an innovative program to provide incentive supplemental payments to in-home nursing agencies if an agency can improve access to care, lower hospital readmissions and meet other specified outcomes to be developed by the program. Assemblymember Maienschein provided the following background information:

> "Currently, there are more children in need of in-home medical support than the Medi-Cal system can serve because of inadequate Medi-Cal rates. Out-of-date reimbursement models and a severe nursing shortage for in-home care caused by Medi-Cal pay rates have resulted in longer hospital stays, frequent hospital readmissions, waiting lists and even no access at all to in-home nursing care in

certain geographic locations throughout the state. This combination causes the state to spend more on unnecessary hospital stays and prevents children from being at home with their families. At present, the Medi-Cal rate is significantly below what surrounding states pay and more than 50% below the average commercial insurance rate making difficult to recruit and retain nursing staff to care for this fragile population at home. In addition, this has caused a significant decrease in in-home agencies willing to serve the Medi-Cal population."

Intermediate Care Facilities/Developmentally Disabled (ICF/DDs)
The Developmental Services Network requests $14,457,916 General Fund to increase Medi-Cal rates paid to ICF-DD facilities. In addition to the AB 97 payment reductions discussed above, rates for intermediate care facilities for the developmentally disabled (ICF/DDs), habilitative (ICF/DD-H), and nursing (ICF/DD-N) are frozen at 2008-09 levels. The rates for ICF-DDs were increased 3.7 percent as a component of the 2016 legislation establishing a new Managed Care Organization (MCO) tax. Without the 3.7 percent increase, the current rates of payment would on average be about 9.3 percent below the DHCS unfrozen rate study. With the 3.7 percent increase, the rates are about 5.6 percent under the DHCS unfrozen rate study.

Concerns have been raised by these providers that ICF/DDs are closing because of the low Medi-Cal reimbursement rates and rate freeze resulting in some patients transitioning to other types of homes (e.g., negotiated-rate homes licensed) overseen by the Department of Developmental Services which have higher reimbursement rates, thereby, resulting in increased costs to the state. The negotiated-rate homes cost the state between $100 and $500 more per person per day than ICF/DDs.

According to the Administration, from 2010 to February 2015, 65 ICF/DD-Ns and ICF/DD-Hs closed and 58 new ICF/DD-Ns and ICF/DD-Hs opened. However, advocates for the facilities report a net reduction of 15 facilities during this time period. The administration reports that there is no evidence of ICF/DDs closing and transitioning into negotiated-rate homes; however, DHCS does not track or know where the individuals in the closed facilities went after their ICF/DD closed.

AIDS Waiver Rates
AIDS Project Los Angeles and the California HIV Alliance propose increasing provider reimbursement rates in the AIDS Medi-Cal Waiver Program to be on par with rates for similar home and community-based services waiver programs. In 2015, the administration provided a preliminary cost estimate of $4.8 million General Fund to achieve parity with other home and community-based services waiver programs.

The AIDS Medi-Cal Waiver Program is a home and community-based services waiver program for eligible Medi-Cal recipients that provides comprehensive case management and in-home services to people living with HIV/AIDS as an alternative to more expensive skilled nursing facility care or hospitalization. Provider reimbursement rates in the AIDS Medi-Cal Waiver Program have failed to keep pace with rates in comparable home and community-based services waiver programs. According to a 2014 analysis by the state Office of AIDS and DHCS, rates in the AIDS Medi-Cal Waiver Program are between 10 and 58 percent lower than other home and community-based services

waiver program rates for the exact same services. Stakeholders state that this disparity in rates is discriminatory and threatens the legal rights of Medi-Cal recipients living with HIV/AIDS.

Stakeholders explain that under the current rate structure, it is impossible for AIDS Medi-Cal Waiver Program agencies to maintain the program with the required level of staffing and not lose money on every patient admitted. Agencies try to make ends meet through charitable donations, but the losses often are not sustainable and force agencies to either reduce services or withdraw from the program entirely. In 2008, the program had 44 contracted agencies providing services in 52 of California's 58 counties. Currently, the AIDS Medi-Cal Waiver program has less than 26 contracted agencies in 19 counties. Nearly all of these agencies have waiting lists for the program, indicating that people living with HIV/AIDS are unable to access the services they need.

Durable Medical Equipment (DME) Rates

The California Association of Medical Product Suppliers (CAMPS) proposes trailer bill language to temporarily freeze the rates paid for DME until Medicare rates stabilize given federal changes to those rates, to which Medi-Cal rates are tied. Currently, state statute requires the Medi-Cal program to reimburse DME at either 80 percent of the comparable Medicare rate or at 100 percent of the Medicare rate for custom rehabilitation equipment and accessories. These rates have been subject to the AB 97 10 percent cut discussed above, and in addition, the federal government changed its Medicare rate setting process for DME to one based on competitive bidding which has driven down the Medicare rates. This combination of rate reductions results in a 40-60 percent overall cut to DME rates, according to CAMPS. For example, the rates for complex ventilator rentals have been reduced from approximately $1,100 per month to $523 per month. CAMPS states that they have heard from CCS providers that it is challenging to discharge a CCS child from the hospital due to the unavailability of providers of the necessary ventilators and support services. CAMPS explains that reimbursement rates for the rental or purchase of DME cover all provider costs for delivery, set-up, maintenance, patient/caregiver instruction, TAR authorization, billing, etc., and therefore can be quite substantial. For example, home respiratory equipment requires 24/7 response for equipment failure or malfunctions.

Clinical Laboratory Rates

The California Clinical Laboratory Association (CCLA) requests: 1) elimination of the application of the AB 97 10 percent rate cut (discussed above) for clinical laboratories; and 2) forgiveness of the retroactive recoupment of uncollected AB 1494 rate reductions. In 2012, AB 1494 (budget trailer bill) imposed an additional 10 percent payment reduction for Medi-Cal clinical laboratory services effective July 1, 2012 through June 30, 2015 and required DHCS to implement a new rate setting methodology for labs. CCLA states that the new rate methodology has caused excessive yearly work for clinical labs in submitting and analyzing the required data. CCLA also states that timely implementation of yearly rates by DHCS has been impossible due to DHCS's "antiquated computer system" thereby resulting in the collection of retroactive payments. Finally, CCLA states that: "The uncertainty of payment levels to providers makes budgeting for clinical laboratory Medi-Cal services excessively difficult."

Physician and Dental Provider Rates
The California Medical Association (CMA) requests that the Proposition 56 funds be used to provide for annual, supplemental payments to Medi-Cal providers. These payments would differ depending on the provider's participation in the Medi-Cal program and number of Medi-Cal patients the provider sees. CMA believes that utilizing an annual incentive based payment model will increase the number of providers providing services to Medi-Cal enrollees as well as reward those providers already heavily participating in the program by linking payments to increased access. CMA states that: "While California has dramatically increased the amount of individuals covered by Medi-Cal, this could be the first real investment the state has made to improve access within the program rather than simply expanding eligibility." CMA further explains that: "The purpose of Proposition 56 was to create a special fund to make targeted investments within Medi-Cal with the goal of providing better access to the 14.3 million individuals currently enrolled in program. This is evident by the plain language of the initiative and the official campaign information conveyed to voters who approved the new tax."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present their proposals on the use of Proposition 56 revenue and the Alternative Birthing Centers trailer bill, provide technical feedback on the stakeholder proposals, and respond to the following:

Does the administration believe that their proposed use of the Proposition 56 revenue, as included in the January budget, is consistent with the spirit and intent of the initiative?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 6: COORDINATED CARE INITIATIVE PROPOSAL AND TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Susan DeMarois**, State Policy Director, Alzheimer's Association

Public Comment

PROPOSAL

The January budget includes and proposes major changes to the Coordinated Care Initiative (CCI) as follows:

1. Formally and legally ends the CCI, per the statutory authority of the administration upon findings of increased costs from the CCI.

2. Proposes trailer bill to reinstate and continue the following key components of the CCI: Cal MediConnect (a pilot program that integrates Medicare and Medi-Cal for dual-eligibles, mandatory enrollment of all dual-eligibles in CCI counties into Medi-Cal managed care, and integration of long-term services and supports (LTSS) (excluding In Home Supportive Services (IHSS)) into managed care. The proposal also delays integration of the Multi-Senior Services Program (MSSP) into managed care and eliminates the required development of a Universal Assessment Tool; and

3. Removes IHSS from the CCI, including: 1) Eliminating the statewide authority for bargaining IHSS workers' wages and benefits; and 2) Re-establishing the state-county share of cost arrangement for the IHSS program that existed prior to the CCI.

This Subcommittee is hearing different aspects of the CCI proposal at different hearings as follows:

- Continuation of Cal MediConnect, mandatory enrollment of duals into managed care, and LTSS in managed care – These issues are being heard today.

- IHSS Components and Universal Assessment Tool – These issues were heard on Wednesday, March 8, 2017.

- MSSP Component – This issue will be heard on Wednesday, March 15, 2017.

BACKGROUND

The purpose and goal of the CCI is to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care). The 2012 budget authorized the CCI, which is being implemented in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The CCI has the following three major components:

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

2. **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded seniors and persons with disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits. This required all dual-eligibles, who do not opt in to Cal MediConnect to transition from fee-for-service to managed care for their Medi-Cal benefits.

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

Factors Affecting the Fiscal Solvency of CCI

SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, contains a poison pill provision that automatically discontinues all components of CCI (including changes in demonstration counties and the IHSS MOE) if the Department of Finance (DOF) determines that the CCI does not generate net General Fund savings and is therefore not "cost‐effective." The DOF assesses the net General Fund savings by conducting a CCI savings analysis by January 10 of every fiscal year in which the CCI is in effect. While the CCI statute mandates the inclusion of certain components within the CCI savings analysis, the statute generally gives DOF broad discretion in estimating the costs and savings of the CCI.

Uniform Assessment Tool

Pursuant to CCI statute, DHCS, DSS, and CDA are to develop a Universal Assessment Tool (frequently referred to as Uniform Assessment Tool) to assess Medi-Cal beneficiary's need for Home and Community Based Services. The goal is to enhance personalized care planning under CCI and create a mechanism that home and community based providers, who are currently using different programmatic based tools, can standardize, communicate and coordinate with each other on beneficiary's assessments and care needs. Under CCI, the long-term services and support which includes home and community-based services (CBAS, IHSS, MSSP) are benefits of the managed care plans. The latter are also required to conduct assessments, care planning, authorizing services and coordinating service delivery with their provider networks, physicians, hospitals, CBAS, County IHSS, NF, MSSP, and other medical services. The Universal Assessment is to create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services.

Legislative Analyst's Office (LAO)

The LAO recently released a report on the CCI (*The 2017-18 Budget: The Coordinated Care Initiative: A Critical Juncture*) which includes the following information on what is known about evaluations and outcomes from the CCI:

> "***Cal MediConnect Has Shown Initial Promise in Reducing Hospitalizations and SNF Placements***. A principal intent of the CCI is to improve care and reduce costs by avoiding unnecessary hospitalizations and SNF placements. Based on analyses carried out by participating managed care plans, between April 2014 and June 2016, Cal MediConnect has helped achieve reductions in hospital and SNF utilization. Managed care plans have reported making use of enhanced care coordination as well as HCBS to help SPDs avoid unnecessary SNF stays and hospitalizations. Because SNF stays and hospitalizations are, on average, so costly compared to HCBS, these avoided SNF placements and hospitalizations have potentially resulted in savings for the state and federal governments and for managed care plans.
>
> ***Relatively High Cal MediConnect Member Satisfaction***. A 2016 beneficiary satisfaction survey jointly carried out by the University of California, Berkeley and the University of California, San Francisco compared the experiences of Cal MediConnect members, dual eligibles who opted out of Cal MediConnect, and dual eligibles in non‑CCI counties. In general, the survey shows relatively high satisfaction on the part of Cal MediConnect members. Cal MediConnect members, for example, were more likely than nonmembers to know they have someone coordinating their care, to report that the quality of their care has improved since the CCI began, and to not have unmet needs for personal care assistance. The survey also showed there is room for continued improvement. For example, the survey identified some disruptions in the continuity of care during the transition to Cal MediConnect."

The LAO also offers the following recommendations specific to the continuation of components of the CCI:

1. Integration of Health Care and LTSS Remains a Worthy Policy Goal.

2. Proposal Will Allow Dual Eligibles to Maintain Joint Medi‑Cal and Medicare Coverage Through Cal MediConnect.

3. Proposal Will Preserve the Financial Alignment of Medi‑Cal and Medicare Under Cal MediConnect.

4. Integration of LTSS Under Managed Care Retains Some Promise Despite Removal of IHSS.

Stakeholder Input

The Subcommittee has received a substantial number of letters from stakeholders, primarily counties or entities directly related to counties, stating their positions on the Governor's proposal. Nearly all of the letters express opposition to ending statewide bargaining for IHSS and support for continuing the key components of the CCI. One letter is from a coalition of organizations including: AARP California, Alzheimer's Association, California Association for Adult Day Services, California Commission on Aging, California Health Advocates, California In-Home Supportive Services Consumer Alliance, California Senior Legislature, Cal PACE, Justice in Aging, LeadingAge California, MSSP Site Association, SEIU, and UDW. This coalition made the following recommendations on the proposal to continue the CCI:

1. To uphold the state's promise for coordinated systems of care, we recommend that health plans and counties be required to coordinate the delivery of IHSS services to enable expedited IHSS enrollment and reassessment for both CMC and MLTSS enrollees.

2. At a minimum, we recommend that the authorizing Trailer Bill Language require the state to develop standardized functional and cognitive assessment elements and guidelines for developing care plans for use by health plans in both the CMC and MLTSS programs.

3. In accordance with the new federal regulations, we recommend the development of Trailer Bill language requiring the state to draft and enforce standards for health plan care coordination of LTSS required benefits, as well as referral to and coordination of services otherwise provided outside the health plan, including IHSS and other home and community-based services. These standards should apply to both CMC and MLTSS enrollees and should be appropriately enforced by the state.

4. While the state is still in the process of drafting these standards, we recommend that additional data be developed to show availability and quantity of home and community-based services on a statewide/county-by-county basis. Such data could help uncover areas of unmet need and patterns of institutional utilization compared to access to MLTSS.

5. We recommend that the reauthorization legislation continue the requirement that PACE be included as a Cal MediConnect enrollment option and also extend the requirement to the enrollment process for beneficiaries who must enroll in a managed care plan in order to receive LTSS.

6. We recommend developing Trailer Bill language requiring that the state develop a plan setting forth priorities for and measuring progress of California's integrated service delivery system, along with transition plan timelines.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present their CCI proposal and trailer bill (with a focus on the components of the CCI that are proposed for continuation), and respond to the following:

1. Please describe what the administration's position is, and efforts have been, with regard to passive enrollment into the CCI.

2. What position(s) have advocates had on passive enrollment?

3. Please provide reactions to the concerns and recommendations of stakeholders as described above.

The Subcommittee requests the Alzheimer's Association to speak to their concerns with the CCI and the Governor's proposal to continue key components of it, and to share the recommendations of a large coalition of seniors/aging advocacy organizations.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 7: GROUND EMERGENCY MEDICAL TRANSPORTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Audits and Investigations (A&I), requests to convert 3.0 three-year limited-term (LT) positions to permanent full-time positions and $393,000 in expenditure authority ($197,000 Federal Fund and $196,000 Reimbursement) to perform mandatory audits on local Fire Districts and Ground Emergency Medical Transportation (GEMT) providers throughout California that receive supplemental payments for GEMT services authorized by AB 678 (Pan, Chapter 397, Statutes of 2011).

BACKGROUND

AB 678 allows for annual supplemental payments to GEMT providers to help offset the cost of providing emergency medical transports. The reimbursement funding will be provided by the public entities receiving the supplemental payments as required by California Welfare & Institutions (W&I) Code, Section 14105.94. DHCS states that the mandated workload will be ongoing and therefore requires these positions to be permanent.

Medicaid regulations establish requirements identifying how public funds can be used to draw down Federal Financial Participation (FFP) via Medicaid. Certified Public Expenditures (CPEs) are one of several funding mechanisms that a state may employ to obtain FFP and to make supplemental payments to Medi-Cal providers without cost to the General Fund. Under a CPE agreement, governmental providers must certify their Medicaid actual expenditures to the state, thus allowing the state to obtain federal reimbursement based on the CPE. States are responsible for ensuring that expenditures are eligible for federal reimbursement by reviewing cost reports filed by each governmental provider.

Under AB 678, state and local government entities have the option to use CPEs to claim FFP for the difference between the reimbursement rate under the Medi-Cal program and the actual allowable cost for providing GEMT services. AB 678 allows, on a voluntary basis, eligible public entities to certify their CPE for supplemental reimbursements for GEMT services. The intent of the legislation is to relieve the financial burden of these eligible public entities by providing a supplemental

reimbursement at no cost to the State of California while maintaining that supplemental payments pertain to medical transportation only.

W&I Code, Section 14105.94(d) (1) authorizes the reimbursement of DHCS' state share of administrative and staffing costs by the public entities. Through a "host-county" contract, the State General Fund is not impacted. For instance, Sacramento Metropolitan Fire District (Sac Metro) has agreed to reimburse the State for DHCS administrative and staffing costs necessary to operate the GEMT supplemental payment program. In turn, Sac Metro will contract with other eligible public providers, who will reimburse a fair share back to Sac Metro.

In 2014, BCP A114-01 authorized A&I a total of 7.0 positions for the GEMT Supplemental Payment Services Program. The positions included 1.0 permanent Health Program Audit Manager (HPAM) I, 1.0 permanent HPA IV, 1.0 permanent HPA III, and 1.0 permanent Office Technician in addition to the 3.0 limited-term (LT) HPA IIIs. These 3.0 LT positions will expire on June 30, 2017. The HPA IV position dedicates approximately 50 percent of productive time to program development and the remaining 50 percent to perform GEMT audits. The 1.0 permanent HPA III and 3.0 LT HPA III positions concentrate strictly on performing GEMT audits of the annual cost report submissions.

GEMT providers are required by law to respond to every emergency call regardless of one's ability to pay. Medi-Cal pays an established rate per transport of a Medi-Cal fee-for-service (FFS) beneficiary through the fee-for-service claiming mechanism. AB 678 allows the use of supplemental payments to claim additional FFP to offset costs beyond what is paid by the FFS reimbursement rate up to the allowable cost of providing the service.

The GEMT Services Program offers a supplemental payment to those eligible participating providers that choose to participate. An annual cost report submission is required in order to determine the actual cost of providing services. Based on the cost information and the number of services provided to a Medi-Cal beneficiary, a final settlement is determined and paid.

California is the first state to implement this program, and additional discussions took place to develop and implement an audit process that maintains the fiscal integrity of the program. These discussions caused a delay in initiating audits for prior year cost reports that were accepted for processing.

In addition to the delay, each year, A&I incurs additional workload of cost report audit production. Approximately 100 local fire districts currently participate in the program. Participation has increased each year and is projected to be at 120 in FY 2017-18. At the inception of the program, A&I faced a large backlog of cost report reviews due to fire districts being able to submit retroactive reports from January 2010.

DHCS explains that, due to the new audit process and more complex audit scope, sustaining the level of audit activity for incoming cost reports will require permanent resources. Each cost report review requires an average of 80 hours to complete.

Scoping tools enable A&I to identify the risk factors involved and determine the appropriate level of audit needed for each report. A&I currently has a backlog of approximately 428 cost reports. In each future year, A&I will receive an additional 120 cost reports that will require some level of audit activity. The 120 annual cost report submissions will become A&I's baseline audit activity once the backlog is depleted.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 8: PUBLIC CLINIC SUPPLEMENTAL REIMBURSEMENT (AB 959) BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Audits and Investigations (A&I), Office of Legal Services (OLS), and Office of Administrative Hearings and Appeals (OAHA) request extension of limited-term resources for another two years (effective July 1, 2017 to June 30, 2019). DHCS requests limited-term resources (equivalent to 10.0 staff) and expenditure authority of $1,394,000 ($697,000 Federal Fund and $697,000 Reimbursement) to address ongoing workload related to AB 959 (Frommer, Chapter 162, Statutes of 2006). Specifically, the new workload stems from AB 959's expansion of California Welfare & Institutions (W&I) Code, Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to State veteran homes and clinics operated by state, city, county, the University of California system clinics and public healthcare systems.

BACKGROUND

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

AB 959 requires an eligible facility to reimburse DHCS for the cost of administering the expansion of W&I Section 14105.965 as a condition of receiving supplemental reimbursement. The Safety Net Financing Division (SNFD) was tasked with creating the actual cost report template that the Centers for Medicare and Medicaid Services (CMS) must approve. An initial version of the cost report was approved by CMS in June 2013; however, the cost report has since been revised based on CMS direction. Once the revised cost report is approved by CMS, the clinics will submit their completed cost reports, which A&I will audit.

According to DHCS, SNFD has been meeting regularly and working closely with CMS to obtain approval for the new AB 959 cost report. SNFD also worked on developing methodologies for tentative settlements, cost reporting acceptance and issuance policies, provider training, etc. Because CMS has not yet approved the new cost report template that these clinics will have to use, no cost reports have been submitted, no audits have been conducted, and no final reports have been appealed. Accordingly, the AB 959 workload will not materialize until a CMS approved cost report is produced; the clinics are given training on its use; and the cost reports are submitted to DHCS.

The facilities eligible for the supplemental reimbursement under AB 959 provide critical public services essential for the health and well-being of low-income individuals as well as to the entire community. DHCS states that the increased reimbursement will better facilitate timely access to appropriate services, thereby avoiding costlier medical interventions, such as hospitalization and permanent institutionalization. The supplemental reimbursement provided under AB 959 will not require any expenditure from the State's General Fund.

The supplemental reimbursement to eligible providers under this program provides additional Federal Financial Participation (FFP) to the public healthcare systems of three state veterans' homes and 33 of the approximately 60 public freestanding outpatient clinics. DHCS explains that the additional reimbursement allows these public facilities to keep pace with advances in medicine and improve the quality of care for Medi-Cal beneficiaries. The requested positions would be funded solely by local reimbursements.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 9: MEDI-CAL MANAGED CARE OMBUDSMAN STAFFING BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Managed Care Operations Division (MCOD), Office of Ombudsman (0MB), requests $1,789,000 ($895,000 General Fund, $894,000 Federal Fund), and a total of 15.0 permanent positions (conversion of 9.0 limited-term (LT) positions to permanent and 6.0 new permanent positions) to address an increase in workload to the Ombudsman call center.

BACKGROUND

The 1995 Budget Act and California Code of Federal Regulations, Title 22, Section 53893, authorized DHCS to establish an 0MB function within its Medi-Cal Managed Care Operations Division. The primary mission of the 0MB office is to investigate and find resolution for health plan member issues regarding access to all medically necessary services. The 0MB accomplishes this mission by assisting beneficiaries in navigating the managed care system, by facilitating discussions between beneficiaries and their health plans so appropriate actions are taken for beneficiaries to get the care and services they need, and by coordinating any care and services with facilities and providers.

The 0MB has 8.0 permanent staff, 7.0 who answer phone calls and 1.0 who performs clerical support. All 7.0 staff performs the same or similar duties. Of the 7.0 staff assisting beneficiaries, 5.0 are on Team A and 2.0 are on Team B. Additionally, there are 14.0 temporary staff positions helping with the call volume (9.0 LT state staff and 5.0 contracted staff). The 9.0 LT resources, approved via a Fiscal Year (FY) 2015-16 Budget Change Proposal (BCP) (Medi-Cal Managed Care Division (MMCD) 15-01 Medi-Cal Office of the Ombudsman), were used as resources to increase first call contact with the 0MB, meaning callers would not have to place multiple calls to the 0MB before getting through to be assisted. This was an attempt to decrease the number of voicemails received, an indication that more beneficiaries received same-day assistance. These positons and funding are set to expire June 30, 2017.

According to DHCS, MCOD'S 0MB serves as a resource for the nearly 10.5 million Medi-Cal members enrolled in managed care and helps solve problems from a neutral standpoint so that members receive all medically necessary covered services. In addition to assisting Medi-Cal beneficiaries, the 0MB provides guidance and assistance to county eligibility workers, the Legislature, stakeholders, other state Departments, and various associations (i.e., foster children, pregnancy related, etc.).

With the increased growth in MCP enrollment, it is expected that the 0MB will experience an increase in the number of beneficiary contacts leading to growth in the current hold and talk time as well, which will have a direct impact on assistance to beneficiaries contacting the 0MB.

Stakeholders
The Western Center on Law and Poverty is in support of this proposal, however also points out that they question whether the proposed nine staff is sufficient, given that the phone wait times, to receive assistance from this office, average 20 minutes.

STAFF COMMENTS/QUESTIONS

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

What are the average wait times for assistance from this office and what are they expected to be based on this request?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 10: USE OF CALWORKS ELIGIBILITY TO DETERMINE MEDI-CAL ELIGIBILITY TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS proposes trailer bill to establish statutory authority to request federal approval to use the determination of eligibility for the CalWORKs program as a determination of eligibility for the Medi-Cal program.

BACKGROUND

Since the inception of the CalWORKs program, DHCS has considered a CalWORKs eligibility determination to also confer automatic eligibility for the Medi-Cal program. This was based on an analysis that demonstrated that individuals qualifying for CalWORKs, under CalWORKs program rules, would also qualify for Medi-Cal. Currently when an individual’s eligibility for CalWORKs ends, Medi-Cal eligibility continues under the 1931(b) program until the next annual renewal or unless the reason for the CalWORKs discontinuance is also a reason for discontinuance for Medi-Cal (e.g. death, move out of state, etc.). Based on recent discussions with the federal Centers for Medicare and Medicaid Services (CMS), CMS has recommended that DHCS request federal approval through a state plan amendment to continue using CalWORKs eligibility determination as a basis for eligibility to the Medi-Cal program.

Under this proposal, DHCS would seek federal approval to continue to determine eligibility for Medi-Cal for beneficiaries based on their eligibility for CalWORKs. This change would also maintain existing administrative efficiencies as well as avoid potential federal audit findings that may result in federal sanctions and/or penalties.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.