AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, MARCH 14, 2016

1:30 P.M. - STATE CAPITOL ROOM 126

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: COORDINATED CARE INITIATIVE OVERSIGHT

PANEL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Governor's budget includes a net General Fund savings of $191.9 million in 2016-17 as a result of the Coordinated Care Initiative (CCI), including General Fund savings from the sales tax on managed care organizations. Without the tax revenue, CCI would have a General Fund cost of $129.7 million in 2016-17.

BACKGROUND

The 2012 budget authorized the CCI, which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. The CCI 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 three-year 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 original eight 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.

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.

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). See table below for enrollment summary information.

Cal MediConnect Enrollment As of February 1, 2016	
County	**Enrollment**
Los Angeles	42,523
Orange	16,973
Riverside	13,663
San Bernardino	13,419
San Diego	15,796
San Mateo	9,573
Santa Clara	12,345
Total	**124,292**

Factors Affecting the Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for the CCI. If the CCI is not cost-effective, all components would cease operation. As part of the budget, the Administration identified the factors below that have occurred since the 2012 enactment that may jeopardize the fiscal solvency of this initiative. According to DOF's current analysis, if these factors do not improve, there would be a net General Fund cost, and consequently, the CCI would cease operating effective January 2017. The Administration indicates that it remains committed to implementing the CCI to the extent that it can generate program savings.

Higher Than Expected Cal MediConnect Opt-Out Rate. The Governor's budget warns that if certain issues are not resolved, the CCI and all of its parts, would cease to operate pursuant to current law. Of the key issues cited by the Administration negatively affecting the CCI, the issue with which the Administration has the greatest ability to have an impact—without statutory changes or changes in the agreement with CMS—is the higher than expected opt-out rate for Cal MediConnect.

DHCS indicates that it is currently undertaking a study as to the demographics of those who have opted-out including trying to get a better understanding for the reasons these individuals opted out of the demonstration. For example, DHCS is trying to assess why 80 percent of those who opted-out are IHSS beneficiaries and why there are

geographical differences in the opt-out rate. Cal MediConnect plans have committed significant financial and other resources to the success of this program. Ensuring a certain level of plan enrollment is critical not only to the success of the demonstration but potentially to the financial viability of the plans. It is essential that the Administration evaluate and address the reasons for the higher than expected opt-out rate. An essential component of this is the enrollment process as there have been anecdotal reports of missing or inaccurate information.

DHCS Dashboard Findings

In an effort to evaluate the effectiveness of the CCI, DHCS has implemented a California MediConnect performance dashboard based on the following performance metrics: 1) Health Risk Assessments; 2) Appeals by Determination; 3) Hospital Discharge; 4) Emergency Utilization; 5) Long Term Care Services & Supports Utilization; and 6) Case Management. DHCS recently released dashboard data and findings and concludes that health plans are performing well on measures related to care coordination. They also report that:

- 88 percent of reachable and willing beneficiaries received on-time health risk assessments.

- 88 percent of those with a case manager/care coordinator were contacted by their case manager/care coordinator or care team.

- 61 percent of hospital discharges during the reporting period result in outpatient follow-up visits within 30 days.

UC/SCAN Foundation Evaluation/Focus Group Findings

The University of California, in partnership with the SCAN Foundation, have undertaken an evaluation of the program which is in progress. The three-year evaluation runs from January 2015 until December 2017 and findings from the first year of the study have been made available. Year one included 14 focus groups (plus interviews with beneficiaries and 10 interviews with seven Cal MediConnect Health Plans). The second and third years of this evaluation will include: 1) a longitudinal telephone survey with beneficiaries; 2) key informant interviews with stakeholders; and 3) case studies. The researchers report the following findings:

On a scale from 1-10, the average overall satisfaction with Cal MediConnect is a 7.8.

Beneficiaries were most satisfied with:

- Care coordinators
- Having one phone number to call
- The abilities of member services to handle problems

Beneficiaries were most dissatisfied with:

- Notification and information provided ahead of time
- Delays in care due to referrals and authorizations

- Having to change doctors
- Problems getting prescriptions and durable medical equipment covered in the beginning
- Lack of autonomy and control due to passive enrollment

Beneficiaries expressed very high satisfaction with care coordinators.

Some beneficiaries reported more streamlined services, better communication between providers, and more communication between plans and beneficiaries.

Some beneficiaries reported problems with referrals to specialty services, often blaming physicians and medical groups for this lack of coordination.

Health Plans identified the following key challenges:

- Beneficiary outreach and notification
- Working with long term care facilities for the first time
- Data sharing across home and community based services (HCBS) agencies
- Reporting requirements
- Accessible and affordable housing
- Steep learning curve for HCBS and social care
- Uncertain financial risk for taking on Long Term Services and Supports
- Pressure between showing cost savings and making more investments
- Provider and beneficiary trust

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the CCI, an update on its major components, and plans for the future of the CCI.

Staff Recommendation: Subcommittee staff recommends no action on this item.

ISSUE 2: PACE TRAILER BILL LANGUAGE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill affecting the Program of All-Inclusive Care for the Elderly (PACE) programs that includes the following key components:

- ***Rate Setting***: DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations, however the FFS data is no longer available. DHCS proposes setting experience/cost-based actuarially sound rates using a methodology that is to be nearly identical to the methodology used to set rates for other Medi-Cal managed care plans.

- ***Cap on the Number of PACE Organizations***: Removal of existing statutory language that caps the number of PACE Organizations with which DHCS can contract.

- ***Not-for-Profit Requirement***: Removal of existing statutory language to align with updated PACE federal rules and regulations.

- ***Administrative Flexibilities***: Addition of new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

BACKGROUND

The PACE model of care provides a comprehensive medical/social service delivery system using an IDT approach that provides and coordinates all needed preventive, primary, acute and long term services and supports (LTSS). Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for

each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT.

PACE enrollment in the State is voluntary for Medi-Cal beneficiaries. Federal regulations (Title 42, Code of Federal Regulations, Section 460.162) specify that a PACE participant may voluntarily disenroll from the program without cause at any time. Participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of Medicare and Medi-Cal services for PACE participants.

The PACE population is comprised predominantly of beneficiaries dually eligible for Medicare and Medi-Cal, and the Seniors and Persons with Disabilities (SPD) Medi-Cal only population. These populations have been transitioned to the Medi-Cal managed care delivery system over the past five years under California's Bridge to Reform Section 1115 Medicaid Waiver. As a result, the enrollment base for PACE Organizations has changed from a majority FFS population to a managed care population over the last four years.

Legislative change is necessary to enable modernization of the PACE as current statute includes limitations which create barriers for DHCS to efficiently administer and oversee the program. DHCS states that the proposed legislative changes would ameliorate these limitations. DHCS provided the following description of the proposed changes.

Rate Setting: The PACE FFS rate methodology does not take into account plan-specific experience and utilization when setting PACE rates. Pursuant to subdivision (e)(1) of Welfare and Institution (W&I) Code Section 14593, DHCS is required to "establish capitation rates paid to each PACE organization at no less than 95 percent of the FFS equivalent cost, including DHCS's cost of administration, that DHCS estimates would be payable for all services covered under the PACE Organization contract if all those services were to be furnished to Medi-Cal beneficiaries." However, there is an erosion of FFS data as Medi-Cal transitions to a managed care delivery system creating a fundamental issue with the current FFS equivalent PACE rate methodology DHCS is required to use to set rates. In December 2015, CMS issued guidance updating rate setting criteria for PACE Medicaid capitation rates. As part of this guidance, CMS has stated that new managed care rates must be based on data no older than three years. The current rate methodology needs to change to address any future data credibility issue(s) regardless of what type of new methodology is established.

Cap on the Number of PACE Organizations: Removing the PACE Organization cap will allow continuing expansion of PACE in California, which aligns with ongoing DHCS efforts to transition to a statewide managed care delivery system. Currently, there are eleven PACE Organizations that are in operation with three additional interested applicants.

Not-for-Profit Requirement: Removal of the existing specification that DHCS enter into contracts only with nonprofit organizations for the purpose of implementing PACE aligns

with recently released federal guidance permitting for-profit entities to apply as PACE Organizations. Removal of the nonprofit specification will also align with ongoing DHCS efforts to transition to a statewide managed care delivery system by further enabling continuing expansion of PACE in California.

PACE Flexibilities: PACE continues to grow at a rate much faster than anticipated, expanding and evolving with the advent of newer health care delivery practices and methods, in contrast with the rules governing PACE. Federal PACE regulations do not provide any flexibility in requirements of the composition of the PACE IDT and frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and the PACE waiver process. The lack of flexibility in the PACE regulations hinders PACE Organizations from keeping up with current best practices and as a result disservices California participants that may benefit from newer methods. Enabling DHCS to seek flexibility in the federal PACE regulations allows for continued modernization of the program in addition to assisting PACE Organizations in their efforts to provide the highest quality of care to Californians.

Stakeholder Concerns

CalPACE, an association of PACE programs, supports the overall direction of this proposed trailer bill but also has concerns, primarily with regard to the proposed new rate-setting methodology. CalPACE states that the bill language should clarify how the rate methodology will reflect the ways in which PACE is different from other managed care. Specifically, PACE programs cover ALL services necessary to improve and maintain participants' health status, yet it is unclear if various services not officially covered by Medi-Cal will be included in the cost analysis used to set the rates. This covers a wide array of costs, from de-fleeing a patient's dog to capital costs, none of which are covered by managed care plans. Also, CalPACE argues that the methodology should include a way to spread out the costs of unusually high-cost patients given that the PACE risk pool is smaller than for typical managed care plans. CalPACE requests the following changes to the trailer bill:

- Specification that the proposed methodology reflects and accounts for all PACE costs.
- Clarification on covering the costs of high-cost (outlier) patients.
- Clarification on covering the costs of high-cost drugs and treatments for chronic diseases.
- Require that each PACE program's cost data be the primary source of data used for rate setting.
- PACE organizations be held harmless from rate changes under the new methodology.
- Rate setting for new PACE programs should be using the current methodology for the first two years of operation, given the absence of experience-based data.
- Align the methodology timeline with the schedule and progress of the PACE actuarial work group.

CalPACE supports the proposed increased regulatory flexibility and states that there are additional areas in need of flexibility beyond those identified in the bill, such as: 1) expansion applications; 2) PACE Innovation Act; and 3) state licensing requirements. In

response to the proposals to remove the cap on the number of programs and to allow PACE programs to be for-profit entities, CalPACE recommends that DHCS carefully review new PACE applications to ensure applicants meet all state and federal requirements in order to ensure quality of care and consumer protections.

Some of the individual PACE programs have shared their significant concerns with the Subcommittee regarding all of the provisions of the trailer bill. They state that the proposed rate setting methodology is lacking in critical detail, and that the combination of lifting of the cap and allowing for for-profit programs opens the market up to competition in a way that might not encourage quality care and may drive good, non-profit PACE programs out of business.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposed trailer bill, explain the origins of its key provisions and respond to the following:

1. Does the trailer bill ensure that all PACE costs, including those described, will be accounted for in the proposed rate-setting methodology?

2. Under this proposal, how will DHCS ensure that non-profit PACE programs are not driven out of business by for-profit programs?

3. How will DHCS ensure that the quality of care in for-profit programs will match the quality in non-profit programs?

4. Does this proposal reflect the department's work with stakeholders?

Staff Recommendation: Staff recommends holding open this proposal to allow for additional discussion of the proposed trailer bill.

ISSUE 3: CALIFORNIA COMMUNITY TRANSITIONS DEMONSTRATION PROJECT 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**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests five-year limited-term resources of $941,000 (Federal Trust Fund). The federal Money Follows the Person (MFP) Rebalancing Demonstration was extended by the U.S. Centers for Medicare and Medicaid Services (CMS) for an additional five years through September 30, 2020. The MFP Rebalancing Demonstration is known as the California Community Transitions (CCT) Demonstration Project in the State. The request for five-year limited-term resources coincides with the grant and close out reporting to CMS. The requested resources will continue the MFP work. The CCT Demonstration Project is 100 percent federally funded through the MFP grant.

BACKGROUND

In 2005, Congress authorized the MFP Rebalancing Demonstration and grant funding under the Deficit Reduction Act (P.L. No. 109-171), and in 2010, Congress extended MFP grants through September 30, 2016 under the Patient Protection and Affordable Care Act (P.L. 11- 148). Current authorization of the MFP Demonstration is set to expire at the end of 2016; however, federal regulation allows MFP grantees to continue to spend grant funding through September 30, 2020 by way of supplemental budgets awarded in federal fiscal year 2016.

In order for a state to receive authorization to use remaining grant funding for the provision of MFP services, grantees were required to submit a sustainability plan that details projected methods for continuing the program and the steps necessary to continue to rebalance the long-term care system and increase transition activities during the final years of the Demonstration. California's approach to developing a Sustainability Plan was accepted on November 6, 2015. The official approval of the budget through September 30, 2020 will be issued by the CMS Office of Acquisition and Grants Management pending review of the final supplemental budget request submitted on October 1, 2015.

The MFP Demonstration targets Medicaid beneficiaries of all ages who have nursing level of care need, and who have continuously resided in hospitals, nursing facilities (NFs), or intermediate care facilities for persons with developmental disabilities (ICF-DD) for three months or longer. CMS views the MFP Demonstration as part of a comprehensive, coordinated strategy to assist states, in collaboration with stakeholders, to make widespread changes to long-term care delivery systems across the nation.

When California was awarded an MFP grant in January 2007, existing staff were re-directed to develop the MFP Demonstration, called California Community Transitions (CCT). CCT was implemented on September 24, 2008, after DHCS accepted the federal Special Terms and Conditions and the state fiscal year 2008-09 budget was signed. The first year and one-half was spent working with stakeholders to develop the federally-required Operational Protocol, build project infrastructure, and recruit and train CCT Lead Organizations on all aspects of the transition process.

Between 2008 and 2011 the growth of CCT accelerated beyond state staffing capacity, and five additional limited-term positions were approved for five years beginning in FY 2012-13 through 2016. Since then the number of local providers has increased from 25 to 32, and the annual number of transitions has increased from 356 transitions in 2011 to 518 in 2014. To date, 2,560 Medicaid beneficiaries have transitioned from an institution to live and receive services in the community.

On October 1, 2010, CMS required all Medicare and Medicaid-certified facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0) assessment tool. MDS 3.0 is part of the U.S. federally-mandated process for assessing residents upon admission, quarterly, annually, and when there has been a significant change in status. The process provides a comprehensive assessment of each resident's functional capabilities and assists nursing facility (NF) staff to identify health problems. MDS 3.0 is one of the first new quality assurance steps CMS is mandating of state Medicaid agencies for better integration and efficiency of the health care delivery system.

In FY 2012-13, the budget included 8.0 limited term positions for four years for the CCT Demonstration Project. Staff are required to fulfill MDS 3.0 mandates, recruit additional CCT Lead Organizations, meet CMS data requirements, coordinate discharge services with managed health care plans, and provide operational and administrative support so that program objectives are addressed in a timely manner.

The requested resources will address the workload performed by existing limited term positions currently set to expire on June 30, 2016. DHCS states that these resources are necessary to maintain the current program, meet MFP benchmarks, build the capacity of the Home and Community Based Services (HCBS) delivery system and providers to sustain institution-to-community transitions beyond the expiration of the MFP grant, and to adequately implement MDS 3.0 Section Q to comply with the U.S. Supreme Court's Olmstead Decision. CCT currently draws down 87% Federal Medical Assistance Percentage (FMAP) for Local Assistance expenditures as compared to 50% for standard Medi-Cal beneficiary assistance,

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this issue open.

ISSUE 4: STATEWIDE TRANSITIONS PLAN - LONG TERM CARE WAIVERS BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests limited-term resources of $1,112,000 ($491,000 General Fund and $621,000 Federal Trust Fund) for the following:

- Three-year limited-term resources to comply with Federal Regulations (2249-F and 2296-F) on Home and Community-Based Settings Final Rule for existing Home and Community-Based Services (HCBS) providers and beneficiaries promulgated on March 17, 2014.

- Four-year limited-term resources to work on the CMS approved Assisted Living Waiver (ALW) program, coordinate activities with the Statewide Transition Plan (STP) and ensure ongoing compliance of ALW providers with the HCB Final Rule. Resources will also address continued work to meet existing Community Based Adult Services (CBAS) workload, coordinate activities with the Statewide Transition Plan (STP) and ensure ongoing compliance of CBAS providers with the HCB Final Rule. The resources will address work done currently by limited-term positions that are set to expire June 30, 2016.

BACKGROUND

Statewide Transition Plan/Assisted Living Waiver

These resources are requested to meet new workload demands to develop, implement, and monitor characteristics of Home and Community-Based (HCB) settings as required by Federal Regulations that became effective March 17, 2014. The federal regulations enacted new HCB setting requirements, which affect all of California's 1915(c) HCBS waivers, 1915(1), 1915(k) State Plan programs and 1115 Demonstration waiver which include CBAS. The federal regulations specify that all 1915(c) waivers, 1915(i) and 1915(k) State Plan programs and other HCB settings as determined by the Secretary must be in full compliance with the Final Rule by March 16, 2019. The Home and Community-Based Settings Rule may require revisions to statutes and regulations, administering and evaluating provider self-surveys for hundreds of thousands of providers, extensive validation of provider self-surveys through on-site assessments and beneficiary self-surveys, and a robust heightened scrutiny process. In addition, the State must take remedial action for all settings that are out of compliance. As the Single

State Medicaid Agency, DHCS is responsible for collaborating with a number of other departments, disseminating and sending information to beneficiaries, providers, family members, stakeholders, advocates, persons potentially eligible for HCBS and other affected parties as required by CMS' public notice process. DHCS must provide to CMS the results of assessment data, statewide compliance data and remedial strategies as a part of the final STP, which identifies California's activities and timeline for coming into compliance with the Final Rule by March of 2019.

DHCS, in collaboration with sister departments, led the development of California's STP for all of Medi-Cal's HCBS 1915(c), (i), (k) and 1115 waivers, programs and benefits. CMS requires states to complete a robust, comprehensive and detailed specific public notice process and attempt to reach as many persons affected and stakeholders as possible throughout the entire STP compliance process. DHCS facilitated stakeholder and sister departmental meetings prior to the completion of California's STP and committed to continuous and ongoing stakeholder engagements and outreach to be conducted over the next four to five years. DHCS originally submitted California's STP to CMS on December 19, 2014 proposing how the State will comply with the new Final Rule, DHCS re-submitted the final California STP to CMS on August 14, 2015 after the public had a chance to provide feedback, and for DHCS to incorporate public comments into the STP. The STP report, dated August 14, 2015, can be viewed on the DHCS's internet site. DHCS received feedback from CMS which includes requests for extensive additions to the STP and transition plan process.

Community Based Adult Services

The CBAS program developed from the elimination of Adult Day Health Care (ADHC) as a Medi-Cal benefit in 2011. CMS approved the State Plan Amendment (SPA) to eliminate the ADHC benefit effective September 1, 2011. However, in June of 2011, ADHC participants filed a motion in federal court to stop the elimination of ADHC "unless and until adequate replacement services were in place," asserting that eliminating the benefit would place beneficiaries at risk of unnecessary institutionalization. The parties reached a settlement agreement that allowed the elimination of the ADHC program on February 29, 2012, and required establishment of the CBAS program on April 1, 2012 to provide similar services in outpatient facilities (CBAS Centers) to seniors and adults with disabilities who meet the eligibility criteria defined in the settlement agreement and the Bridge-To-Reform (BTR) 1115 Waiver.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 5: STAKEHOLDER PROPOSALS: AGED & DISABLED ELIGIBILITY & ESTATE RECOVERY

PANELISTS

- **Linda Nguy**, Policy Advocate, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, DHCS
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Western Center on Law & Poverty (WCLP) has submitted the following two proposals to the Subcommittee:

- Increase the Medi-Cal Aged and Disabled Program income level to 138 percent of the Federal Poverty Level (FPL), at a cost of $30 million General Fund.

- Limit Medi-Cal estate recovery to federal requirements, for an unknown cost less than $26.5 million General Fund.

BACKGROUND

Aged & Disabled Proposal

The Medi-Cal Aged and Disabled (A&D) program is a critical part of the Medi-Cal program that provides free, comprehensive coverage to persons over the age of 65 and those with disabilities. The A&D program was implemented in 2001, with an income eligibility standard of 100% FPL plus income disregards of $230 and $310 for individuals and couples, respectively. When the program was established, the income standard was equivalent to 133% FPL, the same level as many other people enrolled in Medi-Cal. However, the disregards lose real value every year, with the resulting income standard today at 123% FPL. When a senior has even a small increase in their income that puts them over 123% FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost.

A share of cost is the difference between a beneficiary's countable income and the Maintenance Need Income Level (MNIL). The MNIL is a fixed monthly amount that is supposed to be sufficient to cover basic living expenses, such as rent, food, and utilities. The MNIL in California is $600 for an individual and was established in 1989; it has not changed since then. Anything an individual earns over $600 in a month becomes that individual's share of cost. So for example, a 67 year old beneficiary with a monthly income of $1,250 would have to pay $650 for his or her health care before Medi-Cal begins paying for services.

In 2014 California expanded and streamlined Medi-Cal eligibility raising the income threshold to 138% FPL for most adults. Yet, seniors remain in the A&D Program and will

continue to be held to the 123% income threshold. WCLP explains that while millions of Californians are now able to qualify for free Medi-Cal services because the income threshold was raised, it is inequitable to require a person to pay hundreds of dollars monthly simply due to their age. The anticipated fiscal cost would be $30 million General Fund.

Estate Recovery

The federal government requires states to recover against the estates of people who were on Medi-Cal if they: 1) were permanently institutionalized; or 2) were age 55 or older and received nursing facility services, home and community based services or related hospital and prescription drug services. California optionally collects for all medical care. This means the state can recover the total amount spent for Medi-Cal services including the premium payments paid to a health plan for the beneficiary. This is the case even if the beneficiary received few or no health care services. WCLP believes this is unfair and inequitable, especially considering individuals with higher income who receive subsidized coverage on Covered California are not subject to estate recovery.

This proposal would limit recovery to long-term care services such as nursing homes, eliminating recovery for basic health coverage. It would also allow consumers to know the amount their estate may be recovered against by requiring that DHCS provide them or their representative with this information.

The Department of Finance estimated the cost of a policy bill last year containing this same proposal to be $57.9 million total funds ($28.94 million General Fund) annually, however WCLP believes this to be an overestimate.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests WCLP to present these proposals and requests the Department of Finance to provide a cost estimate on both proposals.

Staff Recommendation: Staff recommends holding these proposals open.

ISSUE 6: FAMILY HEALTH ESTIMATE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka,** Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Child Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts (EWC). The costs of these programs specific to Medi-Cal enrollees are captured in the Medi-Cal estimate. The administration is not proposing any substantial policy or fiscal changes to these four programs, however all of them have experienced decreasing enrollment in light of increasing coverage through Covered California and Medi-Cal as a result of the ACA. Nevertheless, the overall Family Health Estimate shows a projected 34 percent increase in funding for 2016-17, as compared to the 2015-16 estimate, as shown in the table below. This significant cost increase reflects the implementation of coverage of a drug, called Orkambi, for people 12 and older with cystic fibrosis who have specific defective or missing proteins resulting from mutations in a specific gene.

Family Health Estimate
2015-16 and 2016-17
(General Fund In Millions)

Program	2015-16 Budget Act	2015-16 Estimate	2016-17 Proposed	CY to BY $ Change	CY to BY % Change
CCS	$97.11	$60.78	$73.44	$12.66	20.1%
CHDP	$1.36	$1.26	$0.46	($0.81)	-64.1%
GHPP	$112.27	$120.03	$169.60	$49.58	41.3%
EWC	$4.40	$0.17	$0.00	($0.17)	-100%
TOTAL	**$215.15**	**$182.24**	**$243.5**	**$61.26**	**33.6%**

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.

The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program 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 2016-17 CCS budget includes total funds of $78.2 million (including $73.4 million General Fund), as compared to the current year (2015-16) estimate of $79.3 million total funds ($60.8 million General Fund). Caseload is expected to decrease in the state-only CCS program and increase in CCS-Medi-Cal reflecting the Medi-Cal expansion to cover all eligible children regardless of immigration status, adopted through SB 75 (2015 budget trailer bill). I.e., caseload is shifting from non-Medi-Cal CCS to Medi-Cal CCS.

CCS Budget (Non-Medi-Cal)		
	2015-16	**2016-17**
TOTAL	**$79,295,800**	**$78,164,100**
Federal Funds	$18,515,600	$4,723,000
General Fund	$60,780,200	$73,441,100
*County Funds	$79,590,700	$78,501,000
Non Medi-Cal Caseload	14,820	13,113
Medi-Cal Caseload	169,387	172,114

*County Funds are shown here, however the Total is the total in the state budget and therefore does not include county funds.

Child 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 2016-17 budget includes $467,000 total funds ($456,000 General Fund), as compared to the current year estimate of $1,274,000 ($1,263,000 General Fund). The program also receives $11,000 in Childhood Lead Poisoning Prevention Funds to cover the cost of blood tests for lead. There are no significant adjustments proposed for this program, and the reduction in funding and costs reflect decreasing caseload due to caseload shifting to Medi-Cal due to the implementation of the Medi-Cal expansion to cover all eligible children regardless of immigration status.

Genetically Handicapped Person's Program (GHPP)

The goal of the GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP, 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. 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.

Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP, however, GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

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		
	2015-16	2016-17
GHPP State Only	887	891
GHPP Medi-Cal	909	931
TOTAL	**1,796**	**1,822**

GHPP Budget

The proposed 2016-17 GHPP budget includes total funds of $183,545,100 ($169,902,200 General Fund), compared to the 2015-16 estimate of $149,256,000 ($120,026,100 General Fund). There are no significant adjustments proposed to GHPP.

Every Woman Counts (EWC)

EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services.

EWC also serves as one of the main gateways for enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment and services for eligible California residents diagnosed with breast and/or cervical cancer. BCCTP applicants are required to be screened and enrolled by CDC providers authorized to participate in EWC. State law allows non-EWC providers, such as non-Medi-Cal providers, to diagnose cancer and make referrals to an enrolled EWC provider for the purpose of enrollment into BCCTP. This process is known as a "courtesy enrollment." The individual seeking cancer treatment through BCCTP must provide the pathology/biopsy report to an EWC provider to confirm diagnosis and request enrollment into BCCTP.

EWC provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC is expected to serve 177,800 women for fiscal year 2016-17.

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

EWC Budget

The proposed 2016-17 budget includes $32,215,000 total funds ($0 General Fund) for EWC, a $5.7 million (15%) decrease from the 2015-16 estimate of $37,912,000 ($173,00 General Fund). This significant decrease reflects a significant decrease in caseload as a result of ACA implementation; it is presumed that much of the EWC caseload has obtained comprehensive coverage through either Covered California or Medi-Cal. Also as a result of this caseload reduction, the costs of the program now can be covered with the other sources of funding, and General Fund is no longer needed.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the Family Health estimate and explain any changes to costs and caseload occurring in any of the programs.

Staff Recommendation: Subcommittee staff recommends holding this estimate open pending updates and changes at May Revise.

ISSUE 7: EVERY WOMAN COUNTS BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka,** Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests three-year, limited-term federal funds authority of $399,000 to perform programming, data analysis, and data management functions for the Every Woman Counts (EWC) program.

BACKGROUND

In 1990, the CDC created the National Breast & Cervical Cancer Early Detection Program (NBCCEDP) through Public Law 101-354. This law authorized CDC to grant funds to states to screen a reasonable number of low income, uninsured women for breast and cervical cancers, provide referrals for follow-up and medical treatment for women with abnormal test results, develop and disseminate information for preventing breast and cervical cancers, improve the training of health professionals in preventing these cancers, and monitor the quality of screening procedures. Health and Safety Code (HSC) Section 104150, provides authorization for participation in NBCCEDP and established the program within the former Department of Health Services (DHS). Assembly Bill 478 (Chapter 660, Statutes of 1993) created the Breast Cancer Act and established the State's Breast Cancer Early Detection Program within DHS. The funding source is derived from a dedicated two-cent increase in the tobacco tax. In October 2007, the state and federal programs were combined to create the existing EWC program.

The 2012 Budget Act and Assembly Bill 1467, (Blumenfield, Chapter 23, Statutes of 2012), transferred EWC from the Department of Public Health to DHCS. The mission of the EWC program is to save lives by preventing and reducing the devastating effects of cancer through early detection and diagnostic services. EWC provides free clinical breast exams, mammograms, pelvic exams and Pap tests to California's low income uninsured and underserved women. These screening services facilitate early detection that may prevent untimely cancer deaths.

This proposal seeks to continue to provide the necessary resources to meet statutory mandates set forth by state and federal legislation. The CDC grant requires EWC to monitor the quality of screening procedures, collect recipient enrollment and outcome data from enrolled primary care providers. Recipient data is reported to the CDC biannually and assessed for outcomes per CDC prescribed Core Program Performance

Indicators. Specific outcome indicators include the number of women who are rarely or never screened for cervical cancer and length of time form screening to diagnosis to treatment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 8: FAMILY PLANNING CONTRACT CONVERSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests 10.0 permanent, full-time state civil service positions and $1,458,000 ($637,000 General Fund/$821,000 Federal Fund) for FY 2016-17 and $1,368,000 ($596,000 General Fund/$772,000 Federal Fund) on-going to replace existing contracted staff. The requested positions will ensure adequate staffing levels to meet state Office of Family Planning (OFP) requirements and comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants.

The current contract funding is built within the Medi-Cal Local Assistance Estimate. DHCS proposes to discontinue the policy change in order to build the expenditure authority in the State Operations budget. The current contract Is annually budgeted at $2,861,000 ($1,430,000 General Fund/$1,431,000 Federal Fund). With the contract conversion to state civil service positions, there is an anticipated cost savings of approximately $1,403,000 ($793,000 General Fund/$610,000 Federal Fund) in Year 1 and $1,493,000 ($834,000 General Fund/$659,000 Federal Fund) in Year 2 and on-going.

BACKGROUND

The OFP was established by the California State Legislature through California Welfare and Institutions (W&I) Code §14500-14512. OFP is charged "to make available to all citizens of the state, who are of childbearing age, comprehensive medical knowledge, assistance, and services relating to the planning of families". The Family Planning, Access, Care and Treatment (Family PACT) program is administered by OFP and has been operating since 1997 to provide family planning and reproductive health services at no cost to California's low-income residents of reproductive age. Family PACT serves 1.8 million income-eligible men and women of childbearing age through a network of 2,300 public and private providers.

Other OFP functions and duties charged by the California legislature include, but are not limited to:

- Establishing goals and priorities for all state agencies providing or administering family planning services.

- Coordinating all family planning services and related programs conducted or administered by state agencies with the federal government so as to maximize the availability of these services by utilizing all available federal funds.

- Evaluating existing programs and establishing in each county a viable program for the dispensation of family planning.

- Developing and administering evaluation of existing and new family planning and birth control techniques.

OFP is required to conduct ongoing monitoring and evaluation of family planning services. OFP has historically used a personal services contract to hire staff to meet this mandate and to assist with the administration of the Family PACT program. Since 1997, the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF) has had business agreements with OFP to provide data for policy and programmatic decisions through a multi-method approach that includes analysis of administrative data; assessment of provider and client perspectives; and medical record reviews. The UCSF business agreement includes a medical consultant who advises OFP regarding evidenced-based and clinical practice guidelines published by professional organizations with respect to reproductive health services.

Family PACT previously operated under the authority of a Section 1115 demonstration waiver with a requirement to have an independent evaluation of the waiver's impact on reproductive health outcomes, utilization and costs, and access. State Plan Amendment 10-014, approved by CMS in 2011 transitioned the Family PACT program into the Medicaid State Plan. The transition from a waiver program to a program under the Medicaid State Plan eliminated the requirements to have an independent evaluator provide monitoring and evaluation of the program's goals. Nevertheless, state law continues to mandate OFP to conduct ongoing monitoring and evaluation of family planning services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 9: THIRD PARTY LIABILITY RECOVERY WORKLOAD BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, DHCS
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests $1,136,000 ($284,000 General Fund and $852,000 Federal Fund) and 10.0 permanent, full-time positions (4.0 Associate Governmental Program Analyst (AGPA), 4.0 Staff Services Analyst (SSA), and 2.0 Staff Services Manager I (SSM I)) to address a growing third party liability workload and to increase savings. Federal and State laws and regulations mandate that Medi-Cal recover expenditures in personal injury cases involving liable third parties so that Medi-Cal is the payer of last resort.

BACKGROUND

Title XIX of the Social Security Act requires the State Medicaid agency (Medi-Cal) to seek reimbursement for beneficiaries whose medical bills were caused by a liable third party. Section 433.139 of Title 42 of the Code of Federal Regulations requires Medi-Cal to avoid payment of claims where third party coverage is available and to initiate post-payment recovery processes. State law requires DHCS to impose liens on a beneficiary's personal injury settlements and make recoveries, thereby that Medi-Cal is the payer of last resort.

Attorneys, county welfare agencies, and insurance companies must notify DHCS of tort actions involving a Medi-Cal beneficiary. DHCS staff review Medi-Cal expenditures paid for injury-related services, then file liens for recovery against any settlement, judgment, or award. DHCS has three years to obtain recovery from the notice of settlement, judgment, or award on these cases. All funds recovered through any of the TPLRD recovery programs are recycled back into the Medi-Cal program to assist in the care of other medically needy individuals, effectively abating General Fund expenses.

Following the implementation of the ACA, Medi-Cal enrollment increased from 8.6 million in December 2013 to 13.3 million in November 2015, a 54 percent increase. From July 2013 through December 2013, prior to ACA implementation, DHCS received on average 3,536 new third party liability case referrals per month. The growth in incoming case referrals accelerated after the implementation of ACA, The average number of incoming case referrals reached 5,983 during the months of January through July 2015. This represents an increase of nearly 70 percent compared to the volume prior to ACA implementation.

All incoming cases are reviewed for eligibility and other factors. Those where recovery is deemed-prudent and necessary are set up for processing by an analyst. From January 2014 through July 2015, DHCS experienced 70 percent growth in its active caseload (cases in research status and those awaiting payment), increasing from 18,527 to 31,480 cases. The rapid growth created a "bottleneck" effect, which partly contributed to the increase in the caseload.

DHCS states that current staffing levels are insufficient to complete a thorough and timely analysis and processing of the growing case volume. Within one year of the January 1, 2014 implementation of the Affordable Care Act (ACA), Medi-Cal enrollment increased by 38 percent. This enrollment increase is correlated with the 70 percent increase in cases. The result Is a loss of revenue, delayed processing times, and an increasing backlog. Overall, DHCS states that this work results in approximately $68 million in revenue redirected into the Medi-Cal budget.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 10: STAKEHOLDER PROPOSALS: MEDI-CAL RATES FOR DIALYSIS CLINICS AND CLINICAL LABORATORIES

PANELISTS

- **Michael Arnold**, Legislative Advocate, California Dialysis Council & California Clinical Laboratory Association
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Dialysis Clinics
The California Dialysis Council is requesting a repeal of the AB 97 ten percent rate cut that was approved in 2011, at a cost of $7,025,000 General Fund.

Clinical Laboratories
The California Clinical Laboratory Association is requesting forgiveness of the retroactive ten percent rate cut that was approved through AB 1494 in 2012.

BACKGROUND

Dialysis Clinics
Dialysis clinics are subject to the ten percent Medi-Cal provider rate cut that was approved through AB 97 (budget trailer bill) in 2011. The retroactive payments that were owed due to the delayed implementation were forgiven through subsequent budget action, however the clinics are receiving the ten percent reduction on an on-going basis. The clinics state that they lose money on every dialysis treatment for every Medi-Cal patient. While clinics can cost-shift between public and private insurance, the clinics with the highest percentage of Medi-Cal patients have the last ability to do so and therefore suffer the most as a result of insufficient rates. Hypertension and diabetes are two of the leading causes of end stage renal disease, which is treated with dialysis, and these conditions are most prevalent in the Latino and African American populations. The clinics believe that inadequate reimbursement rates eventually will lead to clinics not being located in lower-income areas of the state, thereby diminishing access to the clinics for Medi-Cal patients. According to stakeholders, some clinics already have extended treatment hours until 1 am, in order to accommodate more patients who have to travel long distances to get to the clinics.

Clinical Labs
Clinical labs that serve Medi-Cal patients are receiving several reductions simultaneously. The labs were subject to the AB 97 10 percent reduction adopted in 2011. Further, AB 1494 (2012 budget trailer bill) authorized the development of a new

rate methodology as well as an additional 10 percent reduction to be in place until implementation of the new rate methodology. There was a significant delay in DHCS securing CMS approval and therefore the AB 1494 ten percent must be collected retroactively. CMS has approved of the new rate-setting methodology, which clinics believe effectuates an additional 10-15 percent reduction. In summary, labs are subject to up to a 35 percent cut as a result of the following:

1. AB 97 10 percent rate reduction -- since 2011 and on-going.

2. AB 1494 10 percent rate reduction -- approved to take effect only until a new rate methodology is implemented.

3. New rate methodology (10-15 percent reduction) -- implemented in July of 2015.

The labs believe that smaller labs, in low-income areas of the state, may end up closing due to the cumulative effects of these three rate reductions. Clinics also expressed concern regarding the very confusing nature of implementing all three of these, and the difficulty clinics are having in knowing how much they will

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Dialysis Council & California Clinical Laboratory Association to present these two proposals, and requests the Department of Finance to provide a cost estimate for both proposals.

The Subcommittee requests DHCS to please describe the overall implementation of the various reductions to laboratories as well as the timing of annual rate setting.

Staff Recommendation: Staff recommends holding these proposals open.

ISSUE 11: STAKEHOLDER PROPOSAL: AIDS WAIVER RATES

PANELISTS

- **Craig Pulsipher,** State Affairs Specialist, Government Affairs, AIDS Project Los Angeles
- **Assemblymember Gipson**
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

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.

BACKGROUND

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.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests AIDS Project Los Angeles to present this proposal, and requests DHCS to respond to the following:

1. Please explain what why the rates would vary for the same services under different waivers within Medi-Cal?

2. Are there legal or other barriers to increasing the rates for these services under the AIDS Waiver, other than increased costs?

Staff Recommendation: Staff recommends holding this proposal open.

ISSUE 12: STAKEHOLDER PROPOSAL: OPTIONAL BENEFITS

PANELISTS

- **Linda Nguy**, Policy Advocate, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Maricris Acon**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Western Center on Law & Poverty and other advocates and stakeholders request the restoration of optional benefits that were eliminated from the Medi-Cal program in 2009. All the restorations are estimated to cost $307,435,000 ($115,910,000 General Fund), as shown in the chart below.

BACKGROUND

Through the 2009 Budget Act and health trailer bill, the state eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary reasons in response to the fiscal crisis. There is considerable support for restoring these benefits to the Medi-Cal program.

States establish and administer their own Medicaid programs (Medi-Cal in California) and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits." Although these benefits were "eliminated," there were exceptions for certain facilities and populations for which the benefits continue to be covered; they include: Federally Qualified Health Centers and Rural Health Centers, emergency room services, patients with developmental disabilities, pregnant women, children (i.e. EPSDT) and PACE programs. The chart below shows the various optional benefits that were eliminated in 2009 and the estimated costs to restore the benefits.

Adult Dental Services

Adult dental services, with the limited exception of “federally required adult dental services” (FRADS) and dental services to pregnant women and nursing home patients, were eliminated among other benefits. Generally, FRADS primarily involves the removal of teeth and treating the affected area. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013 partially restored adult optional dental benefits on May 1, 2014. The chart below shows the cost to fully restore all dental benefits, including partial dentures which currently are not covered.

Restoration Costs

The table on the following page provides the costs associated with restoring these benefits. As pointed out in the table footnotes, these services would be fully federally funded for the population covered under the ACA-related Medi-Cal expansion. For the balance of the Medi-Cal population, the services qualify for federal financial participation at the state's usual 50:50 matching rate.

	Annual Costs November 2015 Estimate				
	FFS	**Managed Care**	**TF**	**GF**	**FFP****
Optional Benefits Restoration:	A	B	A+B		
Acupuncture	$3,878,000	$1,204,000	$5,082,000	$2,110,000	$2,972,000
Audiology	$4,481,000	$1,391,000	$5,872,000	$2,438,000	$3,434,000
Chiropractic	$560,000	$174,000	$734,000	$305,000	$429,000
Incontinence Cream and Washes	$8,248,000	$6,817,000	$15,065,000	$5,600,000	$9,465,000
Optician / Optical Lab	$11,550,000	$2,423,000	$13,973,000	$5,883,000	$8,090,000
Podiatry	$2,474,000	$768,000	$3,242,000	$1,146,000	$1,896,000
Speech Therapy	$285,000	$88,000	$373,000	$155,000	$218,000
Dental*	$234,498,000	$28,596,000	$263,094,000	$98,073,000	$165,021,000
Grand Total	**$265,974,000**	**$41,461,000**	**$307,435,000**	**$115,910,000**	**$191,525,000**

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

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Western Center on Law & Poverty to present this proposal.

Staff Recommendation: Staff recommends holding this proposal open.

ISSUE 13: CALIFORNIA CHILDREN'S SERVICES TRAILER BILL LANGUAGE

PANELISTS

- **Jennifer Kent**, Director, DHCS
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka,** Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill to redesign the CCS program, ending the managed care carve-out, thereby making this a managed care benefit, at least for CCS kids enrolled in Medi-Cal. This trailer bill proposal would implement the budget related components of the CCS Whole Child Model. Specifically, it would clarify State, county, and Medi-Cal managed care health plan roles and responsibilities in counties where DHCS implements the CCS Whole Child Model, with CCS services carved into managed care contracts. The Whole Child Model is proposed to be implemented beginning in January 1, 2017, in some counties with County Organized Health Systems (COHS).

BACKGROUND

The CCS program serves children and youth with special health care needs, primarily through a fee-for-service delivery system for CCS services, and Medi-Cal managed care system for primary care. In counties with populations of 200,000 or more, county CCS programs determine financial, residential, and medical eligibility, authorize CCS services, and provide care coordination. In smaller counties, DHCS performs some of the CCS eligibility and authorization services. Under longstanding realignment provisions, counties have a shared fiscal responsibility for some components of the CCS program.

DHCS states that this complex system of care among fee-for-service providers, health plans, counties, and the State can be challenging for families to navigate and lacks incentives for coordinated, organized care. This is the basis for this proposal.

While not clearly stated in the proposed trailer bill, DHCS states that the proposal is to incrementally implement an integrated coordinated system of care for the CCS program to eliminate the fragmentation that exists in the current CCS health care delivery system, and consolidate all care for the CCS-eligible child under one system. A CCS Whole Child model will be pursued within the existing COHS managed care model. The program will continue to use CCS provider standards and provider network of pediatric specialty and subspecialty care providers. DHCS's goal is for the implementation process to be gradual, with readiness and monitoring components that will enable continuity of care and continued access to specialty care.

The first phase of implementation of the Whole Child model is anticipated to begin no sooner than January 2017, into certain COHS counties contingent upon meeting readiness review requirements. The trailer bill also authorizes the Whole Child model to be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The extension of the Whole Child model to these counties will begin no earlier than July 2017, and will also be subject to a readiness review by DHCS.

In presenting the proposed Whole-Child Model and soliciting stakeholder feedback, DHCS provided a description of the model in June 2015, and presented corresponding statutory changes in July 2015. Based on stakeholder feedback, DHCS published revised statutory changes in August 2015. Those August 2015 statutory changes included language to address the CCS managed care carve-out, as well as detailed beneficiary protections. DHCS now indicates that it does not need statutory authority to implement these details.

Current state statute prevents CCS services from being delivered through managed care except in a small number of counties. Under current law, this carve-out from managed care will expire January 1, 2017. AB 187 (Bonta, Chapter 738, Statutes of 2015), extended the sunset date by one year for the carve-out of CCS from managed care, to January 1, 2017. This trailer bill proposal will implement the budget related components of the model. DHCS states that it will continue to pursue the policy related components of the Whole Child Model outside of legislation to provide for comprehensive beneficiary protections, e.g., monitoring and oversight standards for participating managed care plans; establishment of standards for composition of an appropriate provider network; oversight of care by a clinical advisory committee; access to out-of-network providers; standards for liaison and communication with Regional Centers and in home supportive services providers serving the managed care plan enrollees; and a requirement for an individual assessment of risk level and needs for each managed care plan enrollee.

Stakeholder Concerns

All of the following organizations have shared with the Subcommittee their significant concerns or opposition with this proposal: California Children's Hospital Association, California Chronic Care Coalition, California Hepatitis C Task Force, Children Now, Children's Regional Integrated Service System, County Health Executives Association of California, Down Syndrome Connection of the Bay Area, Down Syndrome Information Alliance, Hemophilia Council of California, March of Dimes Foundation, SEIU California, and the Urban Counties of California. Stakeholder concerns focus on the following issues:

Quality of Care. The primary concern is whether CCS children will experience a decrease in the quality of their care. DHCS states that the provider standards will be the same and that managed care plans will be required to contract with CCS providers. Nevertheless, it is unclear how the program will retain the care coordination expertise of county CCS workers that has evolved over many decades of doing this work successfully. Moreover, children in the program have greatly benefited from the flexibility that the fee-for-service model affords the program, such as in the form of being

referred to the best specialists regardless of geographic location, and the coverage of transportation to get to those specialists. Will managed care plans provide the same level of care in a capitated financing scheme? Generally, CCS families seem to be quite happy with the program and with the care their children receive.

Financing. Certain aspects of the financing remain unclear. Counties receive an enhanced federal match for the CCS work they do; will managed care plans receive those federal funds if they don't contract back with the counties? What happens to the financing arrangement for children who are not in Medi-Cal?

County Phase-In. Stakeholders generally believe that if CCS is going to be redesigned, the redesign should be phased in very slowly. The trailer bill is not clear on exactly which counties would be part of the start of the redesign and on what schedule additional counties would be phased in. The trailer bill proposes no extension to the sunset on the carve-out, so what happens to CCS in the counties that are meant to be phased in later in the process?

Stakeholder/Legislative Process. Stakeholders argue that DHCS totally abandoned months of good work by stakeholders and the department last year. As described above, the stakeholder process uncovered and arrived at agreement on an array of critical details, described above, that provide the stakeholder community some measure of comfort regarding the future of this program. Little, if any, of that work is reflected in the proposed trailer bill language, nor was there any discussion of pursuing this proposal through the budget. Given this, coupled with the absence of any real budget impact, stakeholders feel strongly that this proposal should be handled through a policy bill.

LAO Recommendation

The LAO recommends that the Legislature reject the proposed TBL. They find that the TBL is not necessary to implement the Medi-Cal budget and that the proposed changes to the CSS program would be better handled through the policy process. LAO states that handling the administration's proposed changes through the policy process would allow for a full discussion of the administration's proposal in light of other proposals to redesign CCS that have been considered.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposed trailer bill and respond to the following:

1. Please explain how DHCS justifies such a significant redesign of one of the most well-liked and respected programs in state government simply to address fragmentation. I.e., can DHCS share real evidence that families are unhappy with the program and that the care will improve with this redesign?

2. How would this proposal affect the non-Medi-Cal children in CCS?

3. For some CCS children, counties refer them to specialists outside of their counties of residence and cover their transportation costs; will managed care plans do the same?

4. Counties receive an enhanced federal match for their services; how will these funds be replaced in counties where managed care plans do not contract back with the county?

5. Is it accurate that there is DHCS data that shows that children in counties where CCS is a managed care benefit wait longer for follow up care after leaving the hospital than children in counties where CCS is carved out?

6. Do you have an evaluation of the San Mateo program that you will share with the Legislature and the public?

Staff Recommendation: Staff recommends denying this proposed trailer bill and requesting that the administration pursue the proposal through the policy bill process.