AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, MARCH 18, 2013
4:00 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: OVERSIGHT: DASHBOARD FOR SENIORS AND PERSONS WITH DISABILITIES AND COORDINATED CARE INITIATIVE

On October 25, 2012, the Assembly Health Committee held an oversight hearing entitled "Managed Care Program Initiatives at the Department of Health Care Services (DHCS)," *Assessing the Promise of Coordinated Care*. The purpose of that hearing was to set a framework for evaluating the Medi-Cal managed care programs at DHCS in light of the significant additions of new and vulnerable populations such as children and seniors and people with disabilities. One of the tools discussed was the development of a Monitoring Dashboard and its use in assessing health care quality, network adequacy and access to care in the Medi-Cal managed care program. The intent of this hearing is as a follow-up with a focus on the status of the Medi-Cal Manage Care Dashboard.

PANELISTS

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

BACKGROUND

Currently Medi-Cal Managed Care (MCMC) in California serves about 5.2 million enrollees in 30 counties, or about 69 percent of the total Medi-Cal population. There are three models. The oldest model is the County Operated Health System (COHS). COHS plans serve about one million enrollees through six health plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors and all Medi-Cal enrollees are in the same health plan. The second model is the two-Plan model in which there is a "Local Initiative" (LI) and a "commercial plan" (CP). DHCS contracts with both plans. The Two-Plan model serves about 3.6 million beneficiaries in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Thirdly, two-counties employ the Geographic Managed Care (GMC) model: Sacramento and San Diego. DHCS contracts with several commercial plans in those counties and there are about 600,000 enrollees.

Senate Bill 208 (Steinberg), Chapter 714, Statutes of 2010 codifies many of the provisions of the Section 1115 Medicaid Demonstration Waiver entitled "Bridge to Reform." The waiver authority authorized DHCS to enroll mandatorily Medi-Cal eligible seniors and persons with disabilities (SPDs) into Medi-Cal managed care plans (MCPs) in counties operating the 14 two-plan and two GMC counties. DHCS obtained Federal approval in November 2010 and enrolled approximately 240,000 SPDs between June 1, 2011 and May 1, 2012 in 16 counties.

SB 208 also required DHCS to establish a demonstration program to begin enrolling persons who are eligible for both Medi-Cal and Medicare (dual eligible) into coordinated health care delivery models in up to four counties. During the 2010 Bridge to Reform Section 1115 waiver negotiations, CMS requested that California pursue the dual eligible pilots through a new federal initiative rather than as part the waiver. California was one of 15 states to receive a $1 million design contract through the Center for Medicare and Medicaid Innovation and the Medicare-Medicaid Coordination Office in April 2011. SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, modified the original authority in SB 208 and created the Duals Demonstration Pilot Project/Coordinated Care Initiative (CCI). SB 1008 provides statutory authority for up to eight demonstration counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI will use a capitated payment model to provide Medicare and Medi-Cal benefits through existing MCPs. It will also shift Long Term Services and Supports (LTSS), including In-Home Supportive Services into MCMC for Medi-Cal only SPDs. The 2012-13 Budget Act assumed implementation would begin in March 2013, however in the 2013-14 budget, the Governor proposes to delay the start date to September 1, 2013 and proposes a phased in transition by county. In San Mateo, all dual eligibles are currently enrolled in the COHS for their Medi-Cal benefits and will enroll in managed care for their Medicare benefits on September 1, 2013. In Los Angeles, enrollment is scheduled to take place over 16 months, beginning September 1, 2013. In the remaining six counties, enrollment is scheduled to be phased in over a 12-month period. California has not yet obtained federal approval for the CCI, which will be in the form of a Memorandum of Understanding between the federal Centers on Medicare and Medicaid Services (CMS) and the state.

In the traditional Fee for Service payment model in the commercial market as well as in Medicare or Medi-Cal, a provider submits a claim for services provided and the claim can be audited and verified. However, under a capitated managed care payment system, the plan is paid a per member per month payment and it is incumbent upon the plan to ensure that the services are provided. A number of regulatory and statutory safeguards have been developed because of the lack of a direct link between the payment and the services. For example, in California most managed care plans operate under the regulatory framework of the Knox-Keene Act of 1975. It is a comprehensive set of statutes and regulations including, mandatory basic services, financial stability requirements, availability and provider accessibility requirements, review of provider contracts, administrative organization requirements, consumer disclosure, and grievance requirements. Among the factors that led to its passage were

a number of scandals associated with Medi-Cal prepaid health plans and lax oversight by the Department of Health Services (now DHCS) in the early 70's when Governor Reagan expanded use of PHPs in the Medi-Cal program as a means of reducing costs. The Department of Managed Health Care (DMHC) administers the Knox-Keene Act. DMHC operates an "HMO Help Center" with a toll free hotline that is answered 24 hours a day. Through coordination among help center, licensing, and enforcement staff, additional audits, investigations, or enforcement activities are initiated if DMHC identifies a pattern of problems through consumer or provider complaints. All MCPs in the two-plan and GMC model are required to obtain a Knox-Keene license but plans operating as a COHS are not, although DHCS requires them to meet the equivalent standards by contract.

DHCS has also established Quality and Performance Improvement Program requirements for all Medi-Cal MCPs. All MCPs are contractually required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing Quality Improvement Projects. DHCS reported at the October 25, 2012 Assembly Health Committee Oversight Hearing, that it had recently developed the Strategy for Quality Improvement in Health Care, a blueprint to improve the health of Californians, improve the quality of all DHCS programs, and reduce the Department's per capita health care costs. According to DHCS, this Quality Strategy and a multi-year implementation plan would emphasize the use of measures, including the Healthcare Effectiveness Data and Information Set (HEDIS) and other quality metrics to guide the establishment and measurement of quality improvement efforts department-wide. DHCS also reported that MCPs are required to report specified HEDIS performance requirements annually. For 2013, in addition to 14 HEDIS measures, DHCS was including one customized measure for determining rates of hospital readmissions within 30 days of discharge and a methodology for stratifying several measures into separate populations including SPDs and non-SPDs.

With the support of the California Healthcare Foundation (CHCF), DHCS has undertaken additional efforts to monitor the performance of Medi-Cal managed Care. A November 2005 Report, Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions was prepared for CHCF to provide recommended health plan performance standards and measures to improve the way people with disabilities and chronic conditions receive services through the MCMC Program. According to that report, people with disabilities account for 40 percent of Medi-Cal expenditures, but represent only 14 percent of the program's enrollees. The 2005 Report also stated that people with disabilities have a wide variety of physical impairments, mental, developmental, and other chronic conditions. In addition, the 2005 Report noted that this population had a complex array of specialty, ancillary, and supportive services, are likely to have multiple chronic or complex conditions and experience a dizzying array of physical, communication, and program barriers.

The 2005 Report was intended to be used as a basis for managed care contract standards. According to an August 2012 report, also prepared for CHCF, there was great concern among advocates that MCPs were not prepared for a large influx of SPDs, did not have the systems in place to coordinate care for this high-cost population, and had incentives to withhold some services. According to the 2012 report, the advocates were also concerned that DHCS was not prepared to monitor access and quality of care for this population. As a result, CHCF led a project, conducted in collaboration with DHCS to ensure that the contracts addressed the needs of this population and made 53 recommendations for performance standards. The August 2012 Report concludes that the next step is for DHCS to ensure that the MCPs with which it contracts meet these standards and must hold them accountable for their performance. It also concludes that a similar process could be used to address the needs of other Medicaid populations such as the dual eligible.

Currently, although there are numerous measures of health plan performance from many different tools and surveys, no structured mechanism exists to pull this information together in one place, prioritize which measures are most important and identify gaps, and assess what it means in terms of performance of the managed care program overall or of participating health plans.

DHCS, with support from CHCF is developing a mechanism for ongoing monitoring of the managed care program and participating health plans. CHCF has contracted with Navigant Consultant for this project. A Technical Assistance Workgroup has been created and the first meeting was held by phone on March 13, 2013.

Navigant will develop the specifications for a tool to monitor the performance of the managed care program as a whole and compare the performance of participating health plans. These specifications will identify the measures, sources of data, frequency of reporting, benchmarks and thresholds, and key comparative indicators.

Navigant will consider numerous measures of managed care program and health plan performance including:

- Quality measures (e.g., HEDIS);
- Member experience/satisfaction (e.g., CAHPS);
- Other data on quality, access and experience (e.g., ombudsman reports; disenrollment rates; Medi-Cal enrollee survey, complaints/grievances/appeals; data collected by the DMHC);
- Other measures of performance (e.g., measures of safety net participation);
- Financial performance indicators (e.g., operating margin; medical loss ratio); and,
- Process measures (e.g. choice rate, opt-out, and Medical Exemption Request (MER) rates, utilization of long-term support services and behavioral health care).

In addition to performance measures, the dashboard will provide basic facts about the program, such as number of enrollees in each plan, demographics by county and plan (language, age, aid categories, etc.). Specific Dashboard development activities include:

- Interview Medi-Cal program officials and other stakeholders including representatives of health plans, safety net and other providers, consumers groups, and other knowledgeable experts to identify the goals and priorities of the Medi-Cal managed care program that should be reflected in the dashboard, to identify potential sources of data, and to gather ideas on potential measures;
- Conduct a scan of performance dashboards used by public or private health care purchasers;
- Identify and review federal guidelines and recommendations (e.g., the Core Set of Health Quality Measures for Medicaid-Eligible Adults) and other pertinent documents (e.g., The 1993 DHS Strategic Plan that created the Two Plan Model);
- Develop criteria for measure selection;
- Identify and review data available from DHCS;
- Identify and assess sources of comparative data - e.g., data for Medicaid managed care programs in other states; data for commercial managed care in California, trend data;
- Review available information about the quality and completeness of data from DHCS and other resources;
- Develop recommendations for the design specifications, including:
  - ✓ individual and composite measures;
  - ✓ benchmarks and thresholds;
  - ✓ longitudinal data;
  - ✓ the use of modules that address specific populations of interest, such as dual eligibles, other seniors and people with disabilities, and children; and,
  - ✓ the frequency of reporting.
- Present recommendations to and solicit feedback from the Chief of the Medi-Cal Managed Care Division (MMCD), to MMCD's Advisory Group, and to a CHCF-sponsored technical work group; and,
- Revise recommendations based on feedback from the technical work group.

Navigant will prepare two versions of a performance dashboard. One version of the dashboard will be for publication by CHCF as a snapshot. The second version of the dashboard will be prepared in a format to be determined by DHCS for ongoing monitoring.

Navigant will prepare a memorandum with recommendations for future improvements to the dashboard that will address important limitations in available data. For example, Navigant might recommend specific data be collected for future versions or it might recommend changes in the way data are reported to DHCS that would allow for more flexible aggregation (e.g., across plans) and disaggregation of data (e.g., by enrollee characteristics).

Navigant will prepare a report for publication by CHCF and present its findings at a briefing in Sacramento. The final report will summarize research findings, present final design specifications, and provide recommendations for ongoing monitoring.

STAFF COMMENTS/QUESTIONS

Advocates for seniors, people with disabilities and children continue to have concerns similar to those identified in the August 2012 Report prepared for CHCF regarding enrollment of people with disabilities into MCPs. However, the Managed Care Dashboard Project is moving forward although not scheduled to be final until June 2013. DHCS has indicated that it will only be for internal purposes at that time.

The Director has assured the Chairman of the Assembly Health Committee that the dual eligible demonstration project will not occur until the Dashboard is in operation. He has also committed to holding public meetings on a quarterly basis to review and monitor the managed care program, but not until after the creation of the Dashboard.

DHCS, with the support of CHCF has made substantial progress towards developing a monitoring plan that truly evaluates the managed care program. The Dashboard will address many of the issues raised by advocates such as performance and outcome measures, medical loss ratios and network adequacy. The legislature remains concerned that without the support of CHCF and the transparency resulting from legislative oversight, public evaluation and oversight of the performance of the Medi-Cal managed care program will not remain a priority.

Staff Recommendation: Oversight issue; no action recommended

ISSUE 2: DEPARTMENT OVERVIEW

The Subcommittee has asked DHCS to provide an overview of the department and its proposed budget. The overview should cover major new and on-going initiatives at the department, major new proposals, and a review of changes to DHCS activities and functions that have occurred over the past four years as a result of the state's fiscal crisis.

PANELISTS

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

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.

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

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

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

Mental Health & Substance Abuse. As adopted in the 2011 and 2012 Budget Acts, DHCS is also overseeing the delivery of community mental health and substance use disorder services.

New Programs. Transferred from the Department of Public Health (as approved through the 2012 Budget Act), DHCS now oversees family planning services, cancer screening services to low income under-insured and uninsured women and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program and the Prostate Cancer Treatment Program.

DHCS Budget

For Fiscal Year (FY) 2013-14, the Governor's Budget proposes $63 billion for the support of DHCS programs (primarily Medi-Cal, which is discussed in more detail below). Of this amount, $518,432 is budgeted for state operations, while the remaining $62.5 billion is for local assistance. The proposed budget reflects a very small increase (.6 percent) over the current year budget.

DEPARTMENT OF HEALTH CARE SERVICES *(Dollars in Thousands)*					
Fund Source	**2011-12 Actual**	**2012-13 Projected**	**2013-14 Proposed**	**BY to CY Change**	**% Change**
General Fund	$15,287,064	$15,328,164	$15,942,266	$614,102	4%
Federal Fund	24,693,118	37,945,375	37,220,657	(724,718)	(2%)
Special Funds & Reimbursements	4,019,615	9,365,490	9,891,302	525,812	5.6%
Total Expenditures	**$43,999,797**	**$62,639,029**	**$63,036,225**	**$397,196**	**.6%**
Positions	**2,762.9**	**3,258.7**	**3,475.2**	**216.5**	**6%**

The Medi-Cal Program. Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 47-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, and people with disabilities. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match of the federal funds.

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

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

Funding for the Medi-Cal program is summarized in the table below. Medi-Cal costs have grown about six-percent annually since 2006-07 due to a combination of health care cost inflation and caseload growth. The proposed 2013-14 Medi-Cal local assistance budget is slightly lower than the estimated 2012-13 budget, which reflects savings achieved through the myriad of reductions made over the past few years.

Medi-Cal Funding Summary (000s)	2012-13 Estimate	2013-14 Proposed	CY to BY $ Change	% Change
Medical Care Services	56,939.6	55,901.3	($1,038.3)	(1.8%)
County Administration (Eligibility)	2,769.1	3,564.4	$795.3	28.7%
Fiscal Intermediaries (Claims Processing)	337.7	312.7	$25.0	(7.4%)
Total Local Assistance	**60,046.4**	**59,778.4**	**($267.9)**	**(.4%)**
General Fund	14,897.1	15,251.1	354.0	2.4%
Federal Funds	37,264.2	35,918.0	($1,346.2)	(3.6%)
Other Funds	7,885.0	8,609.3	$724.3	9.2%

DHCS in 2013

Over the past few years, DHCS has undergone a substantial transformation into a much larger department, though not in terms of dollars or positions. DHCS has undertaken a massive increase in authority and responsibility in terms of both programs that have been transferred from other departments to DHCS as well as significant new Medi-Cal initiatives. The proposed 2013-14 budget for this department is modest in scope, compared to the workload already underway, which is massive in scope, including:

- **ACA Medi-Cal Expansion**. The ACA funds an expansion to state Medicaid programs and the Governor has included a proposal to implement this through the budget, which was the subject of this Subcommittee's hearing on March 6, 2013 and also will be discussed at future hearings.

- **Healthy Families Transition**. In 2012, the Governor proposed and the Legislature approved of the transition of all approximately 860,000 children in the Healthy Families Program to Medi-Cal. The first phase of the transition began on January 1, 2013. This transition was one of the subjects of the Subcommittee's joint oversight hearing on February 28, 2013, and is scheduled to be discussed again on April 22, 2013.

- **Coordinated Care Initiative (CCI)**. In 2012, the Governor proposed and the Legislature approved a modified version of this integrated care model for "dual eligibles" (in Medicare and Medi-Cal), involving the creation of an entirely new way to provide care to this population. Through the proposed 2013-14 budget, the Governor announced a delay in the start of the CCI to September 1, 2013.

- **Seniors & Persons With Disabilities**. In 2011-12, DHCS transitioned 240,000 "SPDs" into managed care, from fee-for-service Medi-Cal. The full impact of this transition remains to be known and is still unfolding.

- **Rural Managed Care**. In 2012, the Governor proposed and the Legislature approved of providing DHCS authority to seek out and establish contracts with managed care organizations to serve Medi-Cal beneficiaries in California's 28 still-fee-for-service and primarily rural counties.

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

- **Substance Use Disorder Treatment Services**. The 2011-12 budget package moved Drug Medi-Cal from the Department of Alcohol and Drug Programs (DADP) to DHCS, and the proposed 2013-14 budget includes the transition of the remaining non-Medi-Cal DADP programs to DHCS. *This proposal will be considered at the Subcommittee's hearing on April 10, 2013.*

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

Fiscal Solutions

The state's recent fiscal crisis had very significant impacts on the state's health care safety net, this department, and the Medi-Cal program in particular. Some of the many reductions and changes included the following: elimination of many “optional benefits” (dental, psychology, audiology, speech therapy, optometry, podiatry, Adult Day Health Care (ADHC), and others); adoption of the first-ever mandatory co-pays in Medi-Cal and a utilization cap of 7 physician visits per patient per year (both pending federal approval); elimination of coverage of enteral nutrition products; implementation of mid-year status reports; repeated suspensions of annual COLAs, coupled with multiple additional funding reductions, to counties for eligibility administration; substantial reductions to hospitals and clinics; and multiple provider rate reductions.

STAFF COMMENTS/QUESTIONS

As with all departments, the Subcommittee has asked DHCS to provide an overview of the department and its budget, with a focus on the impacts of the fiscal crisis on DHCS activities, functions, and programs. The Subcommittee is interested in understanding how Californians, particularly low-income and otherwise vulnerable populations, have been affected by the changes in state government that were a result of the fiscal crisis.

Staff Recommendation: Informational item; no action recommended

ISSUE 3: AFFORDABLE CARE ACT COVERAGE FOR FORMER FOSTER CARE YOUNG ADULTS

Advocates are proposing that the State expand the Medi-Cal program in order to cover former foster youth (FFY) up to age 26, for the first half of the 2013-14 budget year, as a bridge to full implementation of the Affordable Care Act (ACA), which includes coverage of this population under Medicaid, beginning January 1, 2014.

PANELISTS

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

BACKGROUND

The ACA includes provisions ensuring access to insurance for young adults up to age 26. For most young adults, this coverage can be obtained through a parent's employer-based coverage. For young adults who were in the foster care system, the ACA requires state Medicaid programs to provide categorical eligibility for them on January 1, 2014. Therefore, on January 1, 2014, FFY will be eligible for Medi-Cal until age 26, and the state will receive 50 percent federal financial participation for this coverage.

Currently, the Medi-Cal program covers FFY until age 21. Therefore, any FFY who reaches his or her 21st birthday before January 1, 2014, will lose coverage only to become eligible again on January 1. The exception to this is FFY who have a disability or a child and meet current Medi-Cal income eligibility requirements. Advocates' concerns are two-fold: 1) the fundamental inequity in already statutorily ensuring access for young adults through parents and the private market, while leaving this gap in coverage for FFY; and, 2) the likely disruptions in health care coupled with challenges to ensuring this population returns to coverage on January 1, 2014.

If the state chooses to make no changes to the Medi-Cal program, for this group of FFY who reach age 21 this year, many of these individuals would be able to access coverage through their county Low-Income Health Program (LIHP), which is a temporary "bridge" created to provide coverage until the Medi-Cal program expands and the health benefits exchange begins operating in 2014. LIHP coverage would be available to many FFY, but not all, because: 1) not all counties have LIHP programs; and, 2) each county LIHP has its own income eligibility requirement, which a FFY may or may not meet.

Children Now (CN), a children's advocacy organization, has brought this issue to the attention of the Subcommittee and proposes that the state extend coverage to FFY up to age 26, beginning immediately, in order to ensure continuous coverage and continuity of care for this population between now and January 1, 2014. CN has provided a cost estimate of approximately $2.7 million total funds (approximately $1.3 General Fund if California receives federal matching funds) to implement this gap coverage. This proposal would allow all FFY currently in Medi-Cal to stay in Medi-Cal past their 21st birthdays, and would also allow any FFY between ages 21 and 26 to return to Medi-Cal before January 1, 2014. While this proposed policy would ensure the greatest health coverage for the largest number of FFY, CN also has suggested a couple of alternatives, including: 1) extending coverage just to those currently in Medi-Cal who reach their 21st birthdays prior to January 1, 2014; and, 2) various ways to conduct outreach to this population in order to ensure they are aware of their coverage options beginning on January 1, 2014, including:

1. Gathering contact information for gap kids and other newly eligible FFY, so that they can be immediately contacted and enrolled once the state implements the expanded eligibility provision;

2. Providing education and outreach to newly eligible FFY about their current eligibility for coverage programs, including the Low-Income Health Program (LIHP) and Medi-Cal;

3. Enabling former foster youth who seek coverage through the Exchange to self-identify and receive information about their coverage options; or,

4. Ensuring that enrollment portals screen for FFY so that these youth can self-identify when investigating/enrolling for coverage.

STAFF COMMENTS/QUESTIONS

As is well known and documented kids in the foster care system, and young adults who were in the system as children, comprise a particularly vulnerable population. Health care is therefore a critical component to an overall safety net that is necessary to maximize the potential for these young people to make a successful transition to adulthood. When the state fails, or even just skimps, to meet its responsibilities to this population, these kids pay a high price, which ultimately translates into a high price for the state in the form of emergency health care services, criminal justice costs, and the costs of increased dependence on social service programs. The state is obligated to provide FFY with at least the same level of societal supports that are available to their fellow non-foster care citizens.

The Subcommittee has asked DHCS to describe the Administration's position on this proposal and answer the following questions:

1. What is the Administration's cost estimate for providing coverage throughout 2013 to: 1) FFY already enrolled in Medi-Cal who reach their 21st birthday this year; and, 2) to all FFY under the age of 26.

2. How many young adults make up each of the two populations identified in question 1 above?

3. What is the reason that FFP would not be available for this population with approval of a State Plan Amendment or Waiver?

Staff Recommendation: Staff recommends approving of extending Medi-Cal coverage to former foster youth, up to age 26, and adoption of placeholder trailer bill to implement this change.

ISSUE 4: FAMILY HEALTH PROGRAM ESTIMATE

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

PANELISTS

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

BACKGROUND

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, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and the DHCS. Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible; the Medi-Cal program reimburses their care. The cost of care for the other 30 percent of children is split equally between "CCS Only" and "CCS Healthy Families." The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds.

CCS Budget

Excluding Medi-Cal, the proposed CCS budget includes total funds (TF) of $130.9 million ($53.6 million GF), as compared to the current year estimate of $265.6 million TF ($81.6 million GF). This $134.6 million ($27.9 million GF) reduction primarily reflects the transition of approximately 860,000 children from Healthy Families to Medi-Cal. Therefore, this is not a savings for the state, and rather a cost shift from the CCS Healthy Families program to Medi-Cal. Therefore, the Medi-Cal estimate includes an increased cost of approximately $134.6 million (as the state continues to receive 65 percent FFP and 17.5 percent county funding for this population).

The CCS estimate assumes savings of $136,200 (2012-13) and $25,300 (2013-14) as a result of the 10 percent provider rate reduction that was adopted in AB 97 (health budget trailer bill, Statutes of 2011) and anticipated to be implemented in June 2013. Although this portion of CCS is non-Medi-Cal, the non-Medi-Cal CCS rates follow the Medi-Cal rates.

Non-Medi-Cal CCS Budget		
	2012-13	2013-14
CCS Only	$93,184,300	$99,931,900
CCS Healthy Families	$172,418,200	$31,010,400
TOTAL CCS	**$265,602,500**	**$130,942,300**
Federal Funds	$184,012,400	$77,259,050
General Fund	$81,590,100	$53,683,250
Non Medi-Cal Caseload	35,919	19,674
Medi-Cal Caseload	137,184	139,563

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 the Healthy Families program.

CHDP Budget

The proposed CHDP budget includes $1.8 million TF ($1.78 million GF), as compared to the current year estimate of $1.78 million ($1.75 million GF). The program also receives $24,000 in Childhood Lead Poisoning Prevention Funds to cover the cost of blood tests for lead.

GHPP

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

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

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

GHPP Average Monthly Caseload		
	2012-13	2013-14
GHPP Only	862	889
Medi-Cal GHPP	732	765
TOTAL	**1,594**	**1,654**

GHPP Budget

The proposed GHPP budget includes total funds of $107.5 million ($75 million GF), compared to the current year estimate of $85.2 million ($52.6 million GF). This $22.3 million (26 percent) GF in part reflects a $10.4 million settlement that DHCS expects to receive from Bio-Med Plus, Inc., related to provider fraud against the GHPP, in the current year only.

STAFF COMMENTS/QUESTIONS

1. Please explain the $22.3 million (26 percent) increase in the GHPP General Fund, from current year to budget year.

The state is required by the federal government to conduct access studies in order to implement rate reductions within the Medi-Cal program. In compliance with this, DHCS conducted an access study associated with the adoption and planned implementation of the ten percent provider rate reduction included in AB 97 (2011). Based on this study, DHCS exempted certain services from the reduction.

1. The Subcommittee has asked DCHS to clarify which services were exempted, whether or not pediatric services were exempted, and if so why a rate reduction is being implemented in the CCS program.

Staff Recommendation: Staff recommends holding open the Family Health Estimate, pending updated information at May Revise.

ISSUE 5: PROGRAMS TRANSFERRED FROM DEPARTMENT OF PUBLIC HEALTH

The purpose of this item is to ask DHCS to provide an update on the transition and budgets of the following three programs that, through the 2012 Budget, were transferred from the Department of Public Health (DPH) to DHCS: the Every Woman Counts Program (EWC), the Family Planning Access Care and Treatment Program (FPACT), and the Prostate Cancer Treatment Program (also known as IMPACT). The Administration reports that these programs have been transitioned successfully to DHCS, and that they are operating in the same way they were at DPH.

PANELISTS

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

BACKGROUND

As proposed by the Governor last year, these programs were transitioned from DPH to DHCS in an effort to maintain all direct services at DHCS, while keeping the focus at DPH on population-based prevention activities. The following is background and an update on each program:

Every Woman Counts

Every Woman Counts (EWC) provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to California's underserved women. Women qualify for these services if they:

- are 40 years old or older (for breast cancer screening) or 21 years old or older (for cervical cancer screening);
- have low income (at or below 200 percent of federal poverty);
- have medical insurance that does not cover breast cancer screening;
- have a high insurance deductible or co-payment;
- are not getting these services through Medi-Cal or another government-sponsored program; and,
- live in California.

EWC Budget

As shown in the table below, the EWC budget reflects significant fluctuations in General Fund. The 2012 Budget Act appropriated total funds of $44.8 million, including $10.3 million General Fund, however the November 2012 estimate for the current year projects only $38.9 million total funds, including $4 million General Fund. The appropriations rise again in the proposed 2013-14 budget, with total funds of $48.5 million, including $13.9 million General Fund. The 2013-14 increased costs can be explained by the following significant changes within the program:

1. AB 359 (Nava), Chapter 435, Statutes of 2009 authorized the EWC to reimburse providers using digital mammography at the analog mammography rate. At that time, the state was not reimbursing providers for digital mammography; therefore, this bill allowed these providers to receive at least partial reimbursement rather than none at all. AB 359 will sunset on December 31, 2013 at which point DHCS will begin reimbursing providers for digital mammography at a rate higher than analog mammography. The budget estimates increased costs of $4.6 million as a result of this new increased reimbursement rate.

2. SB 1538 (Simitian), Chapter 458, Statutes of 2012 requires health facilities administering mammograms to women, 40 years or older, to notify patients whose breasts are categorized as being heterogeneously or extremely dense and inform the patients that they may benefit from supplementary screening due to the level of dense breast tissue seen on the mammogram. These notices will result in patients requesting additional screening tests, such as magnetic resonance imaging (MRI) and ultrasounds. The bill becomes operative on April 1, 2013 and sunsets on January 1, 2019. The budget estimates the new EWC costs of implementing this bill to be $1 million in 2012-13 and $4.1 million in 2013-14.

Every Woman Counts Program Budget			
	2012-13 Budget	2012-13 November Estimate	2013-14 Proposed
General Fund	$10,317,000	$4,002,000	$13,960,000
Prop 99	$22,081,000	$22,081,000	$22,081,000
Breast Cancer Control Account (tobacco tax)	$7,912,000	$7,912,000	$7,912,000
Federal CDC Grant	$4,509,000	$4,913,000	$4,644,000
TOTAL	**$44,819,000**	**$38,908,000**	**$48,597**
Caseload	295,000	301,760	313,548

Neither DHCS, nor Subcommittee staff, have been contacted by advocates or stakeholders with concerns regarding the transition of the EWC from DPH to DHCS or regarding the implementation of the program, thus far, at DHCS.

Family PACT

Family PACT provides comprehensive family planning services to eligible low-income (under 200 percent federal poverty level) men and women. Family PACT serves 1.6 million income eligible men and women of childbearing age through a network of 2,400 public and private providers. Services include comprehensive education, assistance, and services relating to family planning. The FPACT program operates under the Office of Family Planning, which was moved from DPH to DHCS through the 2012 Budget Act. The FPACT program budget is a component of the overall Medi-Cal estimate.

IMPACT

Prostate cancer is the most common cancer in California men, afflicting one in six men. Men with prostate cancer have a better chance of long-term survival when treatment begins at an early stage of the disease. The Prostate Cancer Treatment Program (PCTP) is also called "IMPACT:" **I**mproving **A**ccess, **C**ounseling & **T**reatment for Californians with Prostate Cancer. IMPACT, which is operated through a contract with UCLA, pays for prostate cancer treatment for up to 12 months for qualified individuals. Treatment is available throughout California. To qualify for services, a man must:

- be 18 years old or older;
- have a diagnosis of prostate cancer;
- have low income;
- have no medical insurance, and do not qualify for Medicare or Medi-Cal; and,
- live in California.

The proposed 2013-14 budget appropriates $3.1 million General Fund for the IMPACT program, the same amount of funding provided to this program for the past several years. Advocates have not raised any concerns about the transition of the program or its operation at DHCS, however they are concerned about the future of the program within the context of ACA implementation, given the Administration's proposal to restrict access to the program (described below under Staff Comments). Advocates point out that there is a vast unmet need for this program; an estimated 5,000 Californians are eligible for the program today, yet the program's funding allows for a caseload of only approximately 500.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to answer the following questions:

1. In EWC, what is the explanation for the GF reduction of approximately $6 million from the 2012 Budget Act to the November 2012-13 estimate?

2. What's the reason that, in EWC, there is no projected caseload reduction, and corresponding budget reduction, for women who will likely gain comprehensive coverage through either Low-Income Health Programs in 2013 or through Medi-Cal or the Exchange in 2014?

Affordable Care Act (ACA)
The ACA requires states to implement simplifications to state Medicaid programs; thus, simplifications can be expected to lead to increased enrollment and retention of currently-eligible individuals. The Administration therefore refers to these ACA-mandates as the "mandatory Medicaid expansion." In order to implement this part of the ACA, the Administration has proposed bill language, in the form of amendments to SB 28, and has included in this language proposed new restrictions on various state-only programs, including EWC, FPACT, IMPACT, and GHPP.

1. The Subcommittee has asked DHCS to describe the changes to these programs that the Administration has included in their proposed language ("amendments to SB 28") to implement various program simplifications that are mandated in the ACA.

Please note that the Subcommittee will have a more detailed and focused discussion on the Administration's proposal to restrict state-only programs at its hearing on Monday, April 8, 2013.

Staff Recommendation: Informational item; no action recommended

ISSUE 6: COMMUNITY MENTAL HEALTH

Over the past two years, major changes have occurred in the organization of community mental health services (all mental health services outside of state hospitals) within state government. Specifically:

- The Department of Mental Health (DMH) was eliminated and replaced by the Department of State Hospitals (which has the sole function of overseeing state hospitals);
- The transfer of community mental health programs and functions from the former DMH to other departments, primarily DHCS;
- The realignment of Medi-Cal mental health programs from the state to counties; and,
- Significant changes to the state administration of Mental Health Services Act (MHSA/Proposition 63) funds.

These changes, transitions, and updates are discussed in more detail below under "Background."

PANELISTS

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

BACKGROUND

Specialty Mental Health Services (Medi-Cal)
Specialty mental health services, formerly referred to as Mental Health Managed Care (for adults) and Early, Periodic, Screening, Diagnosis & Treatment (EPSDT, for children), were realigned from the state to the counties as part of the 2011 realignment. Therefore, while the state, now through DHCS, continues to have responsibility for oversight of the delivery of mental health services through the Medi-Cal program, counties operate and cover the state share of cost for these services. DHCS has replaced DMH in the role of oversight agency.

Given realignment, the state budget primarily reflects the federal financial participation for specialty mental health services, contained in the overall Medi-Cal estimate. The budget appropriations can be seen in the table below:

Specialty Mental Health Funding *(approximate funding amounts)*			
	2012-13 November Estimate	2013-14 Proposed	CY to BY Change
General Fund	$1,548,000	$33,916,000	$32,367,000
Federal Funds	$1,459,657,000	$1,506,569,000	$46,912,000
Local Revenue Funds (Realignment)	$1,243,895,000	$1,298,258,000	$54,363,000
County Funds	$218,702,000	$232,339,000	$13,637,000
TOTAL FUNDS	**$2,926,090,000**	**$3,073,545,000**	**$147,455,000**

The significant developments that affect the overall budget for Medi-Cal mental health services include the following:

1. Katie A. Settlement
   In approximately 2005, the state was sued, in Katie A. v. Diana Bonta, based on insufficient wraparound and therapeutic mental health services being provided to children in foster care and those at risk of foster care placement. In December of 2011, the court gave final approval to a proposed settlement that the parties had agreed to earlier that year. The settlement stipulates that beneficiaries, who meet medical necessity criteria, may receive an increase in existing services that are to be more intensive and effective, and that the state is required to begin providing these additional services by January 1, 2013. The increase in costs associated with these services, and this legal settlement, is estimated to be $9.8 million in 2012-13 and $23.1 million in 2013-14. This is just federal funds; there is no General Fund impact due to the realignment of these services.

2. Healthy Families Program Transition
   AB 1494 (2012 health budget trailer bill) approved of the transition of nearly all approximately 860,000 children from the Healthy Families Program to Medi-Cal. The Administration intends to implement the full transition within the 2013 calendar year. This transition shifts costs from the Healthy Families Program and budget to Medi-Cal, and these new costs can be seen in various parts of the Medi-Cal budget, including in Specialty Mental Health Services. The increase in costs associated with these services is estimated to be $8.3 million in 2012-13 and $33.5 million in 2013-14 in federal funds. There are no General Fund costs in mental health, associated with this transition, since mental health has been realigned to counties.

MHSA/Proposition 63

In addition to the transfer of MHSA oversight responsibility from DMH to DHCS, significant reforms to MHSA administration were adopted through AB 100 (health budget trailer bill, statutes of 2011). Among other provisions, AB 100 reduced the cap on MHSA administration funding from 5 to 3.5 percent, eliminated the review of County MHSA Plans, and required the State Controller to distribute MHSA funds to counties. As the current oversight agency, DHCS produces a report that accompanies both the January and May proposed budgets that outlines the use of the MHSA administration dollars. The funds are proposed to be appropriated through many different departments as is detailed in the following chart:

MHSA/Prop 63 Administrative Expenditures

AGENCY/DEPARTMENT	2011-12 Actual	2012-13 Estimate	2013-14 Proposed
Judicial Branch – funding and positions for prevention and early intervention for juveniles with mental illness in the juvenile court system and for addressing workload related to adults with mental illness	$1,054,000	$1,061,000	$1,049,000
State Controller's Office – funds for the 21st Century Project, a new human resource management system payroll system for state departments	1,733,000	1,584,000	0
Office of Statewide Health Planning & Development – funding and positions to manage the WET component of the MHSA	6,613,000	1,150,000	1,471,000
DHCS – funding and positions for MHSA oversight, developing county performance contracts, reviewing monthly county allocation methodology and other functions	452,000	9,341,000	9,959,000
Dept. of Public Health – funding and positions for the California Reducing Disparities Project	0	17,342,000	17,195,000
Dept. of Developmental Services – funding and one position for coordinating distribution of funds to Regional Centers	1,133,000	1,129,000	1,128,000
Department of State Hospitals – MHSA oversight functions transferred to DHCS	12,210,000	0	0
Mental Health Services Oversight and Accountability Commission – funding and positions to provide oversight and accountability for the MHSA, per the MHSA statute	5,340,000	6,925,000	6,916,000

Dept. of Education – funding and one position to support collaborative work between mental health programs, local education agencies, county offices of education and special education local plan areas to provide mental health services to students	251,000	159,000	179,000
Community Colleges (Board of Governors) – support for one position that develops policies and practices that address the mental health needs of students	109,000	103,000	126,000
FI$CAL – funding to transform the state's systems and workforce to operate in an integrated financial management system environment	103,000	141,000	225,000
Military Dept. – funding and positions to support a pilot behavioral health outreach program related to coordination between the California national Guard, local veterans' services and county mental health departments	539,000	561,000	1,351,000
Dept. of Veterans Affairs – funding and positions to support a statewide administration to inform veterans and family members about mental health services	433,000	496,000	505,000
Statewide General Administrative Expenditures – assessment to the MHSA for recovery of central service costs	24,000	13,000	0
TOTAL ADMIN	**$29,994,000**	**$40,005,000**	**$40,104,000**
LOCAL ASSISTANCE	$1,812,375,000	$1,377,775,000	$1,362,650,000
TOTAL PROP 63 EXPENDITURES	**$1,842,369,000**	**$1,417,780,000**	**$1,402,754,000**

Behavioral Health

DHCS now has a Behavioral Health division to oversee community mental health and substance abuse functions and programs. The mental health functions were transferred from DMH to DHCS in the 2012 budget, and the 2013-14 budget proposes to transfer various substance abuse treatment programs from DADP to DHCS, a proposal that will be discussed in greater detail at the Subcommittee's hearing on Wednesday, April 10th. "Drug Medi-Cal," which provides substance abuse treatment services to people enrolled in Medi-Cal, was already transferred from DADP to DHCS and is discussed in greater detail further on in this agenda.

According to DHCS, this new behavioral health division primarily has taken on various new responsibilities and functions, rather than operating new programs. Some examples of these new functions include: oversight of realigned Specialty Mental Health and Drug Medi-Cal; oversight of the MHSA administrative funding; coordination with the California Mental Health Planning Council; and responsibility for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants. They also operate the State Level Prevention Program, which covers: 1) suicide prevention; 2) stigma and discrimination reduction; 3) students' mental health; and, 4) veterans' mental health.

STAFF COMMENTS/QUESTIONS

The estimate states that the Katie A. v. Diana Bonta settlement mandates the provision of more intensive services to be provided in a more effective manner by January 1, 2013.

1. Are those services now being provided? Please describe these services.

Staff Recommendation: Hold open pending updated information at May Revise

ISSUE 7: TRANSFER OF MENTAL HEALTH LICENSING FROM DSS TO DHCS

The Administration is proposing to transfer mental health licensing (of Psychiatric Health Facilities and Rehabilitation Centers) and quality improvement functions, including 12.0 permanent positions and expenditure authority of $728,000 ($337,000 GF, $391,000 SF, $396,000 FF), from the Department of Social Services (DSS) to DHCS.

PANELISTS

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

BACKGROUND

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

Proposed Trailer Bill

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

STAFF COMMENTS/QUESTIONS

The Subcommittee has not heard from stakeholders or advocates who are opposed or expressing concerns about this proposal. According to DHCS, based on their work with stakeholders on the DMH reorganization, most stakeholders and advocates favored moving these functions to DHCS even last year when they were moved to DSS.

Staff Recommendation: Hold open

ISSUE 8: 1991-92 REALIGNMENT GROWTH—MENTAL HEALTH & CALWORKS MOE SUBACCOUNTS PROPOSED TRAILER BILL

The Administration has proposed trailer bill that would change the growth formula for mental health realignment funds, beginning in 2015-16, in order to share that growth equally between the state and counties.

PANELISTS

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

BACKGROUND

The fiscal structure for 2011 Realignment was established in SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012. As part of that structure, 1991-92 Realignment funds that otherwise would have been deposited into the Metal Health Subaccount are deposited instead into the CalWORKs MOE Subaccount, which is provided to counties for their CalWORKs MOE obligation. Those dollars result in a one-for-one savings of General Fund for the Department of Social Services.

Per SB 1020, 1991-92 Realignment funds are to be deposited into the CalWORKs MOE Subaccount until it reaches a cap of $1.121 billion (expected to be reached in 2013-14), at which time excess funds are routed to the Mental Health Subaccount for counties to spend on mental health programs. 2011 Realignment also provides a set monthly amount for Mental Health, which takes the place of the 1991-92 Realignment funds previously allocated to the Mental Health Subaccount ($93 million per month).

Under the SB 1020 framework, the maximum offset to General Fund expenditures for CalWORKs is $1.121 billion, and all future growth in 1991-92 Realignment that would have gone to that account instead goes to the Mental Health Subaccount. This proposed change would instead share those growth funds beginning in 2015-16 between the CalWORKs MOE and Mental Health Subaccounts.

The Administration's rationale for this proposal is that the SB 1020 structure for the CalWORKs MOE Subaccount was in place before the the Coordinated Care Initiative proposal (2012), and resulting In-Home Supportive Services (IHSS) maintenance of effort (MOE), were finalized. This, they state, will result in lower than usual Social Services Subaccount caseload growth, which will result in more general growth dollars being available to all Subaccounts in 1991-92 Realignment (Health, Mental Health, Social Services). The Administration also states that Social Services caseload growth has first call on growth dollars in 1991-92 Realignment.

The Administration states that county savings will be realized in 2013-14 and future fiscal years as a result of the IHSS MOE agreement between the state and counties, and therefore it is no longer appropriate for 1991-92 Realignment general growth that otherwise would have gone to the CalWORKs MOE Subaccount to solely be deposited into the Mental Health Subaccount pursuant to SB 1020.

Therefore, the Administration believes that, instead, beginning in 2015-16, the growth that currently is directed at the Mental Health Subaccounts should be equally shared between the state and county. To do so, the current growth formula must be changed.

Disability Rights California (DRC) is opposed to this proposed trailer bill, objecting to the loss of community mental health funding. DRC explains that the 1991 realignment revenues for mental health have not kept up with inflation or caseload growth over the intervening years as a result of unanticipated growth in social services programs that diverted funds away from mental health. DRC argues that any increase in funding for mental health simply augments the already-inadequate 1991 realignment funding levels, and fulfills the intent of the 1991 mental health realignment.

STAFF COMMENTS/QUESTIONS

The Subcommittee would like for the Administration to explain this proposed trailer bill, its intent and purpose, and the details of how this would be implemented.

1. How much money would be diverted from mental health to CalWORKs under this proposal?

Staff Recommendation: Hold open

ISSUE 9: DRUG MEDI-CAL ESTIMATE

The Drug Medi-Cal (DMC) program, which provides substance use disorder treatment services to individuals enrolled in Medi-Cal, was transferred from DADP to DHCS in 2011. The proposed 2013-14 budget reflects only a slight decrease from the current year budget with total funds of $206,570,000 as compared to the current year total funds of $208,656,000. The Administration is not proposing any significant policy or fiscal changes specific to DMC.

Please note that the Governor's 2013-14 proposal to reorganize remaining DADP programs will be discussed at the Subcommittee's hearing on April 10, 2013.

PANELISTS

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

BACKGROUND

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

The five covered services for the DMC program listed in Section 4.19B of California's Medicaid State Plan include:

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

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

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

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

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

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

DMC Budget
As stated above, the proposed 2013-14 budget reflects a slight decrease from the current year budget with total funds of $206,570,000 as compared to the current year total funds of $208,656,000. There is no General Fund in DMC as the program was realigned to counties, and therefore the budget is made up of county realignment funds and federal funds. This $2 million difference is a decrease in federal funds, which makes up half of the total difference in the form of savings resulting from the annual rate adjustments that occur in this program. The Administration points out that there has been an increase in utilization in narcotic treatment services, and therefore the budget reflects an approximately $2.3 million increased appropriation for these services.

DMC Transfer
The 2011-12 Budget approved the transfer of the DMC program from DADP to DHCS, effective July 1, 2012 in the interest of improving access and quality, as well as effectively integrating Medicaid services. The action approving this transfer required the departments to convene and consult with stakeholders in the formulation of a transition plan, including specified components, and present this plan to the Legislature by October 1, 2011, with updates on the transfer provided during subsequent budget hearings after that date. It also authorized transition activities to take place in the 2011-12 fiscal year in accordance with the transition plan, with a 30-day notification to the Legislature. The DMC Program had accounted for about a quarter of the functions at DADP.

AB 106 required DHCS to provide the transition plan to all fiscal committees and appropriate policy committees of the Legislature by October 1, 2011, and to provide additional updates to the Legislature during budget subcommittee hearings after that date, as necessary. DADP submitted the required transition plan, and two updates to that plan. As reflected in the Transition Plan, stakeholders made the case that the Administration should use the transfer of the program as an opportunity to transform and improve the program. Specifically, stakeholders recommended that DHCS:

- Review the treatment authorization request (TAR) process for fee-for-service medication services that interact with the DMC Program to avoid TAR delays that result in the loss of treatment opportunities for beneficiaries and frustration for providers;

- Evaluate the provider certification process, and involve providers in the development and review of proposed changes;

- Augment the DMC services beyond the five currently covered and include additional federally approved therapies (buprenorphine, Vivitrol and other new drugs), recognizing that the benefits provided under the current DMC Program are outdated;

- Include drug testing coverage and more individual counseling; and, allow for home counseling and intensive outpatient program services;

- Follow federal requirements only, as current regulations interfere with the delivery of appropriate health care;

- Rely on national accreditation only as the provider application and certification process is duplicative and unnecessary;

- Evaluate and streamline the billing process, and allow same day billing if more than one service is provided in a single visit;

- Address problems with claiming denials; recoupment of funds; lengthy claims processing and reimbursement; and improve communication between the state and providers;

- Review reporting requirements and eliminate cost reports; and,

- Retain experienced and expert staff in the field of substance abuse disorders; that DHCS have leadership that reports directly to the director; and, that the program retain its dedicated focus and separate identity and not be engulfed by DHCS' current Medi-Cal program administration.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to provide an overview of the proposed budget for the DMC program, including any significant fiscal changes to the program. The Subcommittee also would like DHCS to describe the ways in which DHCS has incorporated stakeholder concerns and recommendations, on ways to improve the program that were reflected in the transition plan and iterated above.

Staff Recommendation: Hold open pending updated information at May Revise

ISSUE 10: DRUG MEDI-CAL STAFF COUNSEL BUDGET CHANGE PROPOSAL

DHCS is proposing to make one existing limited-term Staff Counsel III position permanent, to support on-going workload associated with the Drug Medi-Cal (DMC) program, at a cost of $182,000 ($73,000 General Fund, $109,000 Federal Fund).

PANELISTS

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

BACKGROUND

Formerly DADP, and now DHCS, has statutory authority to conduct DMC Post-Service, Post-Payment reviews as well as to deter and detect DMC fraud resulting from questionable billing practices and complaint investigations. By law, when misrepresentation of fact or suspicion of provider fraud is discovered, DADP was required to refer their findings to DHCS and/or to the Department of Justice (DOJ) for criminal investigation and prosecution. The Staff Counsel III acts as liaison between these departments, advises the departments on the suspension of the provider, and develops the necessary legal documentation to support the suspension. According to DHCS, the workload associated with this position is expected to be sustained in the foreseeable future as DMC staff has identified an increasing trend in questionable billing practices within the DMC program.

This Staff Counsel position develops required hearing documents including position statements, and participates in negotiating settlements where appropriate. The position interprets policies and provides technical assistance to counties and other entities that provide DMC treatment program services; drafts amendments to the 1915(b) waiver; negotiates with the federal CMS agency; briefs Agency and the Governor's Office on all DMC issues; drafts legislation necessary to implement DMC programs; and performs research and writes legal opinions; works to improve fraud control efforts; and implements legal corrective actions.

According to DHCS, extending this position will ensure consistent oversight of DMC providers, and will ensure timely investigations of complaints filed by counselor certification organizations, staff and clients. Finally, much of this workload is legal work that DOJ used to provide to DADP, but stopped when ceasing much of its legal work on behalf of General Fund departments.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal.

Staff Recommendation: Hold open