AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLY MEMBER SHIRLEY N. WEBER, PH.D., CHAIR

MONDAY, MAY 19, 2014
9:00 A.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

VOTE ONLY ITEMS

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES
4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: MAJOR RISK MEDICAL INSURANCE PROGRAM ELIMINATION

The May Revise proposes a reduction of $20.8 million (Proposition 99) and trailer bill to:

1. Eliminate, on January 1, 2015, the Major Risk Medical Insurance Program (MRMIP), a state-only program for Californians with pre-existing conditions.

2. Require health care plans to offer their Medicare supplemental insurance products to individuals with End Stage Renal Disease on Medicare who cannot obtain supplemental coverage in the individual market due to statutory restrictions; and

3. Require the development of a transition plan that would be submitted to the Legislature by September 1, 2014 detailing the closure of the program.

PANELISTS

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

BACKGROUND

Since 1991, MRMIP has provided health insurance to Californians unable to obtain coverage in the individual health insurance market due to pre-existing conditions. Californians qualifying for the program contribute to the cost of their coverage by paying premiums, an annual deductible, and copayments. The premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). The program has an annual benefit cap of $75,000 and a lifetime benefit cap of $750,000. Prior to the Affordable Care Act (ACA), because of funding limitations, MRMIP sometimes developed a waiting list.

MRMIP provides comprehensive benefits to subscribers and their dependents. Health plan participation in the program is voluntary. One Preferred Provider Organization and three Health Maintenance Organizations participate in the program. The program has statewide coverage and subscribers have a choice of two or more health plans in most urban areas of the State. Pending approval of the proposed elimination of the Managed Risk Medical Insurance Board, DHCS will assume responsibility for the program July 1, 2014.

MRMIB reports that caseload in MRMIP has decreased 54 percent since the implementation of the ACA, due to the activation of the Exchange and the expansion to Medi-Cal. Furthermore, the ACA prohibits the denial of coverage due to a pre-existing health condition and prohibits health plans from charging individuals with pre-existing conditions a higher premium due to their condition. Enrollment in MRMIP on October 1, 2013 was approximately 6,500; as of April 1, 2014, enrollment is approximately 2,972.

There are approximately 60 MRMIP subscribers with End Stage Renal Disease (ESRD), under age 65, who are covered by Medicare (due to ESRD), and cannot get the Medicare supplemental coverage that most Medicare subscribers need. Their Medicare coverage disqualifies them from obtaining coverage through the Exchange; therefore, MRMIP serves as their Medicare supplement. The administration is proposing trailer bill language to require health plans and insurers that offer Medicare supplemental coverage to offer this coverage to the Medicare ESRD population (not just those in MRMIP -- all Californians with ESRD under age 65 and on Medicare).

DHCS proposes to develop a transition plan, with stakeholder involvement, to be provided to the Legislature by September 1, 2014. The transition plan will cover outreach, education and notification of MRMIP subscribers and future applicants, and address special populations in MRMIP, such as those with ESRD, and those without proof of citizenship.

STAFF COMMENTS/QUESTIONS

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

1. How many current MRMIP subscribers will not qualify for any health insurance once MRMIP is eliminated?

2. What would the costs to health plans be as a result of the proposed requirement for them to provide Medicare supplemental coverage to this population?

Staff Recommendation: Staff recommends holding this proposal open to allow for more discussion with stakeholders.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: FAMILY HEALTH ESTIMATE

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

The overall Family Health Estimate contained in the January Budget shows a projected 3.7 percent decrease in funding in the proposed budget year, compared to the estimate for the current year. This decrease results from a decrease in costs in the CCS program, which reflects the transition of children from Healthy Families to Medi-Cal. The May Revise estimate proposes a $7.5 million General Fund decrease from the November estimate (January budget). This is a result of the following changes:

CCS

1. Safety Net Care Pool Usage of CCS State-Only expenditures as certified public expenditures is expected to decrease by $8.11 million in 2013-14.

2. The estimate for CCS expenditures for services specifically for the Healthy Families program population has decreased by $5.58 million General Fund as compared to the November estimate.

GHPP

1. Safety Net Care Pool Usage of GHPP expenditures as certified public expenditures is expected to increase by $12.8 million in 2013-14.

2. Rebates expected from the Special Rebate Fund are $5.9 million less than the November estimate, due to reimbursements to counties for their share of the CCS rebates.

Family Health Estimate
2013-14 and 2014-15

Program	Budget Act 2013-14	Projected 2013-14	Proposed 2014-15	CY to BY $ Change	CY to BY % Change
CCS	$118,910,000	$107,005,000	$95,781,000	($11,224,000)	(10%)
CHDP	1,795,000	1,632,000	1,713,000	81,000	5%
GHPP	110,741,000	102,634,000	128,739,000	26,105	25%
EWC	52,619,000	52,666,000	58,583,000	5,917	11%
TOTAL	**$284,065,000**	**$263,937,000**	**$284,816,000**	**$20,879**	**8%**

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

PANELISTS

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

BACKGROUND

California Children's Services (CCS)

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

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate. Therefore, a reduction in costs associated with the decreasing number of children in the Healthy Families Program can be seen as an equivalent increase in CCS costs within the Medi-Cal budget.

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

CCS Budget

Excluding Medi-Cal costs, the proposed 2014-15 CCS budget includes total funds (TF) of $95.8 million (including $18 million GF), as compared to the current year (2013-14) estimate of $107 million TF ($10.7 million GF). This approximately $11 million reduction primarily reflects the transition of approximately 760,000 children from Healthy Families to Medi-Cal. Therefore, this is not a savings for the state, but rather a cost shift from the CCS Healthy Families program to CCS Medi-Cal. Therefore, the Medi-Cal estimate includes an equivalent increase in cost (as the state continues to receive 65 percent FFP and 17.5 percent county funding for this population).

Non-Medi-Cal CCS Budget		
	2013-14	**2014-15**
CCS Only	$85,885,000	$91,644,000
CCS Healthy Families	$21,120,000	$4,137,000
TOTAL	**$107,005,000**	**$95,781,000**
Federal Funds	$96,232,600	$77,711,000
General Fund	$10,772,000	$18,070,000
Non Medi-Cal Caseload	18,352	18,012
Medi-Cal Caseload	157,248	160,171

2013-14 CCS Estimate Adjustments:

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

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

2014-15 CCS Estimate Adjustments

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

- Safety Net Care Pool Usage of CCS State-Only expenditures as certified public expenditures is expected to decrease by $5.7 million in 2014-15.

CCS Carve Out

For many years, the CCS program has operated as a managed care "carve out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve out was approved through AB 301 (Pan) Chapter 460, Statutes of 2011, which extended the sunset on the carve out until January 1, 2016. DHCS indicates that although the administration did not include a specific proposal in this year's budget, they believe that the program would greatly benefit from various reforms. DHCS states that these reforms would not

necessarily transition the program to a managed care benefit; however, the program would be operated within the framework of an "organized delivery system." DHCS states that a great deal of confusion results from the current program organization, given that children must leave their managed care networks in order to receive CCS services and it becomes somewhat unclear if the state or the managed care organization holds fiscal responsibility for these services.

Children's Health & Disability Program (CHDP)

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

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

CHDP Budget

The proposed 2014-15 CHDP budget includes $1.7 million total funds ($1.7 million General Fund), as compared to the current year estimate of $1.6 million ($1.6 million General Fund). The program also receives $11,000 in Childhood Lead Poisoning Prevention Funds to cover the cost of blood tests for lead.

Genetically Handicapped Person's Program (GHPP)

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

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

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

GHPP Average Monthly Caseload		
	2013-14	2014-15
GHPP State Only	995	1,024
GHPP Medi-Cal	738	785
TOTAL	**1,733**	**1,809**

GHPP Budget

The proposed 2014-15 GHPP budget includes total funds of $128.7 million ($72.4 million General Fund), compared to the 2013-14 estimate of $102.6 million ($11.6 million General Fund). This $26.1 million (25 percent) increase reflects the following estimate adjustments:

2013-14 GHPP Estimate Adjustments:

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

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

2014-15 GHPP Estimate Adjustments:

- GHPP base treatment costs are expected to increase by $16.3 million General Fund due to growth in expenditures.

- The 2013-14 appropriation included a one-time fund shift of a balance of $31.1 million in Special Rebate Funds to provide General Fund relief. The 2014-15 estimate assumes that $23.1 million in General Fund is needed for reduction in rebates between fiscal years.

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

- Safety Net Care Pool Usage of GHPP expenditures as certified public expenditures is expected to increase by $11.7 million in 2014-15.

Every Woman Counts (EWC)

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

EWC Budget

The proposed 2014-15 budget includes $58.5 million total funds ($20.8 million General Fund) for EWC, a $5.8 million (11%) increase over the 2013-14 estimate of $52.7 million ($18 million General Fund), which primarily reflects a full year of digital Mammography costs, as compared to only a half year in 2013-14.

2013-14 EWC Estimate Adjustments:

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

2014-15 EWC Estimate Adjustments:

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

- Digital Mammography reimbursement became effective January 1, 2014, thereby increasing costs for half of the current fiscal year and the full budget year ($4.6 million).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present an overview of the Family Health Estimate and to highlight changes made to the estimate since the January Budget.

Staff Recommendation: Staff recommends approval of the Family Health Estimate, conforming to any additional changes made to the final Budget Act.

ISSUE 2: MEDI-CAL ESTIMATE

Total Medi-Cal expenditures for 2014-15 are projected to be $90,584,058,000 ($17,401,848,000 General Fund), an increase of $16,575,259,000 ($502,353,000 General Fund) from the Governor's January Budget.

PANELISTS

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

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 48-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match for the federal funds.

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

Beginning this year, the federal Affordable Care Act (ACA) will support the expansion of Medicaid coverage to nearly all non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level. This expansion is estimated to increase Medi-Cal enrollment by 1.4 million Californians by 2019.

Significant Estimate Adjustments Included in the Governor's January Budget

The major budget adjustments include the following:

2013-14 Medi-Cal Estimate Adjustments:

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

- Affordable Care Act (ACA) Expansion

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

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

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

2014 May Revise New Estimate Adjustments:
The following Medi-Cal adjustments are included in the Governor's May Revise:

- Assumes a 60 percent increase (over the January budget) in Medi-Cal caseload (to 815,000) as a result of federally-required program simplifications adopted last year, and associated additional (over the January budget) net General Fund costs of $89.3 million in 2013-14 and $513 million in 2014-15. Assumes total General Fund costs of this caseload increase to be $193 million in 2013-14 and $918 million in 2014-15.
- Assumes a 100 percent increase (over the January budget) in Medi-Cal caseload (to 1.6 million) as a result of the "optional expansion" adopted last year, and associated additional (over the January budget) net federal fund costs of $6 billion in 2014-15.
- Assumes $17.7 million in General Fund savings as a result of the conversion to Modified Adjusted Gross Income (MAGI) eligibility rules.
- Assumes $191.2 million (General Fund) in 2014-15 to cover the costs of increased mental health and substance use disorder benefits in Medi-Cal.
- Assumes $187.2 million (General Fund) for Medi-Cal managed care rate increases in 2014-15.

- Assumes $68.6 million (General Fund) in 2013-14 and $25.8 million (General Fund) in 2014-15 to cover the costs of further delays in resuming Medi-Cal redeterminations through CalHEERS.
- Utilizes a loan authorized by Government Code section 16531.1 to make payments to Medi-Cal providers in light of a current year operating shortfall of $553.4 million.
- Includes an increase of $1.2 million ($600,00 General Fund) and requests Budget Bill Language (*see below) to support the increased county workload necessary to provide semi-annual progress reports and implementation activities, required by the Katie A. v. Bonta settlement agreement.

Medi-Cal Caseload

In January, DHCS estimated the baseline caseload to be approximately 7.7 million average monthly enrollees in 2013-14 and 7.8 million in 2014-15, a one percent increase. The May Revise projects a 60 percent increase (over the January budget) in Medi-Cal caseload (to 815,000) as a result of federally-required program simplifications adopted last year. Further, it projects a 100 percent increase (over the January budget) in Medi-Cal caseload (to 1.6 million) as a result of the "optional expansion" adopted last year.

Total Medi-Cal Caseload Projections			
	2012-13	**2013-14**	**2014-15**
Governor's Budget	7,889,400	9,170,500	10,106,200
May Revise	7,935,100	9,358,200	11,500,500

Projected Caseload Increases Attributable to ACA Implementation				
	2013-14 Nov. Est.	**2013-14 May Est.**	**2014-15 Nov. Est.**	**2014-15 May Est.**
Optional Expansion	326,592	462,678	769,069	1,627,276
Mandatory Expansion	130,046	157,789	508,540	815,358

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the Medi-cal estimate, and to highlight the changes since the January Budget.

The Subcommittee requests LAO to provide reactions to, and analysis of the projected caseload numbers for Medi-cal contained in the May Revise.

Staff Recommendation: Staff recommends holding this item open to allow more time for additional caseload analysis.

**Proposed Budget Bill Language regarding the Katie A. v. Bonta Settlement Agreement:*

4260-101-0001

X. Of the amount appropriated in this item, up to $600,000 is available to counties for semiannual implementation progress reports related to the *Katie A. v. Bonta* settlement and implementation plan, as described in the department's Mental Health Services Division Information Notice No. 13-19 and Information Notice 14-010, and upon approval by the Director of Finance. Prior to approval, the Director of Finance shall consult with the Department of Health Care Services, the Department of Social Services and California State Association of Counties to determine if counties incurred overall cost increases due to the notices outlined in this provision. The Department of Finance shall provide notification of the allocation to the Joint Legislative Budget Committee within 10 days from the approval date by the Department of Finance.

ISSUE 3: COORDINATED CARE INITIATIVE ISSUES

This issue covers the following three aspects of implementation of the Coordinated Care Initiative (CCI):

1. DHCS is proposing trailer bill language to address the issue of expiring Medicare Improvement for Patients and Providers (MIPAA) contracts with Medicare Advantage plans, as discussed at the Subcommittee's hearing on April 7, 2014;

2. Updated CCI savings estimates contained in the May Revise; and

3. Managed Care Organization Tax quarterly reconciliations.

PANELISTS

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

BACKGROUND

Medicare Advantage Plans

Within the 8 Cal MediConnect (CMC) counties, approximately 168,000 frail, elderly, low-income seniors are currently enrolled in comprehensive, integrated Medicare managed care plans, for which the state's contracts expire on December 31, 2014. The administration intends to transition this population into plans participating in CMC. However, CCI implementation has experienced significant delays, thereby potentially creating an unstable situation within which to transition this vulnerable population.

If these Medicare contracts are not extended, dual eligibles covered by these Medicare plans may have their care interrupted and some may even return to fee-for-service Medi-Cal. This same situation existed last year, resulting in the adoption of budget trailer bill that requires DHCS to offer contracts to existing Medicare Advantage Special Needs Plans (D-SNP plans), and to exempt Medicare Advantage and D-SNP beneficiaries from the CMC enrollment provisions, though allows them to enroll voluntarily. Federal legislation was signed recently authorizing the continuation of these plans through 2016.

To address this situation, DHCS is proposing trailer bill that does the following:

1. In non CCI counties, DHCS will offer MIPPA contracts to DSNPs for the duration of the CMC demonstration under same terms and conditions as authorized in 2014.

2. In CCI counties, DHCS will offer MIPPA contracts to DSNPs that are not also CMC plans in a CCI county for the duration of the CMC demonstration subject to the following:

    a. Such MIPPA contracts will contain the same terms and conditions as authorized in 2014; and
    b. Eligible populations will be beneficiaries excluded from CMC and/or CMC-eligible beneficiaries enrolled as of 12/31/14.

3. In CCI counties, DHCS will offer MIPPA contracts to DSNPs for the duration of the CMC demonstration that are also CMC plans only for beneficiaries excluded from CMC.

4. As for passive enrollment into CMC, DHCS will
    a. Passively enroll DSNP enrollees into CMC when DSNP is also a CMC Plan, as authorized under current law; and
    b. Not passively enroll any other MA enrollees into CMC if they are in a non-CMC DSNP or any other MA plan.

The proposed language contains provisions that are unique to Kaiser and SCAN, as follows:

Kaiser -- Exempts Kaiser enrollees from passive enrollment into CMC. The language allows Kaiser to continue to enroll new CMC-eligible members after December 31, 2014 based on a prior affiliation with the plan.

SCAN -- Authorizes DHCS to enter into a contract extension with SCAN, and specifies that individuals already enrolled in the SCAN plan will not be passively enrolled into CMC. Allows SCAN to continue to enroll new CMC-eligible members in 2015.

Stakeholders

The following health plans have submitted a letter in opposition to this proposed language: Health Plan of San Mateo, Inland Empire Health Plan, CalOPTIMA, Community Health Group, LA Care, Santa Clara Family Health Plan, Anthem, and Care First. They are opposing the language because they believe that all of the plans should be treated equally. They state that the language is intentionally vague and should be redrafted to be transparent. These plans also request increased clarity on various provisions and request that the language require certain provisions to be included in MIPPA contracts going forward.

These plans are requesting amendments to the administration's proposed language to: 1) clarify various aspects of the language; and 2) treat Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) and Institutional Special Needs Plans (I-SNPs) consistently with all other D-SNPs for purposes of CMC.

Updated CCI Savings Estimate

The May Revise assumes General Fund savings as a result of the CCI of $20.3 million in 2013-14 and $247.8 million in 2014-15. The Governor's January budget estimated a net General Fund savings of $159.4 million in 2014-15 (DHCS budget only) as a result of the CCI, including the General Fund savings from the sales tax on managed care organizations (MCO).

Managed Care Organization (MCO) Tax Revenue

MCO tax revenue is a critical component to the overall architecture of the Coordinated Care Initiative. This tax was signed into law last year through SB 78 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2013, and includes the following provision requiring a quarterly reconciliation of tax revenue, which DHCS has yet to provide:

> 6184. Notwithstanding Section 7101, all revenues, less refunds, derived from the taxes extended by this article shall be deposited in the State Treasury to the credit of the Children's Health and Human Services Special Fund. Funds deposited in the Children's Health and Human Services Special Fund pursuant to this section are hereby continuously appropriated to the State Department of Health Care Services solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. ***The State Department of Health Care Services shall provide a quarterly reconciliation of tax revenue utilization to Medi-Cal managed care plans including an itemized accounting of the dollars as part of the rate-setting process.***

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the proposed trailer bill, and provide a clear and simple explanation of its need, purpose, and specific provisions.

The Subcommittee requests DHCS to respond to the following:

1. Please explain the ways in which SCAN and Kaiser are treated differently than the other plans, and the justification for this difference.

2. Please provide a response to the trailer bill amendments proposed by the health plans.

3. Please explain the reason that DHCS has yet to provide a quarterly reconciliation of MCO tax revenue utilization, as required by statute.

Staff Recommendation: Staff recommends holding this item open to allow for more discussion with the administration and stakeholders.

ISSUE 4: PEDIATRIC VISION PROPOSAL

The May Revise appropriates $2 million ($1 million General Fund) for a pilot program to increase utilization of pediatric vision services utilizing qualified mobile vision providers to expand vision screenings and services in schools.

PANELISTS

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

BACKGROUND

DHCS proposes to implement a 3-year pilot program, to begin January 2015, to increase utilization of vision services and eye glasses to children by allowing a mobile vision service provider, that has an established Memorandum of Understanding with school districts within Los Angeles County, to provide these vision services at school sites.

DHCS indicates that any capitation rate adjustment for managed care plans to account for the increased utilization would be actuarially-based and developed using projections of contingent events, including targeted populations who will receive these services.

The administration's cost estimate for this pilot assumes 45,000 children screened annually, and assumes that the average cost per child would be $90.48 for examinations, necessary lenses and frames.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends approval of this proposal for $2,036,000 ($1,018,000 General Fund) to implement a school-based vision services pilot program in Los Angeles County.

ISSUE 5: INTEGRITY DATA ANALYTICS

DHCS requests the following resources in order to secure a data analytics contractor to expand on recent data analytics that have enhanced Medi-Cal program integrity (i.e., fraud prevention) efforts:

2014-15: $5 million ($1.25 million GF, $3.75 million FF)

2015-16: $10 million ($2.5 million GF, $7.5 million FF)

2016-17: $10 million ($2.5 million GF, $7.5 million FF)

2017-18: $5 million ($1.25 million GF, $3.75 million FF)

PANELISTS

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

BACKGROUND

This proposal is intended to address two main issues:

1. Recent substantial fraud in the Drug Medi-Cal program; and
2. The 2011 Medi-Cal Payment Error Study (MPES) estimated approximately $1.25 billion in erroneous payments in the fee-for-service (FFS) system, including $473 million of which were identified as potentially fraudulent.

DHCS recently entered into a short-term contract with a vendor to provide advanced data analytics services for the Drug Medi-Cal program, for the period January through July of 2014. Many of the providers identified by the data analytics system as having a high likelihood of being fraudulent were found to actually be fraudulent providers. Hence, based on the findings of the current vendor, and confirmation of those findings through field work, DHCS believes that it would be very beneficial to process all Medi-Cal FFS providers and claims data through a data analytic system in order to identify fraud throughout the FFS system.

Per the proposal, the contractor will allow DHCS Audits and Investigations (A&I) staff to access numerous proprietary databases to gain additional information about providers. The contractor will sort approximately 200 million FFS claims, including mental health and substance use disorder services claims, through statistical models and intelligent technologies to uncover patterns and relationships in Medi-Cal claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent or erroneous.

The A&I division will use suspicious activities alerts generated from this data analytic system to focus their investigation efforts more effectively and identify erroneous patterns and fraudulent schemes that cannot currently be detected due to the volume and complexity of the claims data. The system is also expected to be useful in screening applicants during the provider enrollment process to uncover any problematic business history that poses a risk to the program. DHCS states that managed care data could be integrated into the system in the future.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends approval of this proposal for $5 million ($1.25 million General Fund) in 2014-15 and additional funding in subsequent years to contract with a data analytics contractor to reduce fraud in the Medi-Cal program.

ISSUE 6: COUNTY ADMINISTRATION BUDGET METHODOLOGY (BCPS)

The May Revise includes a proposed BCP related to the development of a new budget methodology for county eligibility administration. This BCP serves as an updated revision to the BCP on the same subject included in the January Budget.

Specifically, DHCS requests $1,485,000 ($742,000 General Fund) and 2.0 3-year limited-term positions and contract services to implement requirements of SB 28 (Hernández & Steinberg), Chapter 442, Statutes of 2013, to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the ACA on county administrative work, and present that methodology to the Legislature no later than March 2015.

PANELISTS

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

BACKGROUND

The state's 58 counties perform eligibility determinations for applicants to the Medi-Cal program as well as case maintenance activities. Currently, counties are budgeted for their activities based on claimed expenditures from previous years, and there is no county share of cost for administrative activities in the Medi-Cal program. DHCS states that, therefore, historically, there has been no incentive for counties to maximize efficiency or to control their administrative costs. According to DHCS, the new methodology will seek to use a performance and outcome-based system to determine accurate county funding levels, reward increased county efficiency, and determine effectiveness of county efforts.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. The administration believes that most of this work should be done by Audits and Investigations (A&I) as they have the experience, expertise and skills necessary to perform these activities. However, DHCS states that A&I lack certain critical expertise in the area of monitoring and evaluation of time studies. Hence, DHCS proposes to hire contract staff with specific knowledge to develop the new methodology, create an ongoing monitoring plan and train A&I staff on monitoring and evaluation of time studies.

Positions Requested

DHCS is requesting the following positions within the Medi-Cal Eligibility Division:

- Associate Governmental Program Analyst (1.0)
- Staff Services Manager (1.0)

STAFF COMMENTS/QUESTIONS

The County Welfare Directors Association raised concerns with the original January BCP which have been addressed to their satisfaction in this new, revised version of the BCP.

The Subcommittee requests DHCS to present this proposal and to clearly explain the differences between this BCP and the January BCP.

Staff Recommendation: Staff recommends approval of the new BCP for $1.5 million and 2.0 limited-term positions to implement SB 28 requirements to develop a new county administration budgeting methodology & rejection of the January Budget BCP on the same subject.

ISSUE 7: MARTIN LUTHER KING JR. COMMUNITY HOSPITAL TBL

Los Angeles County and the University of California are requesting trailer bill language in order to update the financing structure for the MLK Jr. Community Hospital in Los Angeles, in light of significant changes to the overall health care system that have rendered the existing statutory financing scheme unworkable.

PANELISTS

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

BACKGROUND

In 2007, the Los Angeles County-operated Martin Luther King, Jr. public hospital, originally built in the aftermath of the Watts Riot to provide critically needed medical care to one of the most underserved communities in the nation, was closed by Federal regulators after failing to meet patient care standards.

Within a year, the County launched an ambitious effort, in collaboration with the State of California and the leadership of the University of California (UC), to develop a plan for a replacement hospital. The concept that was agreed to was a unique model -- a private, non-profit entity backed by the financial assistance of the County and the medical expertise of UC. In 2010, the County of Los Angeles and the UC Regents signed a coordination agreement for the establishment to the new Martin Luther King (MLK), Jr. Community Hospital.

On September 23, 2010, the Governor signed AB 2599 (Bass and Hall), Chapter 267, Statutes of 2010, sponsored by LA County and UC. This legislation authorized State payments for the new MLK, Jr. Community Hospital and allowed County financing to be utilized to meet the needs of the facility.

Need for Legislation

The former California Medical Assistance Commission (CMAC) was the primary vehicle in AB 2599 for ensuring that the new MLK, Jr. Community Hospital received the necessary financial assistance, and the CMAC rate was to be tied to the anticipated cost of providing services at the new hospital.

Health care financing has changed in significant ways since the passage of AB 2599. CMAC was eliminated as of July 2, 2012 and replaced with a new diagnosis-based reimbursement system. The Affordable Care Act, which took effect January 1, 2014, created a new level of Medi-Cal matching payments

Due to these changes, the original MLK, Jr. Community Hospital financing commitment needs to be restructured. The proposed restructuring is intended to maintain all of the original commitments of the 2010 State, UC and County agreement.

Supplemental financing to ensure the viability of the new MLK, Jr. Community Hospital will come from the County of Los Angeles. This financing will come primarily through two annual payments:

1. $50 million per year IGT (intergovernmental transfer) for the benefit of Medi-Cal patients seen at the hospital.

2. An annual $18 million payment to the hospital to support indigent patient care services.

The County financing will be used to maximize Federal matching dollars for the hospital.

State General Fund costs will remain the same as prescribed in AB 2599 and will continue to be linked to the projected cost of care in the facility and will be capped at a fixed percentage of cost.

No University of California funding will be used.

This legislation also implements the expressed intent language of AB 2599 to remove MLK, Jr. Community Hospital from receiving private hospital Disproportionate Share Hospital (DSH) funding.

Proposed Trailer bill

To ensure that the new MLK, Jr. Community Hospital receives at a minimum the financing committed to in 2010 in a manner that continues to guarantee a cap on the State's contribution, the proposed legislation would do the following:

- The new hospital will receive supplemental Medi-Cal payments tied to the projected costs of providing both in-patient and outpatient Medi-Cal services.

- The State will continue to provide funding linked to the cost of care that is capped at the same percentages agreed to in the 2010 agreement.

- Any non-Federal share (State match) that is required that exceeds the 2010 State commitment will be generated through IGTs provided by the County of Los Angeles

- The State will seek Federal approval as necessary to obtain federal matching funds to the maximum extent permitted by Federal law.

Timing

The new MLK, Jr. Community Hospital is scheduled to open to the public in May 2015. Supporters of this proposal state that legislation to implement this restructured financing must be approved in 2014 to guarantee that the financing promised by the State and County when the original agreement was reached in 2010 is available to fund patient services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the LAO present this proposal, and requests DHCS to provide reactions to the proposal and to respond to the following:

1. Does DHCS have concerns with the proposed trailer bill language?

2. Does the administration have a state cost estimate for this proposal?

Staff Recommendation: Staff recommends holding this item open to allow for more discussion with the administration and stakeholders.

VOTE ONLY ITEMS

4260 DEPARTMENT OF HEALTH CARE SERVICES
4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: MANAGED RISK MEDICAL INSURANCE BOARD ELIMINATION

The Governor's budget proposes to eliminate MRMIB and transfer its programs to the Department of Health Care Services (DHCS). The proposed trailer bill language would:

- Transfer the Major Risk Medical Insurance Program (MRMIP), the Access for Infants and Mothers (AIM) program, and the County Children's Health Initiative Matching Fund Program (CHIM) to DHCS. The Administration proposes no changes to these programs and states that individuals currently in these programs would experience no disruption in care or changes in coverage, benefits, or eligibility;

- Rename the AIM-linked infants program to the "Medi-Cal Access Program" in order to simplify messaging of subsidized coverage options to solely Medi-Cal and Covered California;

- Transition the responsibility for the close-out activities, related to the Healthy Families Program transition to Medi-Cal and the Pre-Existing Conditions Insurance Program (PCIP) transition to the federal government, to DHCS; and

- Transition 27 positions at MRMIB to DHCS and Covered California.

The Subcommittee heard this issue on Monday, April 21, 2014.

Staff Recommendation: Staff recommends approval of the proposed elimination of MRMIB and the proposed transfer of its remaining programs to DHCS, and adoption of "placeholder" trailer bill for implementation.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: COORDINATED CARE INITIATIVE (SB 94/04) BCP

DHCS is requesting 4.0 3-year limited-term positions to implement risk corridors. SB 94 (Committee on Budget & Fiscal Review), Chapter 37, Statutes of 2013, requires DHCS to include risk corridor provisions in its contracts with managed care health plans in the 8 Coordinated Care Initiative (CCI) counties, for populations that are subject to mandatory enrollment for their Managed Long-Term Services and Supports (MLTSS) and who are not enrolled in the Cal MediConnect Demonstration project. Risk corridors are a method of risk sharing that may limit the financial risk of misaligning the payments associated with a contract to furnish long-term services and supports pursuant to a contract under the CCI on an at-risk basis.

The Subcommittee heard this proposal on April 7, 2014.

Staff Recommendation: Staff recommends approval of this BCP for 4.0 3-year limited-term positions to implement risk corridors within the CCI.

ISSUE 2: GROUND EMERGENCY MEDICAL TRANSPORTATION (AI14-01) BCP

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $1 million and 5.5 permanent and 3.0 3-year limited-term positions to perform audits on local fire districts and GEMT providers.

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

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP to convert contract resources to 4.0 2-year limited-term positions in the Every Woman Counts Program.

ISSUE 4: MEDI-CAL ELIGIBILITY DATA SYSTEM MODERNIZATION (ITSD14-03) BCP

DHCS requests $3,480,000 ($528,000 GF, $2,952,000 FF) and 16.0 2-year limited-term positions to modernize the Medi-Cal Eligibility Data System (MEDS). MEDS is a centralized database that stores information on individuals receiving public benefits from Medi-Cal and other health-related programs. It also performs a variety of eligibility, enrollment and reporting functions.

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $3.5 million and 16.0 2-year limited-term positions to modernize MEDS.

ISSUE 5: BREAST & CERVICAL CANCER TREATMENT PROGRAM BACKLOG (MCED14-01) BCP

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $301,000 and authority to extend 6.0 limited-term positions to address the backlog in the Breast & Cervical Cancer Treatment Program.

ISSUE 6: HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) (OHC14-01) BCP

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $1.9 million and authority to convert 7.0 limited-term positions to permanent and to extend 6.0 limited-term positions for 2 years to address the HIPAA workload.

ISSUE 7: DRUG MEDI-CAL PROVIDER RE-CERTIFICATIONS (PED14-01) BCP

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $2.2 million and 21.0 1-year limited-term positions to recertify Drug Medi-Cal providers.

ISSUE 8: DUI PROGRAM EVALUATION (SUDS14-03) BCP

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

The Subcommittee heard this proposal on February 24, 2014.

Staff Recommendation: Staff recommends approval of this BCP for $96,000 to renew a contract to continue evaluating DUI programs.