SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

March 20, 2014

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda

ERRATA (see page 45 for changes)

(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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4150 Department of Managed Health Care

1. Overview

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs).

The Department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all Health Maintenance Organizations (HMOs) and some Preferred Provider Organizations (PPOs) in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the more than 21 million Californians who are currently enrolled in these types of health plans.

Budget Overview. The budget proposes expenditures of $58.97 million and 397.3 positions for DMHC. See table below for more information.

Table: DMHC Budget Overview

Fund Source	2013-14 Projected	2014-15 Proposed	BY to CY Change
Federal Trust Fund	$1,749,000	$75,000	-$1,674,000
Reimbursements	$3,832,000	$3,412,000	-$420,000
Managed Care Fund	$51,432,000	$55,485,000	$4,053,000
Total Expenditures	**$57,013,000**	**$58,972,000**	**$1,959,000**
Positions	**370.5**	**397.3**	**27**

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of DMHC's programs and budget.

2. Federal Mental Health Parity Rules

Issue. The Governor's budget does not include a proposal to implement the new federal rules requiring health plans that offer mental health and substance use disorder benefits do so in a manner comparable to medical and surgical benefits.

Background. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), expands federal mental health parity protections beyond the limited requirements of the previously enacted federal Mental Health Parity Act of 1996 (MHPA). The MHPAEA requires that group health plans and health insurance coverage offered in connection with group health plans that offer mental health and substance use disorder (MH/SUD) benefits do so in a manner comparable to medical and surgical (med/surg) benefits. For most plans, the MHPAEA became applicable to plan years beginning on or after October 3, 2009.

Final Rules. Because the MHPAEA itself does not explain how health plans are to analyze or achieve parity, the Centers for Medicare and Medicaid Services (CMS), the Department of Labor's Employee Benefits Security Administration, and the Internal Revenue Service (collectively, the Departments) issued the Interim Final Rules on the MHPAEA on February 2, 2010, and the Final Rules on November 13, 2013. These regulations provide an in-depth explanation of what the MHPAEA entails.

The Final Rules provide a framework for application and enforcement of the MHPAEA. The Final Rules explain how health plans must classify benefits, and how they must assess financial requirements and treatment limitations (both quantitative and non-quantitative) for parity purposes. The Final Rules also address the applicability, enforcement, and effective dates of the MHPAEA and regulations.

Under the Final Rules (and Interim Final Rules), parity is not determined under a static "matching" approach that compares similar or analogous treatments. Instead, the Final Rules require that all covered benefits must be sorted into specific classifications, and then the broader classifications are compared and analyzed for parity. The Final Rule provides that if the health plan covers any MH/SUD benefit, it must then provide benefits in any classification for which it provides med/surge coverage. See table below for the classification of benefits.

Table: Final Rules Benefit Classifications

Benefit Classification
Inpatient, In-Network
Inpatient, Out-of-Network
Outpatient, In-Network
Outpatient, Out-of-Network
Emergency Care
Prescription Drugs

Financial Requirements and Quantitative Treatment Limitations. Under the Final Rules, health plans must perform a detailed financial and mathematical analysis to determine "parity" for financial requirements and quantitative treatment limitations. The MHPAEA defines "financial requirements" to include deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes aggregate lifetime and annual limits. "Treatment limitations" are defined to include limits on the scope and duration of treatment; "quantitative treatment limitations" (QTLs) are numerical limits, such as limits on the number of visits, episodes, or days of treatment covered under the plan.

Under the MHPAEA and the Final Rules, the financial requirements and treatment limitations applied to MH/SUD benefits in a classification cannot be more restrictive than the *predominant* (more than one half) requirements or limitations applied to *substantially all* (at least two-thirds) med/surg benefits in the same classification.

Implementation Dates. The MHPAEA has always applied to large group, and the Final Rules for large group apply as of July 1, 2014. For small group, the MHPAEA applies as of January 1, 2014, and the Final Rules apply as of July 1, 2014. For the individual market, the MHPAEA applies as of January 1, 2014. Although, the Final Rules apply as of July 1, 2014, because the individual market in California is now based on the calendar year, the Final Rules will be effective for individual plan contracts as of January 1, 2015.

DMHC's Implementation of the State's Mental Health Parity Laws. DMHC currently enforces the Knox-Keene Act's mental health parity statute, Health and Safety Code section 1374.72, which requires health care service plans to cover nine enumerated severe mental illnesses, as well as serious emotional disturbances of a child, under the same terms and conditions plans apply to medical conditions. DMHC reviews plan Evidences of Coverage for compliance with Section 1374.72, focusing generally on whether services to treat the limited enumerated conditions are covered the same as medical conditions. The DMHC's implementation of California's mental health parity statute has primarily focused on ensuring the mandated benefits are covered and parity for the cost-sharing provisions of the plan benefit designs.

DMHC's Implementation of the New Federal Final Rules. In contrast, the MHPAEA and its associated regulations require a detailed parity analysis whereby plans must: (1) classify all benefits into six federally-mandated classifications, (2) mathematically analyze all benefits to ensure that the financial requirements (such as copayments or coinsurance) and quantitative treatment limitations (such as visit limits or days of treatment) for MH/SUD use disorder benefits are not more restrictive than the predominant requirements or limitations applied to substantially all med/sur benefits in the same classification, and (3) analyze all benefits to ensure that any non-quantitative treatment limitations (such as medical management standards regarding medical necessity) apply comparable processes, strategies, and evidentiary standards for both mental health/substance use disorder and med/sur benefits.

This detailed analysis required by the federal rules requires both clinical and actuarial expertise whereas the implementation of California's mental health parity law was a more straightforward legal analysis. DMHC indicates it has never applied such a clinical/actuarial

analysis of health plan benefit designs and; consequently, it is taking additional time to evaluate how to conduct such an analysis. Moreover, DMHC must correspondingly expand its existing parity compliance review not only to evaluate plans' implementation of the complex mathematical and analytical processes the MHPAEA requires, but also to oversee plans' treatment of the mental health/substance use disorder conditions to which the MHPAEA extends, including all conditions in the Diagnostic and Statistical Manual IV (DSM-IV) (for small group and individual plans, per California's Essential Health Benefit statute) and any conditions large group plans cover beyond those required by Section 1374.72.

Subcommittee Staff Comment and Recommendation—Hold Open. DMHC indicates that it is currently assessing how it will enforce the new federal rules and the workload associated with this new federal requirement. The new federal requirement includes processes and assessments that are different from what DMHC currently performs. For example, the new rules include a "non-quantitative" component to assess parity.

Given that these rules are effective July 1, 2014 and January 1, 2015 (depending on the rule type and plan type), it would be expected that DMHC complete its analysis of (1) the implementation of these rules and (2) the resources that may be needed before the start of the next fiscal year.

Subcommittee staff recommends keeping this item open as discussions continue on implementation and the resources that may be necessary to ensure that millions of Californians, who are suffering from mental health and substance abuse disorders, get the help they need.

Questions.

1. Please provide an overview of the new federal requirements and how these requirements differ from state law.

2. When does DMHC plan to have an assessment of how the state will implement these federal rules and the resources that may be needed?

3. New Customer Relationship Management System

Budget Issue. DMHC requests two positions and a reduction of $50,000 for 2014-15 and ongoing to provide information technology (IT) programming services for the Customer Relationship Management (CRM) system that is currently performed by contracted vendors. This request includes the redirection of existing contract resources to fund the two positions.

Background. DMHC's Office of Technology and Innovation (OTI) provides programming support for all departmental databases, applications, public and internal websites, and secured web portals that deliver mission-critical services to DMHC staff and stakeholders. As part of the DMHC's components of consumer assistance, all interaction between the DMHC's Help Center and consumers is tracked in a CRM database system. This system is the data warehouse for all consumer complaint contact information and provides essential case tracking, workflow, automated correspondence, email notifications, reminders, workload tracking, and customized reporting.

Since 2000, the DMHC has used a CRM system known as Clarify. This system was procured in order to meet legislatively mandated requirements. At that time, the availability of the CRM technology needed to meet these requirements was very limited and the tailored programming necessary for the business and functional requirements was not available through the civil service system. Over the years, the Clarify system has been extensively customized to meet the continuously changing and increasing needs of the DMHC, including the ability to track all forms of consumer contacts, e.g., telephone, email, web forms, US mail and faxed complaints. The CRM system also has been modified to include similar tracking of health care provider complaints. Because the Clarify system requires expert programmer knowledge not found in the civil service system, the DMHC has used contracted consultants to perform all work necessary on Clarify, including ongoing maintenance, database and report customization, and customer support.

The company which owns the Clarify CRM software recently announced it would no longer provide support and maintenance of the Clarify software used by DMHC. The Clarify CRM software utilized by DMHC uses an esoteric programming language (Clear Basic) that requires specialized programming expertise not currently available in the civil service system.

According to DMHC, following a comprehensive review of business and functional requirements, a review and demonstrations of available CRMs, and a comparison of CRM software systems, the DMHC selected an off-the-shelf CRM product, OnContact, as the recommended replacement for Clarify. The OnContact CRM system is compatible with the DMHC's technical environment and programming standards.

DMHC proposes that OnContact be maintained and supported by Senior Programmer Analysts, a civil service classification. Redirection of consultant services to establish two in-house programmers will also comply with Government Code Section 19130(b)(3), which states that contracting is allowed only when the services contracted are not available within civil service.

DMHC is currently working with the OnContact CRM vendor to complete the migration of data and reports from Clarify to OnContact. This migration is scheduled to be completed by June 30, 2014. Once the migration is complete, DMHC will no longer need to contract with a vendor for support of the outdated Clarify system and will fully utilize the OnContact CRM software system.

DMHC plans to build the following customized reports in the OnContact system:

1. Case Audit Field and Grids Combo
2. Complaints Report
3. Independent Medical Review (IMR) Report
4. Aging Case Details, including inquiries
5. Aging Case Details, IMR only
6. Aging Case Details, Reopens
7. Aging Case Summary
8. Aging Case Summary – IMR only
9. Aging Case Summary – Reopens
10. Requested Response Timeliness
11. Activity Case Details – All Case Types (Urgent, Quick Resolution, Complaint, Inquiry)
12. Case Control Sheet
13. Independent Medical Review (IMR) Case Details
14. Closed/Open Cases by Type
15. Consumer Contact Data
16. Incoming Mail
17. IMR Medical Records Report
18. Volume Trending
19. Open Case Volume Report
20. Closed Case Compliance Determinations
21. Global Summary Report
22. Recovered Funds

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised regarding this item; however, it is recommended to hold this item open as discussions continue on DMHC's budget.

Questions.

1. Please provide an overview of this proposal.

4. AB 1 X1 – Medi-Cal Expansion Workload

Budget Issue. DMHC requests 18.0 positions and $2,404,000 for 2014-15 and $2,356,000 for 2015-16 and ongoing, to address increased workload resulting from implementation of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. This request includes $312,000 for 2014-15 and $416,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

DMHC states that these positions are necessary to address the increased workload associated with newly-enrolled consumers in Medi-Cal managed care plans licensed by DMHC. This new workload includes answering consumer calls, reviewing and resolving consumer complaints and Independent Medical Review (IMR) applications, resolving urgent nurse cases, and enforcing the managed health care laws that protect this new population.

The requested permanent positions are as follows:

Position	2014-15
Help Center	
Attorney	2.0
Nurse Evaluator II	2.0
Associate Governmental Program Analyst	5.0
Consumer Assistance Technician	6.0
Office of Enforment	
Attorney	1.5
Associate Corporations Investigator	1.5
Total Positions	**18**

Background. AB 1 X1 implements a key provision of the Affordable Care Act (ACA) by expanding the state's Medi-Cal program, effective January 1, 2014, to a new group of adults aged 19 - 64 with incomes up to 138 percent of the federal poverty level and who are not eligible for Medi-Cal today. AB 1 X1 also implements the Medi-Cal expansion by implementing federal rules to simplify and streamline Medi-Cal eligibility determination, enrollment, and renewal.

In addition, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session implements the Medi-Cal expansion by establishing the Medi-Cal benefit package for the expansion population which includes the same benefits all full-scope Medi-Cal enrollees receive. SB 1 X1 also expands the benefit package for the existing Medi-Cal population to include mental health and substance use disorder benefits that mirror those provided under the Essential Health Benefits (EHB) for the individual and small group markets. SB 1 X1 requires Medi-Cal managed care (MCMC) plans that are regulated by the DMHC to provide mental health benefits that are not covered by county mental health plans under the Specialty Mental

Health Services Waiver. AB 1 X1 and SB 1 X1 together implement the Medicaid expansion in California.

The Medi-Cal program is administered by the Department of Health Care Services (DHCS). The DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. The KKA provisions apply to Medi-Cal managed care plans, except as specifically exempted. Health plans that arrange for services provided to Medi-Cal beneficiaries through the Medi-Cal managed care program are required to be licensed by the DMHC. Accordingly, Medi-Cal managed care beneficiaries can avail themselves of all the consumer assistance and complaint resolution processes offered by the DMHC. (Except in those in an exempted County Organized Health System.)

DHCS estimates approximately 1,390,000 new beneficiaries will be enrolled in the Medi-Cal managed care program over the next three years as a result of the expansion of Medi-Cal eligibility. As reported by DHCS, the annual breakdown is as follows:

Fiscal Year	Optional Total Enrollees	Mandatory Total Enrollees	Total New Enrollees (Cumulative)
2013-14	326,592	333,372	**659,964**
2014-15	769,069	551,912	**1,320,981**
2015-16	821,634	568,469	**1,390,103**

AB 1 X1 Medi-Cal Expansion Call Data. The Help Center has been able to identify 551 Medi-Cal calls for the period January 1, 2014, to March 10, 2014, see table below for details. The Help Center is unable to confirm the number of Medi-Cal calls that were specifically related to AB 1 X1 as the consumer did not identify the call was related to AB 1 X1. The Help Center is currently discussing methods to specifically identify these consumers.

Table: Medi-Cal-Related Help Center Calls – January 1, 2014 – March 10, 2014

Category	Medi-Cal Managed Care	Medi-Cal Fee For Service/Seniors and Persons with Disabilities
Access	27	3
Appeal of Denial	8	0
Claims/Financial	10	1
Coordination of Care	14	1
Coverage/Benefits	41	4
Covered California	7	6
Enrollment Disputes	35	13
General Inquiry	227	141
Plan Service	9	1
Provider Service	3	0
Total	**381**	**170**

Help Center. Based on the DMHC's historical experience, Medi-Cal populations typically contact the DMHC at a higher rate than the existing commercial managed care population. DMHC anticipates an increase in consumer assistance, complaint resolution, and Independent Medical Review (IMR) workload as approximately 1,390,000 new enrollees enter the Medi-Cal managed care arena. In turn, the DMHC anticipates an increase in enforcement referrals from the Help Center regarding violations of the new law.

The Help Center uses a conservative standard of three percent in increased contact rate when projecting consumer assistance workload for new populations it serves. Based on this percentage and the estimated number of new enrollees provided by the DHCS, the Help Center estimates 39,629 additional contacts resulting from the Medi-Cal expansion.

For 2014-15, these contacts are in the form of:

- 31,703 calls
- 4,755 pieces of correspondence
- 1,189 Quick Resolution cases
- 793 Standard Complaints
- 396 Independent Medical Reviews (IMRs)
- 793 Urgent Nurse cases

For 2015-16, and ongoing, the Help Center estimates 41,703 additional contacts. This is based on the total new enrollment for 2013-14 through 2015-16 as reported by the DHCS. These contacts will generate:

- 33,362 calls
- 5,004 pieces of correspondence
- 1,251 Quick Resolution cases
- 834 Standard Complaints
- 417 IMRs
- 834 Urgent Nurse cases

Office of Enforcement. The Office of Enforcement handles the litigation needs of DMHC, representing DMHC in actions to enforce the managed health care laws including the quality, accessibility, and continuity of care and the denial of treatment and claims in enforcing the managed health care laws. Cases are referred to this office from the Help Center, as well as other DMHC divisions that review the activities of health care service plans for compliance with the managed health care laws.

Based on the projected increased enrollment of 1,390,000, DMHC estimates that the Office of Enforcement will experience a 20 percent annual increase in referrals based on the rate of referrals currently made to Enforcement by the Help Center.

Of the anticipated annual referrals to the Office of Enforcement, DMHC estimates that approximately 10 percent of the enforcement referrals involving this new law will result in a trial. This equates to three trials in 2014-15 and four trials in 2015-16 and ongoing as a result of AB 1 X1 and is based on the current actual percentage of enforcement referrals that typically go to trial. Cases that go to trial require several contracts including those for expert consultants/witnesses, court reporting/deposition and exhibit preparation. Each trial will require two expert consultant/witness contracts at approximately $45,000 per contract (for a total of $90,000 per trial); an average of six administrative discovery depositions at approximately $2,000 per deposition (for a total of $12,000 per trial) and exhibit preparation (i.e. x-rays, large format printing and photos, and 3D models of buildings where illegal solicitation occurred) at approximately $2,000 per trial for a total of $104,000 per trial. The total contract costs for 2014-15 is $312,000 (3 trials x $104,000 = $312,000) and the total contract costs for 2015-16 is $416,000 (4 trials x $104,000 = $416,000.) These estimates are based on actual costs incurred for similar trials the Office of Enforcement has conducted.

Proposed Responsibilities of Requested Positions. DMHC proposes the following responsibilities for the requested positions:

Help Center

- **Attorneys** would review 21 percent of Standard Complaints and five percent of general correspondence (including calls and correspondence) from consumers enrolled in the Medi-Cal managed care. These positions require direct enrollee and health plan contact for case clarification, and to request additional information. Once the requested documentation has been received the attorneys review this information and apply case facts to the KKA and relevant regulations. Once a finding is complete, the attorneys draft correspondence advising of compliance, and discusses complaint findings with the

enrollee, health plan, and/or provider. These positions require documenting progress in the case management database and drafting closing letters to the health plans and enrollees.

- **Nurse Evaluators** would review and respond to the Medi-Cal enrollee Urgent Nurse cases within the mandated timeframes. The Nurse Evaluator receives requests from the Help Center's Call Center staff to review cases where the pre-determined Urgent Nurse case trigger has been noted. Once the Urgent Nurse case has been initiated the nurse reviews the submitted complaint documentation, medical records and other relevant clinical information; confers with Help Center management and legal staff; contacts the consumer, health plan and provider to gather information and documents this research in the case management database. The Nurse Evaluator is responsible for researching Current Procedural Terminology (CPT) codes, emerging medical treatments, standards of care, and health plan contracts. These positions require the information exchange between parties and negotiating resolution with health plan representatives. Once the case has been resolved the Nurse Evaluator is responsible for composing closing letters to the health plans and enrollees.

- **Associate Governmental Program Analysts (AGPAs)** would perform the initial review of incoming Medi-Cal managed care standard complaints and IMR requests, which includes direct contact with enrollees to clarify complaint issues and provide enrollees with additional direction and a review and application of the KKA to determine plan compliance and potential violations.

- **Consumer Assistance Technicians (CATs)** would answer incoming enrollee calls, research and reference policies and procedures, and document pertinent enrollee information in the case management database.

Office of Enforcement

- **Attorneys** would represent DMHC in actions to enforce managed health care laws including the quality, accessibility, continuity of care, and the denial of treatments and claims.

- **Investigators** would investigate complaints, conduct financial reviews, conduct hearing/trial support, and conduct background investigations.

LAO Comment and Recommendation. LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in Medi-Cal managed care. LAO finds that there will be more reliable estimates of 2014 Medi-Cal managed care enrollment available with the next couple of months. Consequently, the LAO recommends the Legislature: (1) hold this proposal open, (2) direct the Administration to report on estimates of enrollment in Medi-Cal managed care at the time of the May Revision and (3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on DMHC's budget and updated estimates are received at the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. Please describe how the call center responds to questions that are beyond its purview, such as eligibility and general inquiries.

5. SB 2 X1 – Individual Mandate Workload

Budget Issue. DMHC requests 13.5 positions and $1,518,000 for 2014-15 and 19.0 positions and $2,010,000 for 2015-16 and ongoing to address the increased workload resulting from the implementation of SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session related to the individual market. These positions will be responsible for providing consumer assistance and resolving consumer complaints.

The requested permanent positions are as follows:

Help Center	2014-15	2015-16
Attorney	2.0	3.0
Nurse Evaluator II	1.5	1.5
Associate Governmental Program Analyst	5.0	7.0
Consumer Assistance Technician	5.0	7.5
Total Positions	**13.5**	**19.0**

Background. DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

Existing federal law, the Affordable Care Act (ACA), enacts major health care coverage market reforms that take effect January 1, 2014. With the passage of SB 2 X1, California law now conforms to the ACA requirement that beginning January 1, 2014 health plans that offer health coverage in the individual market accept every individual that applies for that coverage.

As a result, DMHC is now responsible for providing consumer assistance and regulatory oversight to potentially millions of new enrollees and new health plans and products offered in Covered California.

Based on a November 7, 2012 Covered California report, it is estimated that by the end of 2015-16 approximately 1,701,000 previously uninsured new enrollees will enter the individual market and be enrolled in health plans that are regulated by DMHC.

It is likely that many of these individuals will not have had health care coverage and will be unfamiliar on how to use a health care coverage delivery system. DMHC's Help Center uses a conservative standard increase of three percent in consumer assistance, complaint resolution and Independent Medical Review (IMR) workload as new consumers enroll in health plans that are regulated by the DMHC. The three percent factor is based on historical experience of serving new populations.

SB 2 X1 Help Center Data. The Help Center has been able to identify 1,149 calls (out of 7,288 total calls) related to SB 2 X1 for the period January 1, 2014, to March 10, 2014. DMHC has opened 743 formal complaints from information gained through these 1,149 phone calls. The table below breaks down the categories/issues raised by enrollee's related to SB 2 X1. Enrollee's may have raised more than one issue when contacting DMHC. Because of this, the total number of issues noted in the spreadsheet (1,166) is greater than the total number of calls (1,149) received.

Table: SB 2 X1-Related Help Center Calls – January 1, 2014 – March 10, 2014

Categories/Issues	Number of Issues Identified
Enrollee (EE) did not receive ID cards/enrollment packet	209
EE could not confirm premium payment was received by the Plan	66
Incorrect premium amount on statement	64
EE cannot obtain medication due to lack of enrollment confirmation	112
EE cannot access care due to lack of enrollment confirmation	140
EE cannot confirm enrollment with the Plan/Covered CA	183
EE could not reach the Plan	78
EE could not reach Covered CA	25
EE unsure where to send premium payment	48
EE states their effective date is incorrect	65
EE is requesting premium reimbursement	28
EE states the Plan has incorrect personal data	22
EE states Provider is not accepting Covered CA Plans	51
EE wants to cancel current Covered CA Plan	19
EE states Covered CA Plan was cancelled due to lack of premium payment or personal data confirmation received by the Plan	55
EE states their medications are not on the Plan formulary	1
Total Issues	**1,166**

Projected Workload. For 2014-15, DMHC estimates a total of 37,271 additional contacts. This is based on 1,242,000 new enrollees for 2013-14 and 2014-15.

- 29,808 calls
- 4,471 pieces of correspondence

- 1,129 Quick Resolution cases
- 745 Standard Complaints
- 373 Independent Medical Review (IMR)
- 745 Urgent Nurse cases

For 2015-16, DMHC estimates 51,031 additional contacts. This is based on 1,701,000 new enrollees through 2015-16.

- 40,824 calls
- 6,124 pieces of correspondence
- 1,531 Quick Resolution cases
- 1,021 Standard Complaints
- 510 IMRs
- 1,021 Urgent Nurse cases

Proposed Responsibilities of Requested Positions. DMHC proposes the following responsibilities for the requested positions:

- **Attorneys** would review 21 percent of Standard Complaints and five percent of general correspondence (including calls and correspondence) from consumers enrolled in the individual market. These positions require direct enrollee and health plan contact for case clarification, and to request additional information. Once the requested documentation has been received the attorneys review this information and apply case facts to the KKA and relevant regulations. Once a finding is complete, the attorneys draft correspondence advising of compliance, and discusses complaint findings with the enrollee, health plan, and/or provider. These positions require documenting progress in the case management database and drafting closing letters to the health plans and enrollees.

- **Nurse Evaluators** would review and respond to individual market enrollee Urgent Nurse cases within the mandated timeframes. The Nurse Evaluator receives requests from the Help Center's Call Center staff to review cases where the pre-determined Urgent Nurse case trigger has been noted. Once the Urgent Nurse case has been initiated the nurse reviews the submitted complaint documentation, medical records and other relevant clinical information; confers with Help Center management and legal staff; contacts the consumer, health plan and provider to gather information and documents this research in the case management database. The Nurse Evaluator is responsible for researching Current Procedural Terminology (CPT) codes, emerging medical treatments, standards of care, and health plan contracts. These positions require the information exchange between parties and negotiating resolution with health plan representatives. Once the case has been resolved, the Nurse Evaluator is responsible for composing closing letters to the health plans and enrollees.

- **Associate Governmental Program Analysts (AGPAs)** would perform the initial review of incoming Individual Market Standard Complaints and IMR requests, which includes

direct contact with enrollees to clarify complaint issues and provide enrollees with additional direction and a review and application of the KKA to determine plan compliance and potential violations.

- **Consumer Assistance Technicians (CATs)** would answer incoming enrollee calls, research and reference policies and procedures, and document pertinent enrollee information in the case management database.

LAO Comment and Recommendation. LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in DMHC-regulated individual market products under the ACA. The proposal assumes that additional enrollment will be 90 percent of projected Covered California enrollment. The open enrollment period for Covered California will end on March 31 and the LAO expects that there will be more reliable estimates of 2014 enrollment in DMHC-regulated individual market health insurance products available with the next couple of months. Consequently, the LAO recommends the Legislature: (1) hold this proposal open, (2) direct the Administration to report on estimates of enrollment in DMHC-regulated products at the time of the May Revision and (3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on DMHC's budget and updated estimates are received at the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. Please provide a highlight of the types of calls the Help Center has been receiving related to SB 2 X1.

4280 Managed Risk Medical Insurance Board & 4260 Department of Health Care Services

1. Eliminate MRMIB

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

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

- Rename 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.

- Delete reference to adults from the CHIM Program provisions as the program was never expanded to cover parents.

- Transition 27 positions at MRMIB to DHCS.

Background. AB 60, Chapter 1168, Statutes of 1989, established the Major Risk Medical Insurance Board, which was renamed in 1993 to the Managed Risk Medical Insurance Board (MRMIB or Board). MRMIB administers the following programs:

- **Healthy Families Program (HFP).** Established in 1998, the HFP was California's version of the national Children's Health Insurance Program (CHIP) and provided comprehensive health, dental, and vision benefits through participating health plans to children ineligible for Medi-Cal. Pursuant to AB 1494 (Committee on Budget) Chapter 28, Statutes of 2012, as amended by AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, and in accordance with federal approvals, the HFP transition to Medi-Cal was implemented in four major phases and was completed on November 1, 2013. It is proposed that any remaining close out activities will transfer to DHCS.

- **Access to Infants and Mothers (AIM).** The AIM program, established in 1992, provides medically necessary services to pregnant women with incomes above 200 percent and up to and including 300 percent of the federal poverty level (FPL) through participating health plans. Eligibility for the AIM program requires the pregnant woman

to have no maternity insurance or have health insurance with a high (over $500) maternity-only deductible, and have a family income too high to qualify for no-cost Medi-Cal, up to 300 percent of the FPL. The total cost to eligible women enrolled in AIM is 1.5 percent of the family's adjusted annual household income after applying applicable deductions.

The AIM Program has a monthly statewide enrollment of approximately 6,000 women. The program provides covered services throughout the pregnancy, hospital delivery and through the month of which their 60th day of postpartum care falls. Under the prior HFP statute, infants born to AIM program subscribers, referred to as AIM-linked infants were automatically enrolled into HFP for one year without review of the family's income. Pursuant to AB 82 (Committee on Budget) Chapter 23, Statutes of 2013, AIM-linked infants with incomes above 250 percent and up to and including 300 percent of the FPL transitioned to DHCS beginning on November 1, 2013.

- **Major Risk Medical Insurance Program (MRMIP).** 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. The premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Prior to the 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. DHCS will assume responsibility for the program July 1, 2014. See table below for enrollment figures.

Major Risk Medical Insurance Program Enrollment by Month

Jan-11	6,913	Jan-12	6,196	Jan-13	5,737
Feb-11	6,679	Feb-12	6,110	Feb-13	5,716
Mar-11	6,648	Mar-12	6,051	Mar-13	5,828
Apr-11	6,622	Apr-12	5,997	Apr-13	6,022
May-11	6,637	May-12	5,971	May-13	6,295
Jun-11	6,632	Jun-12	5,957	Jun-13	6,397
Jul-11	6,610	Jul-12	5,878	Jul-13	6,463
Aug-11	6,560	Aug-12	5,858	Aug-13	6,536
Sep-11	6,563	Sep-12	5,823	Sep-13	6,570
Oct-11	6,499	Oct-12	5,757	Oct-13	6,492
Nov-11	6,420	Nov-12	5,726	Nov-13	6,321
Dec-11	6,334	Dec-12	5,713	Dec-13	5,678
				Jan-14	4,782

- **County Health Initiative Matching (CHIM) Program.** AB 495 (Diaz), Chapter 648, Statutes of 2001, created the CHIM program. MRMIB administers this program, which is funded through the use of intergovernmental transfers of local funds. Originally there were four proposed pilot counties – Alameda, Santa Clara, San Francisco and San Mateo, however, prior to federal approval Alameda withdrew its application for program participation. Under this program, local county funds are used as the non-federal share to draw down unused federal State CHIP/Title XXI funds for CHIP-eligible children. Eligible children are uninsured with family incomes above 250 percent and up to 300 percent of the FPL and are otherwise ineligible for Medi-Cal and AIM-linked infants program. Counties have the option of going up to 400 percent.

  In order to ensure compliance with Affordable Care Act (ACA) maintenance-of-effort requirements, the state budget includes approximately $212,000 General Fund for 2013-14 and $424,000 General Fund for 2014-15 for the local match.

  CHIM serves approximately 2,100 children in the three counties and total county expenditures are estimated to be $629,000 in 2013-14 and $509,000 in 2014-15.

- **Pre-Existing Conditions Insurance Program (PCIP).** SB 227 (Alquist), Chapter 31, Statutes of 2010 and AB 1887 (Villines), Chapter 32, Statutes of 2010, authorized MRMIB to establish and administer a new federal high risk pool program, contingent on a contract with the U.S. Department of Health and Human Services and receipt of adequate federal funding for the program.

  California's program, known as PCIP, offered health coverage to medically-uninsurable individuals who live in California. As of July 1, 2013, the federal government took over operations of the PCIP program from MRMIB. MRMIB is required to complete closeout activities of the state-run PCIP program through 2013-14. Any residual closeout activities beyond 2013-14 will transition to DHCS effective July 1, 2014.

Reason for Request. With the transition of HFP to DHCS, the Administration argues that MRMIB has been relieved of most of its workload. It contends that transitioning the remaining MRMIB duties to DHCS makes operational sense and further streamlines California's publicly-financed health care programs. In addition, the Administration finds that it simplifies the enrollment process for consumers applying through Covered California to two options: Medi-Cal or Covered California. This would reduce confusion and the need for branding of a separate program that provides similar benefits and delivery system to traditional Medi-Cal.

Future of MRMIP. MRMIP was designed for a time when individuals could be denied coverage because of a pre-existing health condition. Given the new Affordable Care Act (ACA) prohibition against the denial of coverage for pre-existing health conditions, the purpose of MRMIP has evolved. Most individuals with pre-existing conditions can now seek coverage through Covered California. However, there will still be situations in which individuals may not be eligible for coverage through Covered California, such as when the Covered California open enrollment period is closed.

MRMIB estimates that between 3,000 and 3,200 individuals will remain enrolled in MRMIP in 2014-15. Prior year monthly enrollment was generally around 6,000 (see table on previous page). The Governor's budget includes $41.7 million for MRMIP. This assumes a full caseload of about 7,500 (the MRMIP cap). (The annual cost per MRMIP subscriber is about $5,500.)

AIM and Covered California. CalHEERS, the online enrollment system for Covered California, did not originally include the ability to perform a Modified Adjusted Gross Income (MAGI) determination for AIM, as required by the ACA. Maximus, the AIM administrative vendor, and CalHEERs have developed a workaround to apply the MAGI rules and then transmit the eligibility determination to Maximus. It is anticipated that this functionality will be incorporated into CalHEERs in June.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

- **Need for Funding for Full Enrollment in MRMIP Unclear.** MRMIB estimates that only about 3,200 individuals (on a monthly basis) would be enrolled in MRMIP, yet the budget includes funding for a caseload of about 7,500. While funding to close-out reconciliation from prior year MRMIP claims may be necessary, it is too soon to estimate for post ACA caseload.

- **No Detailed Transition Plan.** The Administration indicates that it working on a detailed transition plan outlining administrative and operational issues (e.g., the process for transitioning contracts). This plan is not yet ready. It is critical that administrative and operational issues are outlined and worked out prior to any such transition. Although the caseload for these programs is small in comparison to other DHCS-run programs and Covered California, it is important that individuals who may be eligible for these programs are told of the programs and that enrollment into these programs is seamless through CalHEERs and at counties.

Questions.

1. Please provide a brief overview of MRMIB's programs and of this proposal.

2. Please comment on the future of MRMIP and why full year funding is proposed for MRMIP.

3. Please provide an update on integrating AIM into CalHEERs? Please explain the process to enroll women into AIM until this integration occurs. Have all pregnant women who applied through Covered California been evaluated for AIM eligibility?

4260 Department of Health Care Services

1. Overview

The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner. DHCS programs include:

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 8.3 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and, as of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services.*** The Children's Medical Services coordinates and directs the delivery of health services to low-income and seriously ill children and adults; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

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

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

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

See following tables for DHCS budget summary information.

Table: DHCS Program Budget Summary (dollars in thousands)

	Program	Actual 2012-13	Estimated 2013-14	Proposed 2014-15
	Health Care Services	$51,947,445	$72,252,490	$76,133,952
	Medi-Cal	49,902,847	70,133,209	73,979,370
	Children's Medical Services	351,581	317,051	299,861
	Primary and Rural Health	1,031	3,086	3,070
	Other Care Services	1,691,986	1,799,144	1,851,651
	Administration	25,109	35,947	35,966
	Distributed Administration	-25,109	-35,947	-35,966
Total Expenditures (All Programs)		**$51,947,445**	**$72,252,490**	**$76,133,952**

Table: DHCS Fund Budget Summary (dollars in thousands)

Fund	Actual 2012-13	Estimated 2013-14	Proposed 2014-15
General Fund	$15,117,724	$16,480,591	$17,212,283
Federal Trust Fund	27,186,874	42,405,766	45,111,444
Special Funds and Reimbursements	9,642,847	13,366,133	13,810,225
Total Expenditures (All Funds)	**$51,947,445**	**$72,252,490**	**$76,133,952**

Medi-Cal. DHCS administers the Medi-Cal program (California's Medicaid health care program). This program pays for a variety of medical services for children and adults with limited income and resources.

The Governor proposes total expenditures of $73.9 billion ($16.9 billion General Fund) which reflects a General Fund increase of $670 million or 4.1 percent above the Budget Act of 2013. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government.

Caseload is anticipated to increase by about 935,700 for a total of about 10.1 million average monthly eligibles, primarily due to the implementation of federal health care reform.

See following table for a summary of the proposed Medi-Cal budget.

Table: Medi-Cal Local Assistance Funding Summary

	2013-14	2014-15		
	Revised	**Proposed**	**Difference**	**Percent**
Benefits	$65,641,000,000	$69,725,300,000	$4,084,300,000	6.2%
County Administration (Eligibility)	$3,622,500,000	$3,361,900,000	-$260,600,000	-7.2%
Fiscal Intermediaries (Claims Processing)	$414,300,000	$419,300,000	$5,000,000	1.2%
Total	**$69,677,800,000**	**$73,506,500,000**	**$3,828,700,000**	**0.2%**
General Fund	$16,229,900,000	$16,899,500,000	$669,600,000	4.1%
Federal Funds	$43,631,300,000	$45,752,500,000	$2,121,200,000	4.9%
Other Funds	$9,816,700,000	$10,854,500,000	$1,037,800,000	10.6%

LAO Comments. The LAO finds that the baseline Medi-Cal caseload estimate (program caseload absent changes associated with recent major policy changes) is reasonable. Additionally, the LAO finds that the projected Medi-Cal caseload changes resulting from implementation of the Affordable Care Act (ACA) are generally reasonable. The Administration estimates that nearly 1.5 million additional average monthly enrollees in 2014-15. This caseload increase includes additional enrollment associated with the optional expansion, mandatory expansion, hospital presumptive eligibility, and Express Lane enrollment.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of DHCS's programs and major budget proposals.

2. Restoration of Adult Dental Benefits

Oversight Issue. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013 restores partial adult optional dental benefits on May 1, 2014. The goal of this restoration is to enable members, ages 21 and older with full scope Medi-Cal, to be brought up to a basic level of dental health. Basic preventive, diagnostic, and restorative services will be made available to meet this goal, and the program will allow complete dentures and related procedures. DHCS submitted a State Plan Amendment (SPA) regarding this restoration to the federal CMS on December 30, 2013. CMS confirmed receipt of the SPA and is currently reviewing it. For a complete list of services that will not be restored, please see Appendix A.

The budget includes $10.8 million ($3.3 million General Fund and $7.6 million federal funds) in 2013-14 and $239.5 million ($72.9 million General Fund and $166.6 million federal funds) in 2014-15 to restore this benefit and assumes a six month phase-in until full caseload is reached. Additionally, DHCS expects that there is some pent up demand for these services.

Background. Adult Dental Services, with the limited exception of "federally required adult dental services" (FRADS) and dental services to pregnant women and nursing home patients, were eliminated as an "optional" Medi-Cal benefit in 2009 due to the state's fiscal crisis. Generally, FRADS primarily involves the removal of teeth and treating the affected area.

Preparation for Restoration. Beginning mid-January 2014, DHCS began sending notifications directly to Medi-Cal beneficiary heads of households regarding the forthcoming restoration of some adult dental benefits through the department's *Jackson vs. Rank* quarterly mailing for the first quarter of 2014. The department also intends to send a secondary notification to Medi-Cal beneficiaries in the second quarter of 2014. The notification that was sent to the beneficiaries can be found at:

http://www.denti-cal.ca.gov/bene/notice_of_reinstatement_dental_services_12-6-13.pdf

DHCS indicates that it has been working with stakeholder groups and associations regarding the content of notices and informing and working with providers about re-activation into the Denti-Cal program. A streamlined provider enrollment process, known as the Preferred Provisional Provider enrollment, is available to providers who qualify. (This streamlined process was developed during the Healthy Families Program transition to Medi-Cal to expedite the enrollment of Healthy Families Program dentists as Medi-Cal providers.)

The total number of unduplicated providers enrolled in Denti-Cal is 15,549, as of February 2014. However, data is not available to determine whether or not these Denti-Cal providers will accept new enrollment and to what degree.

The dentist-to-beneficiary ratio that DHCS uses to assess the Denti-Cal fee-for-service (FFS) network is 1:2000. This is the standard that is used in counties that provide dental services through managed care (Sacramento and Los Angeles). DHCS adopted this ratio for the purposes of assessing the network for the Healthy Families Program transition.

DHCS states it will monitor utilization of these services based on submitted claims and is working with the federal CMS on how to monitor the utilization of these services.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an update on DHCS's preparations to implement the partial restoration of adult dental benefits.

2. Please explain how DHCS plans to monitor the implementation of this restoration.

3. Please describe DHCS' plans to measure access and utilization in fee-for-service and managed care. What metrics will be used? Will the data be publically reported? What is the status of the dental dashboard?

4. Has DHCS set targets for utilization?

3. Pregnancy Only Proposal

Budget Issue. DHCS' pregnancy only proposal has two main components:

1. **Provide Full Scope Medi-Cal for Pregnant Women Below 109 percent FPL.** DHCS proposes to provide full-scope coverage—rather than pregnancy-only coverage—to all pregnant women below 109 percent of the federal poverty level (FPL) who receive coverage from Medi-Cal (who are not otherwise eligible for full-scope). DHCS estimates no additional costs associated with providing full-scope coverage instead of pregnancy-only coverage, based on the assumption that there are no significant differences in coverage.

2. **Provide Medi-Cal Cost-Sharing and Benefit Wrap for Pregnant Women between 109 percent and 208 percent FPL.** DHCS also proposes to shift pregnant women between 109 percent and 208 percent of FPL who qualify for Medi-Cal pregnancy-only coverage to plans offered through Covered California. The budget assumes General Fund savings of $17 million in 2014-15 related to this component of the proposal since the federal government (through Covered California) would pick up the costs of comprehensive health coverage for these women. DHCS would implement this provision beginning January 1, 2015 and estimates that 8,100 Medi-Cal enrollees currently receiving pregnancy-only coverage would shift into Covered California.

Background. Beginning January 1, 2104, under the federal Patient Protection and Affordable Care Act (ACA), adults with incomes at or below 138 percent of the FPL who are under 65 years of age, not pregnant, and who meet other eligibility criteria and who are not otherwise eligible can enroll into Medi-Cal and receive full-scope services as a newly-eligible adult.

If the newly-eligible adult is a childless woman and she subsequently becomes pregnant while enrolled in Medi-Cal under this coverage group, she has the ability to remain in this coverage group and can continue with her full scope coverage of Medi-Cal services. However, if the same individual applies for coverage and is pregnant at the time of enrollment, based on her income, she will be ineligible for the new adult group and may only be eligible for the limited scope pregnancy-related services.

Furthermore, individuals with income above applicable Medi-Cal limits but below 208 percent of the FPL can enroll into coverage via the California Health Benefit Exchange, also known as Covered California, and receive applicable premium tax credits and cost sharing reductions, under certain conditions, and are provided with comprehensive health care coverage including pregnancy related care. To the extent individuals enrolled in coverage through Covered California subsequently become pregnant, and become income eligible for Medi-Cal for pregnancy-related services; they will have the option to either remain in coverage through Covered California or can move to Medi-Cal for coverage under the pregnancy-only program.

For purposes of minimum essential coverage (MEC), as required by the ACA, individuals enrolled in limited-benefit programs, such as the pregnancy-only program under Medi-Cal,

would not meet the MEC standard and they would need to seek coverage via Covered California where they may receive premium tax credits to purchase insurance and cost-sharing reductions to meet MEC.

Background--Comprehensive Perinatal Services Program. The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal program that provides women with prenatal care, health education, nutrition services, and psychosocial support for up to 60 days after the delivery of their infants. Over 1,500 Medi-Cal providers are approved as CPSP providers, in both fee-for-service and managed care systems. Providers include physicians, clinics, certified nurse midwives, and family nurse practitioners.

Proposed Medi-Cal Cost-Sharing and Benefit Wrap. For pregnant women with incomes between 109 percent and 208 percent of FPL who qualify for Medi-Cal and who enroll in a qualified health plan offered through Covered California, DHCS would:

- Pay the woman's premium costs minus the woman's premium tax credit.

- Pay for any cost-sharing (e.g., copays) for benefits and services under the Covered California health plan.

- Provide any Medi-Cal benefits (e.g., dental and nonemergency transportation) that are not offered by the Covered California health plan.

- Provide access to Medi-Cal providers who do not contract with the Covered California health plan for services that are not available in the qualified health plan. This may include, but is not limited to perinatal specialists and services in Comprehensive Perinatal Services Program (CPSP).

DHCS indicates that it is currently analyzing how its current Medi-Cal managed care plans provide CPSP services and whether health plans offered in Covered California provider CPSP-like services. For example, according to one qualified health plan that offers products through Covered California, the only Medi-Cal and CPSP benefits that it does not provide are dental benefits and nonemergency medical transportation. This plan contracts with birth centers and utilizes midwives as part of its network.

Additionally, DHCS is in the process of assessing if there is a difference in the outcomes from services if they are provided by certified CPSP providers or non-CPSP certified providers.

LAO Comments and Recommendations. The LAO finds that the Governor's proposal would (1) likely reduce General Fund spending, while potentially providing more generous benefits, (2) full-scope coverage would eliminate coverage inconsistencies for pregnant women, and (3) that certain details of the proposal remain unclear, such the differences in covered services and costs between full-scope and pregnancy-only coverage. The LAO recommends the Administration clarify (1) the differences in covered services between full-scope Medi-Cal and pregnancy-only Medi-Cal and (2) continuity of coverage and plan choice for individuals moving between Medi-Cal and Covered California.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and more information is obtained from the Administration.

Some consumer advocates highlight the inequity of the Administration's proposal in that adults, female and male with incomes under 138 percent of the FPL are eligible for full-scope Medi-Cal; however, pregnant women (with incomes under 138 percent of the FPL) who apply and are eligible for Medi-Cal could only receive pregnancy-only Medi-Cal or could choose comprehensive coverage through Covered California, with Medi-Cal providing a cost-sharing and benefit wrap. Additionally, consumer advocates urge the strengthening of the Medi-Cal benefit wrap provisions and consumer protections in the Administration's proposal. Many advocates find that CPSP services must be delivered comprehensively as a program and by CPSP-certified providers and do not think that the success of this program can be duplicated as a "wrap" service.

Questions.

1. Please provide an overview of this proposal.

2. Please provide an update on DHCS' analysis of how Medi-Cal managed care plans provide CPSP services.

3. Please provide an update on DHCS' analysis of whether or not qualified health plans offer CPSP services.

4. What are the differences in benefits and costs between full-scope and pregnancy-only coverage?

5. If the wrap is enacted, pregnant women will have multiple options including, the wrap and pregnancy-only Medi-Cal. How does DHCS propose to inform women of the multiple options?

6. How does DHCS propose to inform Medi-Cal eligible pregnant women of their right to receive services that are not available in their qualified health plan?

7. How does DHCS propose to coordinate pregnancy-related wrap services that may be received outside the Covered California qualified health plan?

4. AB 85 - County Realignment - Request for Positions

Budget Issue. DHCS requests $3,446,000 ($1,723,000 General Fund and $1,723,000 federal funds) in 2014-15 and $3,410,000 ($1,705,000 General Fund and $1,705,000 federal funds) in 2015-16 and ongoing to fund 18 positions and contract funds to implement and maintain the provisions of AB 85 (Committee of Budget), Chapter 24, Statutes of 2013.

The 18 positions requested in this proposal are for the Safety Net Financing Division (SNFD), Audits and Investigations Division (A&I), Office of Legal Services (OLS), Office of Administrative Hearings and Appeals (OAHA), and the Capitated Rates Development Division (CRDD). If the request for these positions is not approved, implementation of the bill requirements will be delayed as current staff cannot absorb this workload and maintain their current workload.

Effective July 1, 2013, DHCS administratively established 12.0 positions and will absorb the costs, in the current year. This proposal requests authorized position and expenditure authority, effective July 1, 2014. DHCS states that resources were redirected in the current year, but that this redirection is not sustainable.

DHCS also requests $1.2 million ($600,000 General Fund and $600,000 federal funds) for consultant contracts:

- $1.0 million for a contract with Mercer (actuarial services). The Mercer contract will fund critical aspects of the program such as rate development and financial reporting.

- $200,000 to contract for a subject matter expert on public hospital data.

Background. Under the Affordable Care Act (ACA), county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to health care coverage. The state-based Medi-Cal expansion will result in indigent care costs previously paid by counties shifting to the state. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, modifies 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties will experience from the implementation of federal health care reform effective January 1, 2014.

According to the Administration, county savings are estimated to be $300 million in 2013-14 and $900 million in 2014-15, and those savings will be redirected to counties for CalWORKs expenditures. This redirection mechanism frees up General Fund resources to pay for rising Medi-Cal costs. Counties can either choose a reduction of 60 percent of their health realignment funds, including their maintenance-of-effort, or choose a formula that accounts for the revenues and costs of indigent care programs in their county. Counties have the following options:

- **Option 1** uses a formula that measures actual county health care costs and revenues. The state receives 80 percent of any calculated savings, with the county retaining 20

percent of savings to invest in the local health care delivery system or spend on public health activities.

- **Option 2** transfers 60 percent of a county's health realignment allocation plus the county maintenance-of-effort (MOE) to the state to be captured as savings; the county retains 40 percent of its realignment funding for public health, remaining uninsured, or other health care needs. (To receive health realignment funds, counties are required to meet a MOE. Under this option, a percentage of the MOE is considered in the calculation.)

Counties participating in the County Medical Services Program (CMSP) are subject to an alternative similar to Option 2. Total realignment funding for CMSP consists of a direct allocation that grows over time and $89 million that CMSP counties collectively contribute annually to the CMSP Governing Board. For CMSP counties, AB 85 redirects the $89 million as savings, and the Governing Board will be responsible for covering the remainder of the amount equal to 60 percent of the program's total realignment and MOE funding.

Future year savings for all counties will be estimated in January and May, prior to the start of the year, based on the most recently available data. Further, for counties that choose the formula, reconciliation will occur within two years of the close of each fiscal year. Counties had until January 22, 2014 to adopt a resolution to select Option 1 or Option 2 and inform DHCS of the final decision.

DHCS issued a final determination on the historical percentage spent on indigent health care to each county and it can be found at:
http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/DHCS_Historical_Determinations.pdf

Counties had until February 28, 2014 to appeal to the County Health Care Funding Resolution Committee (created by AB 85) DHCS' determination on the historical percentage, petition to change options, and petition for an alternative cost calculations. This committee is composed of representatives from the California State Association of Counties, DHCS, and the Department of Finance. Eight counties have submitted appeals to this committee, three of these have been withdrawn.

Details on Proposed Positions. The proposed positions are:

Safety Net Financing Division – 7.0 Positions
5.0 Permanent Positions
1.0 Staff Services Manager (AE)
2.0 Associate Government Program Analyst (AE)
2.0 Health Program Auditor IV

2.0 Limited-Term Positions
2.0 Associate Government Program Analyst

Audits and Investigations – 1.0 Position
1.0 Permanent Position
1.0 Health Program Auditor IV

In the current year, these positions developed and calculated the historical percentages of county indigent care spending, and developed interim calculations for 2013-14 and 2014-15. Staff will also need to develop estimates of redirected amounts to include in the May 2014 Estimate. Throughout the next year, these staff would work with counties to finalize data, develop the final calculation model, and complete final calculations. The final calculations for 2013-14 must be completed by December 31, 2015.

In the budget year and ongoing, these positions would perform interim and final calculations annually until the latter of 2023 or until amounts in the formula are fairly static. The formula looks at all health care costs and revenues and then determines the portion of those costs and revenues spent on Medi-Cal and the uninsured. Different county groups have different kinds of costs and revenues, and counties capture and record data differently. The calculations contain numerous steps, including comparisons of each year's actual data to the historical data for that county, adjustments to data depending on different variables, cost containment limits, weighted trend factors, a low income shortfall calculation, and other steps. This workload will be ongoing.

Office of Legal Services – 3.0 Positions
2.0 Permanent Positions
1.0 Attorney IV (AE)
1.0 Attorney I (AE)

1.0 Limited Term Position
1.0 Legal Analyst (AE)

These positions would be responsible for developing regulations related to AB 85 and represent DHCS on any county appeals of the calculations,

Office of Administrative Hearings and Appeals – 3.0 Positions
3.0 Permanent Positions
1.0 Administrative Law Judge II (AE)
1.0 Administrative Law Judge II
1.0 Legal Analyst (AE)

These positions would process appeals, conduct hearings, and produce proposed decisions related to AB 85.

Capitated Rates Development Division – 4.0 Positions
2.0 Permanent Positions
2.0 Research Program Specialist II (AE)

2.0 Limited Term Positions

2.0 Research Program Specialists I (AE)

These positions will plan, organize, and conduct studies and provide consultation regarding the impact on Medi-Cal managed care plans with the implementation of AB 85, analyze Medi-Cal managed care data and extract data specific to the newly-eligible beneficiaries enrollment to be used by the actuaries in the development of capitation rates; provide analyses to determine the accuracy and reasonableness of the data by specific service type; and develop critical evaluations of AB 85 and develop written narratives (briefing papers, issue memos and policy letters) advising on proposals and alternatives related to the newly-eligible population.

The requested $1.0 million for Mercer Health and Benefits LLC contract for actuarial services (Mercer) would fund two aspects of the program:

- Implementation of AB 85 requires specified percentages of newly-eligible Medi-Cal beneficiaries to be assigned to public hospital health systems in an eligible county until the county public hospital health system meets its enrollment target. Actuarially sound capitation rates need to be calculated to pay the managed care plans at least 75 percent of the rate range available so they can in turn pay county public hospitals at cost for services.

- Managed care plans are to pay the entire rate range as additional payments to county hospitals for providing and making available services to newly-eligible enrollees under the 133 percent Federal Poverty Level (FPL).

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and the updated estimates on county savings are included in the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. What county programs and services are funded with health realignment funds? Is there any reporting to the state on how counties use this funding or how counties have changed or propose to change their services as a result of AB 85?

3. Please provide an update on implementation of AB 85 and DHCS' work on calculating the 2014-15 county savings.

5. AB 1 X1 – Medi-Cal Eligibility Under ACA – Request for Positions

Budget Issue. DHCS requests eight positions and expenditure authority of $1,062,000 ($295,000 General Fund and $767,000 federal funds) in 2014-15 and $1,046,000 ($290,000 General Fund and $756,000 federal funds) in 2015-16 needed to implement the various statutory requirements of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. Specifically, AB 1 X1 authorizes DHCS to implement various Medicaid provisions of the Affordable Care Act (ACA).

Background. AB 1 X1 authorizes the DHCS to implement various Medicaid provisions of the ACA. Specifically, AB 1 X1 1implements the new "adult group" in California; transitions Low Income Health Program (LIHP) beneficiaries to Medi-Cal beginning January 1, 2014; implements the use of the Modified Adjusted Gross Income (MAGI) methodology; simplifies the annual renewal and change in circumstances processes for Medi-Cal beneficiaries; requires DHCS to use electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; permits Covered California to make Medi-Cal eligibility determinations in limited situations; and establishes performance standards for DHCS, Covered California, and the Statewide Automated Welfare Systems (SAWS).

Details on Proposed Positions. Of the requested positions, the Medi-Cal Eligibility Division requests four two-year limited-term, full-time positions as follows:

- Two Health Program Specialists II
- Two Associate Governmental Program Analysts

The Medi-Cal Eligibility Division (MCED) is responsible for the planning, development, coordination, and implementation of Medi-Cal regulations, policies, and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. These positions would provide extensive technical program consultation on the implementation requirements of the legislation; assist in the development of policies in the form of All County Welfare Director Letters, Medi-Cal Eligibility Division Information Letters, and regulations in support of the policy changes mandated by the legislation; conduct ongoing policy reviews and analyses of the eligibility requirements; review and interpret ongoing federal guidance; and obtain stakeholder and county perspectives.

The Information Technology Division requests four two-year limited-term positions as follows:

- One Senior Information Systems Analyst Specialist
- One Staff Information Systems Analyst
- One Senior Programmer Analyst Specialist
- One System Software Specialist III

The Information Technology Division (ITSD) provides a secure, reliable information technology environment to support program and administrative objectives of DHCS, the California Department of Public Health (DPH), and the California Health and Human Services Agency.

These positions would provide requirements definition, design, development, implementation and ongoing support of the various Medicaid provisions of the ACA. This work includes provisions contained in AB 1 X1, and will require system enhancements to Medi-Cal Eligibility Data System (MEDS) and related systems including the Statewide Client Index (SCI), and interfaces in the following major areas: eligibility, enrollment, systems integration, and the establishment of performance standards for DHCS, Covered California and SAWS.

LAO Findings and Recommendations. The LAO finds that based on the timelines provided the proposal, it appears most of the activities that will be performed by the requested positions are scheduled to be complete by June 2015, with many of them completed even earlier. Currently, it is unclear why the department is requesting positions through June 30, 2016 when the activities are scheduled to be completed by June 2015. The LAO recommends the Legislature direct the department to report on the activities these positions will be performing after June 2015, at which point it appears most of the workload associated with this request is scheduled to be complete.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and implementation of federal health care reform.

Questions.

1. Please provide an overview of this proposal.

2. Please comment on the LAO's findings that justification for these positions in 2015-16 is unclear. What will these positions perform after June 2015?

6. SB 1 X1 – Medi-Cal Eligibility Under ACA, Hospital Presumptive Eligibility

Budget Issue. DHCS requests funding for the information technology consultant costs associated with enhancing the business functionalities and reporting requirements of the Medi-Cal Eligibility Determination System (MEDS) to create a Hospital Presumptive Eligibility gateway and implement the Hospital Presumptive Eligibility (PE) program, as set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session.

The costs associated with the implementation is estimated at $1,583,000 ($396,000 General Fund, $1,187,000 Federal Fund) with an on-going cost of $239,000 ($60,000 General Fund, $179,000 Federal Fund) per year. The contracted vendor will assist DHCS to develop the Hospital PE gateway and enhance MEDS, including developing requirements, validation, training, and user ownership.

Background. On July 5, 2013, the federal Centers for Medicare and Medicaid Services (CMS) released Part 2 of the Medicaid Final Rule regulations to implement various provisions of the Affordable Care Act. The Part 2 packet provided final regulations on the implementation of the Hospital PE program established by the ACA at 42 Code of Federal Regulations (CFR) Section 435.1110.

To implement the Hospital PE program, California enacted Welfare & Institutions Code Section 14011.66, as prescribed in SB 1 X1. The Hospital PE program provides temporary no share-of-cost Medi-Cal benefits during a presumptive period to individuals determined eligible by a qualified hospital, on the basis of preliminary information. The Hospital PE program is effective as of January 1, 2014. To ensure compliance with the Hospital PE program's effective date of January 1, 2014, DHCS enhanced the MEDS by leveraging the system functionalities established for the Child Health and Disability Prevention (CHDP) Gateway program. However, this strategy was a short-term approach to meet the mandate; the enhancements do not provide the means to meet critical program requirements on oversight and monitoring, performance standards development, and program integrity and compliance with applicable state and federal policies, statutes, and regulations.

To date, 124 hospitals are providing Hospital PE and 11,000 individuals have been approved to receive Medi-Cal under the Hospital PE program.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised. DHCS developed short-term solutions to ensure that this program was implemented quickly and, as a result, over 11,000 individuals have qualified for Medi-Cal Hospital PE. This proposal will provide for a long-term technology solution to support the Hospital PE program.

Questions.

1. Please provide an overview of this proposal.

7. SB 3 X1 – Health Care Coverage: Bridge Plan – Request for Positions

Budget Issue. DHCS requests four three-year limited-term positions and $460,000 ($229,000 General Fund and $231,000 Federal Trust Fund) to implement the provisions of SB 3 X1 (Hernandez), Chapter 5, Statutes of 2013-14 of the First Extraordinary Session. The bill requires DHCS to ensure that its contracts with Medi-Cal managed care health plans meet various requirements, including providing coverage in bridge plans to Medi-Cal managed care enrollees and other specified individuals.

DHCS states that these positions are necessary to provide legal advice, litigation support and regulation development. Additionally, the positions would be needed to address managed care bridge plan policy implementation and to avoid potential negative consequences including noncompliance with state and federal mandates, the loss of federal funding, and litigation.

Background. SB 3 X1 requires the California Health Benefits Exchange (known as Covered California) to enter into contracts with and certify as a qualified health plan (QHP) Medi-Cal managed care plans that offer "bridge plan" products meeting specified requirements; specify the populations that would be eligible to purchase a bridge plan product; and require DHCS to ensure its contracts with Medi-Cal managed care plans meet specified requirements. A bridge plan product is the individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with Covered California.

The bill requires Covered California to submit an evaluation to the Legislature of the bridge plan program in the fourth year following federal approval and would sunset the bridge plan program five years after federal approval, unless a later enacted statute deletes or extends the dates of operation. The purpose of SB 3 X1 is to improve continuity of coverage for Medi-Cal enrollees and their families, and provide more affordable coverage to low-income individuals.

SB 3 X1 establishes a bridge health insurance plan for low-income individuals, the parents of Medi-Cal and Healthy Families Program-eligible individuals, and individuals moving from Medi-Cal coverage to subsidized coverage through Covered California. The purpose of the bridge is to promote continuity of care, provide an additional low-cost coverage choice to hard-working Californians, and reduce the negative effects of "churning" back and forth between systems of coverage where individuals are required to shift health plans and health coverage programs because of changes in their household income. By allowing individuals to remain within their current health plan when they shift health subsidy programs, SB 3 X1 prevents disruptions in individuals' provider networks and improves continuity of care.

LAO Findings and Recommendations. The LAO finds that the workload appears to be based on an assumption that a significant number of Medi-Cal managed care plans will be offering a Bridge Plan product. The federal government has yet to approve the state's Bridge Plan proposal and—even assuming the proposal is approved by the federal government—it is unclear how many Medi-Cal plans will offer Bridge Plan products. If very few Medi-Cal plans offer Bridge products, the workload for this proposal may be overstated. Second, the authorizing statute (SB 3 X1) gives DHCS the authority to delegate much of the

implementation responsibility to Covered California. Currently, it is unclear why DHCS chose to implement these activities rather than delegate these activities to Covered California. The LAO recommends the Legislature direct DHCS to report on the following: (1) how many Medi-Cal plans they expect to offer Bridge Plan products, (2) the degree to which the number of plans offering Bridge Plan products affects the workload associated with this proposal, (3) which Bridge Plan implementation activities are being delegating to Covered California, and (4) why the department is requesting resources to implement the activities described in this proposal, rather than delegating the activities to Covered California.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open. The federal CMS has not yet approved the state's proposal to create a bridge plan and it is unclear if any health plans will apply to become bridge plans. Additionally, DHCS' proposed role in implementing the bridge plan program does not appear consistent with SB 3 X1, as SB 3 X1 envisioned that Covered California would be primarily responsible for implementation.

Questions.

1. Please provide an overview of this proposal and rationale for DHCS' request for four staff to implement this program.

8. ACA - Estimated Savings Due to Claiming Enhanced Federal Funds

Budget Issue. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, requires DHCS to report to the Legislature, each January and May, the projected General Fund savings attributable to claiming enhanced federal funding for previously eligible Medi-Cal beneficiaries. The law also required DHCS to confer with applicable fiscal and policy staff of the Legislature by no later than October 1, 2013 regarding the potential content and attributes of the information provided in its savings estimate.

This information was not included in the Governor's January budget. The Administration indicates that it was unable to provide this figure because it did not have data (as the change occurred in January 2014) to base its assumptions and hopes to have this information in the May Revision.

Background. Under some of the new ACA eligibility rules and the optional expansion, the state may be able to claim a 100 percent federal match for some enrollees who would have previously qualified for a 50 percent match.

LAO Comments and Recommendations. The LAO finds that preliminary fiscal estimates of factors that will likely have significant effects on the amount of General Fund spending in the Medi-Cal Program should be included in the budget even if these estimates are highly uncertain and subject to change in the coming months. The Medi-Cal budget frequently contains preliminary estimates and assumptions that are based on limited data and experience. For example, many of the other ACA–related fiscal estimates included in the Medi-Cal Estimate are subject to substantial uncertainty and are based on assumptions that are based on limited actual experience, yet these estimates are included in the budget. Such estimates serve as placeholders until more refined estimates can be completed and allow for more informed budget deliberations because the Legislature has an opportunity to assess the Administration's estimates and assumptions and discuss the budget with a more complete understanding of the factors affecting expected General Fund spending.

LAO recommends that the Administration report at budget hearings on the reasons it failed to confer with all of the relevant legislative staff and provide a fiscal estimate of enhanced federal funding available for previously eligible beneficiaries, as required by state law. In addition, the LAO recommends that the Legislature direct the Administration to describe: (1) the previously eligible populations that may now be eligible for the 100 percent federal match, (2) the total amount of General Fund that was spent on these populations in previous years, (3) the major sources of uncertainty that led to the decision to not include a fiscal estimate in the budget, and (4) the Administration's timelines for providing its fiscal estimate. LAO finds that with this additional information, the Legislature can begin to assess the potential magnitude of the fiscal effects and account for these effects as it discusses the 2014-15 budget.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. The Administration has a wealth of Medi-Cal data and often estimates

based on unknown experiences; this information, as required by law, should be provided to the Legislature no later than the May Revision.

Questions.

1. DHCS, please describe (a) the previously eligible populations that may now be eligible for the 100 percent federal match, (b) the total amount of General Fund that was spent on these populations in previous years, (c) the major sources of uncertainty that led to the decision to not include a fiscal estimate in the budget, and (d) the Administration's timeline for providing its fiscal estimate.

9. Statewide Outpatient Medi-Cal Contract Drug List

Budget Issue. DHCS requests trailer bill language to:

1. **Statewide Formulary.** Establish a core statewide outpatient Medi-Cal contract drug list (CDL) formulary for all Medi-Cal beneficiaries, including the Family Planning, Access, Care and Treatment Program (FPACT). Any of the drugs on this statewide formulary would be available without a treatment authorization request. Managed care plans would be required to use this core formulary, as a minimum, and could add additional drugs at their discretion.

2. **Additional State Supplemental Drug Rebates.** Negotiate supplemental drug rebate contracts with manufacturers for all Medi-Cal programs, including managed care plans and FPACT. The budget estimates General Fund savings of $32.5 million in 2014-15 and annual General Fund savings of at least $65 million as a result of these supplemental drug rebates.

Background. DHCS is one of the largest purchasers of drugs in the State. The fee-for-service (FFS) pharmacy program contract drug list formulary (CDL) is established and maintained by DHCS in consultation with the Medi-Cal Contract Drug Advisory Committee (MCDAC) and ongoing recommendations from the Medi-Cal Drug Use Review (DUR) Board. Currently, beneficiaries in Medi-Cal's FFS program have access to drugs listed on the Medi-Cal CDL without having to obtain prior authorization.

However, Medi-Cal managed care plans are only required to establish drug formularies that are comparable in scope to the Medi-Cal CDL. Each managed care plan develops and manages its own formulary, and as a result, Medi-Cal beneficiaries may receive different drug formulary options and be subject to different utilization controls when they move between health plans. Current regulations (California Administrative Code Title 22, § 53854) do not require a plan to include in its formulary every drug listed on the Medi-Cal formulary and do not prevent a plan from performing utilization review to determine the most suitable drug therapy for a particular medical condition.

There are currently more than twenty different Medi-Cal managed care plan formularies. Additionally, beneficiaries under FPACT may receive different drugs because FPACT administers its own outpatient drug formulary which is separate and apart from the Medi-Cal CDL.

The federal Medicaid Drug Rebate Program was created by the 1990 Omnibus Budget Reconciliation Act and requires drug manufacturers to have a national rebate agreement with the federal Department of Health and Human Services in order for states to receive federal funding for outpatient drugs dispensed to Medicaid enrollees. Prior to 2010, drugs provided to enrollees in Medicaid or Medi-Cal managed care plans were excluded from these federal rebates.

The Affordable Care Act modified this and now drug utilization from Medi-Cal managed care plans is subject to the federal drug rebate program. Pursuant to Welfare and Institutions Code Section 14105.33, DHCS is able to also negotiate with pharmaceutical manufacturers for additional rebate revenue (state supplemental rebates) over and above the mandated federal rebates for drugs provided to beneficiaries in the Medi-Cal FFS program and County Organized Health Systems. This state supplemental rebate program excludes drugs provided to beneficiaries in Medi-Cal managed care plans. The expansion of Medi-Cal managed care into all 58 counties and mandatory enrollment of families, children, seniors and persons with disabilities into managed care reduces the ability of the State to obtain the supplemental rebates for drugs provided to these beneficiaries under managed care arrangements.

Reason for Request. DHCS states that historically, its clinical and fiscal benefit design (for its pharmaceutical program) has been based on a FFS foundation for predominantly FFS-weighted pharmaceutical utilization. The shifts in population (e.g., seniors and persons with disabilities) and pharmaceutical utilization from FFS to managed care have highlighted two key issues:

1. **Inequity in the Pharmaceutical Benefit Design –** Each managed care plan develops its own drug formulary. Consequently, as people move from one managed care plan to another plan, Medi-Cal enrollees may receive different drug options and may be subject to various forms of drug utilization controls before they can receive a drug that they were previously prescribed. DHCS contends that this proposal would provide continuity of pharmaceutical benefits when a person changes plans.

2. **Lost Opportunities for General Fund Savings –** DHCS finds the state could obtain additional supplemental drug rebates resulting in General Fund savings if it had the ability to negotiate on the behalf of all Medi-Cal delivery systems, including Medi-Cal managed care plans and FPACT.

   According to DHCS, Medi-Cal drug spending includes:

Medi-Cal Fee-For- Service for Pharmacy	$2.1 billion	State supplemental rebates are collected.
Medi-Cal Managed Care Rate Pharmacy Line Item	$1.3 billion	State supplemental rebates are not collected.
Medi-Cal Managed Care Carved Out Pharmacy (e.g., HIV drugs)	$672 million	State supplemental rebates are ~~**not**~~ collected.

   ~~**DHCS finds that close to $2 billion in Medi-Cal drug spending could be subject to state supplemental rebates and that DHCS should play a more significant role in the establishment of this benefit.**~~ **The proposal would allow DHCS to collect state supplemental rebates for managed care utilization on drugs for which there is a supplemental rebate agreement.**

DHCS recognizes that as a result of the statewide drug formulary, managed care rates may need to be adjusted since managed care plans will not have the same negotiating power and may not have the same ability to managed pharmaceutical utilization. DHCS indicates that the need for this rate adjustment would be evaluated as this proposal is implemented.

DHCS also notes that this proposal makes no changes to the existing Knox-Keene continuity of care protection for drug benefits. If a drug is not on the state's core formulary and not on the health plan's formulary (if it provides supplemental drugs), then the existing treatment authorization process would still occur.

DHCS states that this proposal does not impact the list of drugs (e.g., certain HIV drugs) that are carved out of Medi-Cal managed care.

DHCS anticipates that this process will take 18 months to implement, as federal approval is necessary, but is proposing that the changes related to the state supplemental rebates be retroactive to July 1, 2014.

DHCS held four stakeholder workgroup meetings this past week with providers, health plans, the pharmaceutical industry, and beneficiary advocates.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. This is a very complex issue and discussions with stakeholders have recently commenced. It will be important for the Legislature to carefully consider the potential tradeoffs of this proposal. These tradeoffs include the additional General Fund savings and a core statewide drug benefit compared to restricting some aspects of a managed care plan's ability to control and manage pharmacy benefits which potentially could lead to pressure for increased managed care rates. It is also not clear whether or how this proposal may interfere with a plan's ability to coordinate and manage the care of enrollees, particularly those with chronic conditions.

Questions.

1. Please provide an overview of this proposal.

2. Please provide highlights of issues and concerns raised during this week's stakeholder meetings.

3. Please provide an overview of the timeline for this proposal and how DHCS intends to work with stakeholders to develop the statewide formulary.

4. Please provide an overview of the existing continuity of care protections related to prescriptions and medication. Do these only apply when an individual changes plans? Would these protections apply if this proposal is implemented and there is change due to a drug no longer being part of the formulary (but the person remains in the same health plan)?

5. Please explain how the FPACT drug formulary and the current Medi-Cal FFS drug formulary are different. Please comment on how the Administration plans to evaluate those drugs that are on the FPACT formulary and whether or not they should be included on the new formulary.

6. Please comment on the potential need to adjust Medi-Cal managed care rates as a result of this proposal.

10. Impact of Minimum Wage Increase on Medi-Cal

Budget Issue. AB 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014 and $10 per hour on January 2016.

The Governor's budget does not account for the impact to Medi-Cal as a result of this wage increase, even though many Medi-Cal providers (e.g., skilled nursing facilities) and Medi-Cal Waiver programs (e.g., the AIDS Wavier) would likely experience an increase in wage costs as a result of AB 10.

Both the In-Home Supportive Services budget and the Department of Developmental Services (DDS) budget include rate adjustments (i.e., increased General Fund expenditures) to account for the increase in wage costs as a result of AB 10.

The Administration states that it is currently evaluating the impact of AB 10 on Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic. Given that both the IHSS and DDS budgets have been adjusted to account for the wage costs increases, it would be expected to see a similar adjustment in the Medi-Cal budget.

Questions.

1. Please provide an overview of this issue and any reasoning for why Medi-Cal would not experience a similar adjustment to account for the wage costs increase.

11. Fingerprinting and Criminal Background Checks

Budget Issue. DHCS seeks statutory authority to receive the results of criminal background checks of applicants and providers from the Department of Justice (DOJ) in order to screen or enroll the Medi-Cal provider applicants and providers.

Trailer bill language is also requested to clarify that applicant/providers will be responsible for reimbursing DOJ the cost to complete the expanded background checks and fingerprinting. The added language provides DOJ with clear legal authority to charge the providers for the fingerprinting and background checks.

Background. DHCS is responsible for the enrollment and re-enrollment of fee-for-service health care service providers into the Medi-Cal program. There are approximately 150,000 enrolled Medi-Cal providers who serve the medically necessary needs of the Medi-Cal population.

In compliance with 42 Code of Federal Regulations (CFR) §455.434 and provisions of the Patient Protection and Affordable Care Act of 2010 (ACA), DHCS is required to establish a screening process for applicants or providers based on the provider types' categorical risk for fraud, waste, or abuse. The federal regulations establish three screening levels (per 42 CFR §455.450). The screening levels include "limited", "moderate" and "high", under which there are minimum requirements for screening and research to be conducted during the application review process:

- "Limited" categorical risk level providers are subject to license verification and database checks.

- "Moderate" categorical risk level providers are subject to all screening measures applicable to "limited" risk provider types in addition to onsite inspections.

- "High" categorical risk level providers are subject to all screening measures applicable to "limited" and "moderate" risk provider types in addition to the submission of fingerprints for a criminal background check (CBC).

Medi-Cal applicants or providers who CMS or DHCS designates as a "high" risk to the Medi-Cal program, and any individuals who have a five percent or greater direct or indirect ownership interest in the provider, will be required to be screened at a "high" categorical risk level and to submit fingerprints for a CBC within 30 days of a request. Furthermore, if CMS determines that "high" risk providers require federal CBCs, those providers designated as "high" risk would be required to undergo a federal CBC at the time of revalidation as DOJ does not provide federal update reports as it does for State level CBCs.

Provider types that have been designated as "high" categorical risk by Medicare are required to be screened by Medicaid programs at that same level. Currently, newly-enrolling durable medical equipment providers and newly-enrolling home health agency providers have been

designated as "high" categorical risk by Medicare. In addition to those provider types designated as "high" categorical risk, any applicant or provider will be elevated to the "high" categorical risk level if the provider has a payment suspension that is based on a credible allegation of fraud, waste, or abuse; has an existing Medicaid overpayment based on fraud, waste or abuse; has been excluded by the federal Department for Health and Human Services' Office of the Inspector General or another state's Medicaid program within the previous ten years; or, a moratorium has been lifted within the previous six months prior to applying in the Medicaid program and the applicant/provider would have been prevented from enrolling due to the moratorium.

DHCS is to designate all other provider types not recognized by Medicare to an appropriate screening level based on fraud, waste, or abuse.

SB 1529 (Alquist), Chapter 797, Statutes of 2012, sponsored by DHCS, implemented various program integrity provisions required by the ACA, including the provision requiring Medi-Cal applicants or providers, who are required to be screened at a "high" categorical risk level for fraud, waste, or abuse to provide fingerprints for a CBC. Although DHCS currently has statutory authority to require fingerprints for a CBC, the California Department of Justice (DOJ) requires specific statutory authority authorizing DOJ to accept fingerprints and furnish DHCS or its agents with CBC results. As such, this proposal seeks to establish authority for DOJ to provide criminal history information to DHCS for certain applicants or providers in the Medi-Cal program in order to become fully compliant with federal Medicaid requirements.

Reason for Request. Without the proposed trailer bill language, DHCS indicates it will not be able to implement the ACA requirement for CBCs. States are required to implement within 60 days of final guidance. This trailer bill language is in preparation to meet implementation requirements upon final guidance issuance. DHCS anticipates that guidance will be issued shortly. If California does not implement within the 60 day requirement, there would be an increased risk of losing federal financial participation (FFP) for the Medi-Cal program. State legislation is necessary in order to meet the requirements established by the federal regulations. As the single state Medicaid agency, DHCS is responsible for making sure it is in compliance with the federal regulations. DHCS intends to implement the federal minimum requirements when final guidance is issued.

Federal regulations must be followed in the administration of the Medi-Cal program, in order to guarantee the receipt of FFP dollars, on which the State's Medi-Cal budget heavily relies.

IHSS Providers. Questions have been raised about the applicability of this proposal to In-Home Supportive Services (IHSS) providers. IHSS providers are providers covered under the ACA and are not explicitly designated as a "high" risk provider category. The current procedures for obtaining and submitting fingerprints and notification by DOJ of criminal record information for IHSS workers is set forth in Welfare and Institutions Code Section 15660(a). The process currently requires a state level CBC but does not require a federal level CBC. DHCS is awaiting final guidance from CMS whether a federal level CBC will be required for "high" risk providers. In the event that final federal guidance does require a federal CBC for

"high" risk providers, DHCS will work with Department of Social Services on the steps necessary to meet these requirements.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic and further clarifications are received from the federal government.

Questions.

1. Please provide an overview of this issue.

2. Please comment on the issues raised regarding IHSS providers. Are IHSS providers considered "high risk?" Please explain.

3. What is the timeline for implementing this federal requirement?

12. Ground Emergency Medical Transportation

Budget Issue. DHCS requests five and one-half permanent positions, three three-year limited-term positions, and $1,013,000 in expenditure authority ($507,000 Federal Fund and $506,000 Reimbursement Fund) to perform audits on approximately 160 local Fire Districts and Ground Emergency Medical Transportation (GEMT) providers throughout California that will receive supplemental payments for GEMT services as authorized by AB 678 (Pan), Chapter 397, Statutes of 2011.

The change in allowable reimbursement methodology under AB 678 allows for retroactive supplemental payments through cost reports. This creates an estimated initial backlog of approximately 800 cost reports and will result in the submission of approximately 160 cost reports annually for GEMT services. The reimbursement funding will be provided by the public entities receiving the supplemental payments as required by current law.

Background. In their first response capacity, local fire departments participate in transporting Medi-Cal patients at an increasing rate. Ambulance transports of Medi-Cal patients have increased by 13 percent between 1997 and 2006 and by 19 percent between 2006 and 2009. Of the approximately 3.1 million emergency transports provided in California, it is estimated that 300,000 of those transports will be provided to Medi-Cal beneficiaries; half will be transported by fire departments or GEMT service providers that are owned and operated by public entities.

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

Under AB 678, state and local entities would have the option to claim FFP for the difference between the reimbursement rate under the Medi-Cal program and the actual allowable cost for providing this service. AB 678 allows, on a voluntary basis, eligible public entities to certify their CPEs for supplemental reimbursements for GEMT services. The intent of the legislation is to relieve the financial burden of these eligible public entities by providing a supplemental reimbursement at no cost to the State of California.

At the time of program inception, the total supplemental reimbursement was estimated to be approximately $75 million based on 160 participating Medi-Cal providers. In further discussions with the Centers for Medicare and Medicaid Services (CMS), DHCS now estimates annual supplemental reimbursements of approximately $300 million. The higher estimate results from CMS not applying an upper payment limitation and additional costs not historically reimbursed will be included in the allowable reimbursement methodology.

AB 678 authorizes retroactive supplemental payments to January 2010 via a cost report mechanism. The retroactive status will create an initial backlog of approximately 800 cost reports. The department anticipates approximately 160 cost reports annually thereafter. CMS approved the State Plan Amendment (SPA) and cost report format on September 4, 2013.

Currently, DHCS has 1.5 positions for the GEMT services. Initially, these positions were dedicated to establishing program protocol and oversight of the cost report audit function and once the protocol and cost reporting process was established DHCS would request the positions to implement the program.

Reason for Request. Approximately 160 local fire districts have expressed interest in participating in the GEMT Supplemental Reimbursement Program. As of June 30, 2014, DHCS' Audits and Investigations (A&I) unit will have a backlog of approximately 800 cost reports based on the retroactive implementation date of January 2010 for the GEMT Services Program. Cost Reports for five fiscal periods will be due at the time (160 x 5 = 800). An additional 160 cost reports will be filed each year thereafter.

The proposed positions will constitute an entire production unit designated to the GEMT audit activity. A&I will review approximately 275 cost reports annually for the first five years to significantly reduce the backlog. Thereafter, A&I will review approximately 225 cost reports annually for the next three to four years in order to reduce the inventory down to one fiscal year's worth of cost report audit production.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised.

Questions.

1. Please provide an overview of this proposal.

13. MEDS Modernization

Budget Issue. DHCS requests 16.0 two-year limited-term positions and other costs associated with a new, six-year, Information Technology (IT) project to modernize the Medi-Cal Eligibility Data System (MEDS). Funding in this proposal is requested to support the Project Planning and Requirements Elicitation activities of the project. DHCS requests $3,480,000 in expenditure authority ($528,000 General Fund and $2,952,000 Federal Funds) for the 16.0 two-year limited-term positions.

Background. Since 1983, DHCS and its partners have relied on a centralized database known as MEDS to store information on individuals receiving public benefits from the Medi-Cal and other health-related programs; as well as provide a variety of eligibility, enrollment and reporting functions. MEDS and its related subsystems provide consolidated information on beneficiary eligibility in an environment where eligibility is determined on a decentralized basis, mostly by county welfare departments through three consortia, each using a different county-based eligibility system.

Data maintained in the MEDS originates from California's 58 counties, state and federal agencies, health plans, and in the fall of 2013, from Covered California, the State's Health Benefit Exchange. Access to the MEDS' database is provided to over 35,000 distinct users involved in the administration of the state's health and human services programs. While MEDS currently supports records for about 8 million beneficiaries, program changes related to the Patient Protection and Affordable Care Act of 2010 (ACA) is expected to add up to 2 million additional beneficiaries in 2014.

Currently, MEDS serves as the 'system of record' for numerous publically subsidized health care programs including, Medi-Cal, California Work Opportunity and Responsibility to Kids (CalWORKS), the Cancer Detection Programs: Every Woman Counts (CDP:EWC) program, the Child Health and Disability Prevention Program (CHDP), Breast and Cervical Cancer Treatment Program (BCCTP), and houses eligibility for Healthy Families [the State's Children's Health Insurance Program (CHIP)], the Supplemental Nutritional Assistance Program (SNAP), and the Family Planning Access Care and Treatment (Family PACT) Program.

Maintenance and Operation (M&O) of the existing MEDS is currently supported by 85 full-time and 10 part-time, permanent staffing resources. These resources not only operate and perform routine maintenance on the MEDS, they also perform numerous tasks to assess and accommodate on-going change requests in response to ever changing program demands. Recently, these staffing resources have been burdened by increased workload demands associated with consolidation of the state's Mental Health and Alcohol & Drug programs with Medi-Cal, and impacts of the federally-required ACA implementation.

In April 2011, the Centers for Medicare and Medicaid Services (CMS) issued a new Medicaid Program Final Rule that provides enhanced federal financial participation (FFP) available at the 75 percent rate for operation of eligibility determination systems that meet the standards and conditions of the Medicaid Information Technology Architecture (MITA) initiative by

December 31, 2015. This new rule also stated FFP at the 90 percent rate for the design, development, installation, or enhancement of Medicaid eligibility determination systems that met CMS' requirements is available up to December 31, 2015. In subsequent discussions with states, CMS has indicated they will consider extending the availability of enhanced FFP beyond this date, if the state has submitted and CMS has approved the state's plan for otherwise meeting CMS' requirements.

Reason for Request. Due to the MEDS outdated technology platform and the declining workforce skilled in these technologies, it is becoming increasingly difficult for the system to meet DHCS' and other entities' data and functionality demands in a timely and cost efficient manner. The current design of MEDS also does not meet CMS' seven MITA conditions and standards for enhanced 75 percent FFP, which is jeopardizing the ability of DHCS to maintain this enhanced FFP for the system's maintenance and operations (M&O) costs. As a result, modernization of MEDS in the immediate future has become a top priority of DHCS.

DHCS will be working with CMS to ensure eligibility for enhanced 75 percent FFP to operate the existing MEDS is maintained, and the availability of 90 percent FFP is maximized for the planned MEDS Modernization Project.

DHCS plans to develop the modernized MEDS project in a way that reduces duplication of functionality in existing or planned systems. The project to modernize MEDS is expected to begin in July 2014 and continue through June 2020.

LAO Findings and Recommendation. LAO finds that (1) the modernization of MEDS is a worthwhile objective given the antiquated nature of the technology system and the increasing difficulty in maintaining the system caused in part by the decline in staff skilled in the outdated technology, (2) the current MEDS does not meet CMS' MITA standards and that failure to comply with CMS' MITA standards jeopardizes the state's ability to secure enhanced federal funding for maintenance and operation of MEDS, and (3) the focus on MEDS planning is a reasonable approach given the longer-term consequences of not allocating sufficient resources at the front-end of a project. It recommends approval of this proposal and the reporting of status of this project at 2015-16 budget hearings.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised.

Questions.

1. Please provide an overview of this proposal.

14. Breast and Cervical Cancer Treatment Program

Budget Issue. DHCS requests the extension of six limited-term positions for the Breast and Cervical Cancer Treatment Program (BCCTP) be extended to June 30, 2016. The current positions will expire on December 31, 2014. The extension of the positions will address the backlog associated with annual redeterminations, the initial eligibility determinations workload, and the processing of requests by applicants for retroactive coverage.

The total cost of these resources would be $301,000 ($151,000 General Fund and $150,000 Federal Fund) for 2014-15. For 2015-16, the total cost is $603,000 ($302,000 General Fund and $301,000 Federal Fund). Of the six positions requested, four are Associate Governmental Program Analysts, one is a Staff Services Manager, and one is an Office Technician position.

Background. BCCTP provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer, who otherwise would not qualify for other Medi-Cal programs. BCCTP is comprised of both federal-state funded and state-only funded program components.

Federal BCCTP provides full-scope Medi-Cal benefits to women, who require treatment for breast or cervical cancer. Under the federal program, eligibility is restricted to women screened and diagnosed with breast and/or cervical cancer through state screening programs, funded by the Centers for Disease Control and Prevention, who are uninsured or under insured, under 65 years of age, and are United States citizens or have satisfactory immigration status. A woman remains eligible for federal BCCTP as long as she continues to meet the federal criteria and is still in need of treatment. Recognizing the need in California for breast or cervical cancer coverage beyond the limitations of federal law; which only provides coverage for women, AB 430 (Cardenas), Chapter 171, Statutes of 2001 also established a corresponding State-funded program for women and men, who do not meet the eligibility criteria for the federal program. State-funded BCCTP is limited to 18 months for breast cancer and 24 months for cervical cancer.

Since the program's inception in 2002, BCCTP has received 45,744 applications; the active BCCTP caseload has continued to increase from 5,000 cases in the first year of operation to 14,248 active cases as of July 1, 2013. Of these active cases, there are 5,337 federal cases that are overdue for an annual redetermination and another 1,324 federal cases that are currently due for an annual redetermination, which amounts to almost 7,000 cases needing a redetermination.

Reason for Request. According to DHCS, the ongoing workload associated with initial eligibility determinations, annual redeterminations, and the processing of requests by applicants for retroactive coverage makes it essential that these six positions be extended for two more years until the workload stabilizes. DHCS notes that the Affordable Care Act (ACA) will result in a reduction in the number of new applicants in the federal BCCTP by about 15 percent per year. As the number of applications diminishes, the number of completed redeterminations increases resulting in a decrease in the backlog, as show in the table below.

Table: BCCTP Projected Workload Outcomes

Workload Measure	2012-13	2013-14	2014-15	2015-16
Applications Received	4,970	4,320	3,760	3,270
Active Case Load	14,248	12,389	10,773	9,367
Completed Annual Redetermination	5,760	6,410	6,970	7,460
Backlog Annual Redetermination	7,144	4,268	3,803	1,907

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the two-year extension of these positions.

Questions.

1. Please provide an overview of this proposal.

2. Please explain why there is a backlog in annual redeterminations and how this requests proposes to address the backlog.

15. Baseline HIPPA Staffing

Budget Issue. DHCS' Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance requests the conversion of seven and one-half previously approved limited-term positions to permanent status and the extension of six limited-term positions for an additional two years, effective July 2014 as these positions will expire on June 30, 2014.

The positions would cost a total of $1,907,000 ($320,000 General Fund and $1,587,000 Federal Fund, 80:20) and are necessary to maintain efforts on existing workload, current federal and state HIPAA rules, address new codified HIPAA rules and continue oversight of privacy and security requirements.

This proposal seeks to convert seven and one-half previously approved limited-term positions to permanent status and extend six limited-term positions an additional two years effective July 2014, to coordinate and carry out the workload required by HIPAA rules and updates. The permanent positions are: one Nurse Consultant III, one Senior Information Systems Analyst, two System Software Specialists II, two Staff Information Systems Analysts, and one full-time and one half-time Associate Governmental Program Analyst. These positions are to be permanent as they are supporting Affordable Care Act (ACA) requirements and new permanent HIPAA rules, such as Operating Rules, Claims Attachment Standards, National Health Plan Identifier and Health Plan Certification, Medicaid Information Technology Architecture, along with the new OMNIBUS Privacy and Security Rule.

The six limited term positions are: one Data Processing Manager II, three Senior Information Systems Analysts, one Associate Information Systems Analyst, and one Staff Information Systems Analyst (Specialist). These positions remain limited-term positions as they are all related to the existing HIPAA-2 project (the change to ICD-10 transactions) and CA-MMIS updates, which are temporary workloads that will result in future system conversion(s).

Background. The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. HIPAA affects all individuals, providers, payers, and related entities involved in health care. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information.

DHCS' Office of HIPPA Compliance is responsible for the successful implementation by DHCS of all of the final rules of HIPAA under Title II - HIPAA Administrative Simplification.

Reason for Proposal. DHCS states that HIPAA-related workload has evolved to become a permanent undertaking. Additionally, there is new workload attributed to Health Care Reform, new federal HIPAA regulations, and integration and expansion of technological systems due to the Medicaid Information Technology Architecture (MITA) initiative. Failure to maintain or achieve HIPAA compliance by the established federal deadlines, or MITA alignment with the goals established for Medi-Cal would have the following implications for DHCS: additional administrative burden for Medi-Cal providers, increased risk of federal penalties (monetary and the withholding of federal financial participation (FFP)), loss of support to HIPAA-implemented solutions and additional breach reporting costs.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request.

Questions.

1. Please provide an overview of this proposal.

16. Oversight on Nursing Home Referrals to Community-Based Services

Oversight Issue. AB 1489 (Committee on Budget), Chapter 631, Statutes of 2012, requires the Department of Health Care Services, in collaboration with the Department of Public Health, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. This analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report; it is almost one year overdue.

Background. On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

The state's California Community Transitions (CCT) project (funded with a federal Money Follows the Person grant) targets Medi-Cal enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal of this program is to offer a menu of social and medically necessary services to assist these individuals to remain in their home or community environments. By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. Subcommittee staff has continually checked on the status of this report.

Given the state's efforts, with CCT and other initiatives, to provide services in home- and community-based settings, and the opportunity to receive enhanced federal funding for certain nursing home residents who transition to receiving services in the community, it is important to understand how and when nursing homes are making referrals to local agencies.

Questions.

1. Please provide an overview of this issue.

2. What is the status of the report? When will the Legislature receive this report?

3. How does the Administration ensure that nursing facilities make the appropriate referrals to local contact agencies?

17. Medi-Cal – Electronic Health Records Meaningful Use Federal Grant

Budget Issue. The federal government will provide a 90 percent match for activities related to health information technology (HIT), including efforts tied to electronic health record (EHR) adoption and support. Previously, these efforts were funded with federal grant funds. These grant funds have expired.

The state has the opportunity to draw down $37.5 million in federal funds (over multiple years) if it can provide a state match of $4.1 million. The Governor's budget does not include a proposal on this.

Background. The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. Since 2011, eligible Medi-Cal professionals and hospitals have been receiving incentive payments to assist in purchasing, installing, and using electronic health records in their practices.

The Office of Health Information Technology (OHIT) has been established in DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments. OHIT works closely with the Office of the Deputy Secretary for Health Information Technology in the California Health and Human Services Agency to coordinate the Medi-Cal EHR Incentive Program with wider health information exchange efforts throughout California and the nation.

The Medi-Cal EHR incentive payments are 100 percent funded by the federal government. California's providers have received over $1 billion in these incentive payments. The operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. Currently, $190,000 General Fund is used as the match for the state's operations.

A federal grant was used to provide the technical assistance support to implement EHR and achieve meaningful use. This technical assistance was provided at Regional Extension Centers and other entities. This grant has expired.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on ways the state can draw down $37.5 million in additional federal funds to support the meaningful use of EHRs in the state.

Questions.

1. Please provide an overview of this issue.

2. Please discuss the role of technical assistance in the success of meaningful implementation of electronic health records.

Appendix A - Adult Dental Procedures Not Included in the May 1, 2014 Restoration

DIAGNOSTIC	
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0240	Intraoral - occlusal film
D0340	Cephalometric film
LABORATORY CROWNS	
D2710	Crown-Resin-Based Composite (Indirect)
D2712	Crown- ¾ Resin-Based Composite (Indirect)
D2721	Crown-Resin with Predominantly Base Metal
D2740	Crown-Porcelain/Ceramic Substrate
D2751	Crown-Porcelain Fused to Predominantly Base Metal,
D2781	Crown- ¾ Cast Predominantly Base Metal
D2783	Crown- ¾ Porcelain/Ceramic
D2791	Crown-Full Cast Predominantly Base Metal
PINS AND POST AND CORE	
D2951	Pin Retention – Per Tooth, in Addition to Restoration
D2970	Labial veneer (resin laminate) - chairside
D2980	Crown repair, by report
D2999	Unspecified restorative procedure, by report
ENDODONTICS	
D3221	Pulpal Debridement, Primary and Permanent Teeth
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)
D3347	Retreatment of Previous Root Canal Therapy-Bicuspid
D3348	Retreatment of Previous Root Canal Therapy-Molar
D3410	Apicoectomy/Periradicular Surgery-Anterior
D3421	Apicoectomy/Periradicular Surgery-Bicuspid (First Root)
D3425	Apicoectomy/Periradicular Surgery-Molar (First Root)
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)
D3999	Unspecified endodontic procedure, by report
PERIODONTICS	
D4210	Gingivectomy or Gingivoplasty-Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4211	Gingivectomy or Gingivoplasty-One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant

D4260	Osseous Surgery (Including Flap Entry and Closure)-Four or More Contiguous Teeth or Tooth Bounded Spaced Per Quadrant
D4261	Osseous Surgery (Including Flap Entry and Closure)-One to Three Contiguous Teeth or Tooth Bounded Spaced Per Quadrant
D4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant
D4342	Periodontal Scaling and Root Planing – One to Three Teeth Per Quadrant
D4910	Periodontal Maintenance
PROSTHODONTICS	
D5211	Maxillary Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)
D5212	Mandibular Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)
D5213	Maxillary Partial Denture-Cast Meal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)
D5214	Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)
D5421	Adjust Partial Denture-Maxillary
D5422	Adjust Partial Denture-Mandibular
D5620	Repair Cast Framework
D5630	Repair or Replace Broken Clasp
D5640	Replace Broken Teeth-Per Tooth
D5650	Add Tooth to Existing Partial Denture
D5660	Add Clasp to Existing Partial Denture
D5740	Reline Maxillary Partial Denture (Chairside)
D5741	Reline Mandibular Partial Denture (Chairside)
D5760	Reline Maxillary Partial Denture (Laboratory)
D5761	Reline Mandibular Partial Denture (Laboratory)
D5899	Unspecified removable prosthodontic procedure, by report
Maxillofacial	
D5991	Topical medicament carrier
Implants	
D6010	Surgical placement of implant body: endosteal implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6053	Implant/abutment supported removable denture for completely edentulous arch
D6054	Implant/abutment supported removable denture for partially edentulous arch
D6055	Connecting bar - implant supported or abutment supported
D6056	Prefabricated abutment, includes placement

D6057	Custom abutment, includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment for supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078	Implant/abutment supported fixed denture for completely edentulous arch
D6079	Implant/abutment supported fixed denture for partially edentulous arch
D6080	Implant maintenance procedures, including removal of prosthesis cleaning of prosthesis and abutments and reinsertion of prosthesis
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutmant supported prosthesis, per attachment
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6094	Abutment supported crown (titanium)
D6095	Repair implant abutment, by report
Fixed Prosthodontics	
D6211	Pontic - cast predominantly base metal
D6241	Pontic - porcelain fused to predominantly base metal

D6245	Pontic - porcelain /ceramic
D6251	Pontic - resin with predominantly base metal
D6721	Crown - resin with predominantly base metal
D6740	Crown - porcelain /ceramic
D6751	Crown - porcelain fused to predominantly base metal
D6781	Crown - 3/4 cast predominantly base metal
D6783	Crown - 3/4 porcelain/ceramic
D6791	Crown - full cast predominantly base metal
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated
D6972	Prefabricated post and core in addition to fixed partial denture retainer
D6980	Fixed partial denture repair, by report
Oral and Maxillofacial Surgery	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypoerthroped and hyperplastic tissue)
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibilaris
D7485	Surgical reduction of osseous tuberosity
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7880	Occlusal orthotic device, by report
D7899	Unspecified TMD therapy, by report
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not identical to another
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch
D7972	Surgical reduction of fibrous tuberosity
ADJUNCTIVE:	
D9120	Fixed Partial Denture Sectioning
D9951	Procedure Occlusal Adjustment-Limited
D9952	Occlusal Adjustment-Complete