SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 4, 2013

9:30 AM or Upon Adjournment of Session
(whichever is later)

Room 4203, State Capitol
(John L. Burton Hearing Room)

(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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VOTE ONLY CALENDAR

4150 Department of Managed Health Care

1. Transfer of Legislative Unit to Director's Office

Budget Issue. The Department of Managed Health Care (DMHC) requests an internal transfer of the Legislative Unit from the Office of Legal Services to the Director's Office. This will include the transfer of four positions and $530,000 for 2013-14 and ongoing from the Health Plan Program to Administration. This is an organizational change only. There is no increase in funding or positions.

Subcommittee Staff Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

ISSUES FOR DISCUSSION

4150 Department of Managed Health Care (DMHC)

1. Overview

The mission of DMHC is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These 122 health care plans provide health insurance coverage to approximately 57 percent of all Californians. DMHC is also responsible for the oversight of 200 Risk Bearing Organizations (RBOs), who deliver or manage a large proportion of the health care services provided to consumers.

Budget Overview. The budget proposes expenditures of $52.1 million and 346 positions for DMHC. See table below for more information.

Table: DMHC Budget Overview

Fund Source	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
Federal Trust Fund	$5,391,000	$691,000	-$4,700,000	-87%
Reimbursements	$1,186,000	$2,739,000	$1,553,000	131%
Managed Care Fund	$49,715,000	$48,677,000	-$1,038,000	-2%
Total Expenditures	**$56,292,000**	**$52,107,000**	**-$4,185,000**	-7%
Positions	**352.8**	**346**	-7	-2%

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested DMHC respond to the following:

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

2. Medi-Cal Dental Managed Care Program Oversight

Budget Issue. DMHC requests to convert two limited-term positions to permanent to address the increased workload attributable to the expanded oversight of the Medi-Cal Dental Managed Care (DMC) plans and the transition of the Healthy Families Program (HFP) children to the Medi-Cal DMC program.

DMHC also requests $130,000 for consultant services to provide specialized dental expertise for the dental plan surveys. DMHC indicates that consultants provide specialized dental expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to dental care.

Total cost of this request is $378,000 (on an ongoing-basis) and would be funded by 50 percent Managed Care Fund and 50 percent federal funds (through reimbursement from the Department of Health Care Services seeking the federal match).

The requested positions would conduct triennial dental surveys and financial audits of Medi-Cal DMC plans commencing July 2013. The requested permanent positions are as follows:

- 0.5 Health Program Specialist (HPS) II
- 0.5 Associate Health Care Service Plan Analyst (AHCSPA)
- 1.0 Corporation Examiner

Background. Medi-Cal DMC plans are licensed and regulated by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The DMHC is mandated by the Knox-Keene Act to conduct dental surveys and financial audits of dental managed care plans on three-year survey and five-year audit schedules.

The DHCS Medi-Cal Program contracts with Liberty Dental Plan, Access Dental, and Health Net Dental Plan in Sacramento county, effective January 1, 2013, and Los Angeles county, effective July 1, 2013, for a total of six DMC plans. Each dental plan receives a negotiated monthly per capita rate from the state for each Medi-Cal beneficiary enrolled in the plan. Medi-Cal DMC beneficiaries enrolled in contracted plans receive dental benefits from providers within the plan's provider network.

In Sacramento County, the dental Geographic Managed Care (GMC) is a mandatory program where certain populations of Medi-Cal recipients who are eligible to receive dental services must select one of the three available GMC plans for their dental care. In Los Angeles County, the dental managed care program is voluntary.

Increased DMHC Oversight of Dental Managed Care. In February 2012, a Sacramento Bee article describing significant access and quality of care problems in the dental GMC program in Sacramento County generated an influx of consumer complaints to the Help Center and concern about the lack of access to dental care for children in that county. As a result, the subcommittee took action to adopt legislatively proposed trailer bill language and approve a

May Revise proposal to require DMHC to conduct non-routine surveys of DMC contracts operating in Sacramento County and conduct additional onsite dental surveys of the dental plans participating in the DMC program.

Prior to the non-routine audits described above, DMHC did not directly survey Medi-Cal DMC products. Additionally, DMHC did not review, assess, or evaluate the plan's performance of their Medi-Cal DMC contractual deliverables; nor did they request, review, or evaluate DMC's enrollment data, quality issues, network adequacy, language assistance, or any other potential barriers to care.

Transition of Healthy Families Program. In addition to the expansion of DMHC oversight responsibilities described above, children currently in the HFP are in the process of transitioning to Medi-Cal in four phases, beginning January 1, 2013 through September 1, 2013. This will result in the addition of approximately 249,242 HFP children into the Medi-Cal DMC program. The DHCS indicates approximately 221,357 HFP children in Los Angeles County and 27,885 HFP children in Sacramento County will enroll in dental managed care plans in these two counties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as more information regarding the Healthy Families Program transition (as discussed later in the agenda) is forthcoming.

Questions. The Subcommittee has requested DMHC respond to the following:

1. Please provide an overview of this budget proposal.

2. Please provide a brief review of the findings from non-routine DMC surveys and the resulting corrective actions.

3. Health Premium Rate Review

Budget Issue. DMHC requests to convert two limited term positions, set to expire June 30, 2013, to permanent and $344,000 (on an ongoing-basis) from the Managed Care Fund to address the health premium rate review workload as specified in the Affordable Care Act (ACA) and supported by SB 1163 (Statutes of 2010).

The positions requested are one Senior Life Actuary and one Associate Life Actuary.

Background. SB 1163 (Statutes of 2010) requires health plans to submit premium rate information and giving the DMHC the authority to review premium rate filings effective January 1, 2011. Under SB 1163, health plans are required to submit premium rate information to the DMHC at least 60 days in advance of implementing a rate increase. Upon receipt of a premium rate filing, DMHC documents and publicly posts receipt of the rate filing, reviews the rate filing and makes a determination as to whether or not the proposed rate increase is justified, and then publicly posts the DMHC determination.

SB 1163 provides the rate review authority for all individual and small group market products, but limits review authority in the large employer market to only those rate increases deemed "unreasonable" through actuarial review.

SB 1163 requires the DMHC to make premium rate filing information available on its website and to accept and post public comments regarding the rate filings on the website. In addition, SB 1163 imposes a reporting requirement on the DMHC to submit quarterly reports to the Legislature with regard to any unjustified or "unreasonable" rate increases received. States are also required to monitor premium rate trends both inside and outside Exchanges established under federal health care reform.

Prior to January 1, 2011, the DMHC had limited authority to review health plan rate filings. The only rates that were required to be filed, with very limited scope review, were for the small group market Health Insurance Portability and Accountability Act (HIPAA)-guaranteed issue and conversion products. Health plans were not required to file individual and small group commercial products for premium rate changes. At the time, the DMHC did not have a rate review program or employ actuaries.

In response to the enactment of SB 1163, the DMHC submitted a 2011-12 budget request to address the new anticipated workload associated with the receipt, review and reporting of health premium rate data. The DMHC was granted two Associate Life Actuary positions for a two-year limited-term. Additionally, $600,000 was approved to obtain external actuarial consultant services.

Federal Grant for Rate Review Program. In addition to the above resources, DMHC applied for and received federal Cycle I and Cycle II grants to develop an approved premium rate review program. The use of the federal funds is limited to carrying out the requirements set forth in the federal grant. The federal grant's funding focus is policy oriented on the

development of a good rate review program, while the focus of SB1163 is on the actual collection and analysis of the premium rate data to determine if rate increases are justified, and the reporting of unreasonable rate increases to the Legislature.

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

Questions. The Subcommittee has requested DMHC respond to the following:

1. Please provide an overview of this budget proposal.

4. Coordinated Care Initiative (CCI)

Budget Issue. DMHC requests to extend 13.0 limited term positions, set to expire June 30, 2013, and add 3.5 new limited term positions to address the workload associated with the transition of dual eligible enrollees in eight counties into managed health care under the Coordinated Care Initiative (CCI). These positions would expire on June 30, 2016.

DMHC also requests $334,000 for consultant services to perform triennial medical plan surveys and financial audits. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to the care for dual eligible beneficiaries.

This proposal would be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking a federal match.

The requested positions are:

Help Center – 11.5 Positions

- Attorney III (1.5)
- Health Program Specialist II
- Nurse Evaluator II
- Associate Health Care Service Plan Analyst
- Associate Governmental Program Analyst
- Consumer Assistance Technicians (5.0)
- Office Technician

Division of Financial Oversight – 2.0 positions

- Corporation Examiner IV Specialists

Provider Solvency Unit – 2.0 positions

- Corporation Examiners

Division of Licensing – 1.0 position

- Health Program Specialist I

Background. The 2012 budget authorized the Coordinated Care Initiative (CCI), by which persons eligible for both Medicare and Medi-Cal (dual eligibles) would receive medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single health plan in eight demonstration counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

AB 1468 (a 2012 budget trailer bill) requires the Department of Health Care Services to enter into an Interagency Agreement with the DMHC to perform certain oversight and readiness review activities related to CCI, including:

- Provide consumer assistance to beneficiaries;
- Conduct medical plan surveys;
- Conduct financial audits;
- Conduct financial solvency audits, and
- Conduct reviews of the adequacy of provider networks of participating health plans.

In 2012-13, DMHC received a one-time augmentation of $1,097,000 and 13.0 one-year limited- term positions to address new workload attributable to the evaluation of plan readiness and oversight of health plans providing managed health care services for CCI.

Subcommittee Staff Comment and Recommendation—Hold Open. As will be discussed in more detail later in this agenda, details regarding CCI are still forthcoming; consequently, it is recommended to hold this item open.

Questions. The Subcommittee has requested DMHC respond to the following:

1. Please provide an overview of this budget proposal.

2. Please provide a brief description of the CCI-related activities in which DMHC is currently engaged.

5. Medi-Cal Managed Care Rural Expansion

Budget Issue. DMHC requests 3.5 positions and $510,000 for 2013-14 and $470,000 for 2014-15 and ongoing to address workload attributable to the expansion of Medi-Cal managed care into 28 rural counties, as mandated by AB 1468 (a 2012 budget trailer bill).

This request also includes $130,000 for consultant services to perform annual medical surveys of health plans. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to this managed care expansion.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking the federal match.

The Help Center positions requested are:

- 0.5 Nurse Evaluator II – Provide clinical review of cases and handle urgent nurse cases.
- 0.5 Associate Governmental Program Analyst – Resolve standard complaints involving a review of the complaint, contacting the patient, and reviewing the health plan response.
- 0.5 Associate Health Care Service Plan Analyst – Prepare, organize, conduct, and lead survey teams performing surveys on an annual basis.
- 2.0 Consumer Assistance Technicians – Respond to consumer phone calls and correspondence.

Background. AB 1467 (a 2012 budget trailer bill) authorizes the expansion of the Medi-Cal Managed Care program into 28 rural counties that currently offer only fee-for-service (FFS) Medi-Cal. AB 1468 (a 2012 budget trailer bill) DHCS to enter into an interagency agreement with the DMHC to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties.

On February 28, 2013, DHCS announced that the state has chosen four health plans to provide managed care services to more than 400,000 Medi-Cal members in 28 rural counties, expanding Medi-Cal managed care to all of California's 58 counties.

Subcommittee Staff Comment and Recommendation—Hold Open. When this budget proposal was prepared, it was anticipated that only two health plans would be selected to serve the 28 rural counties. However, subsequent to the preparation of this proposal, DHCS announced that it has chosen four health plans to provide managed care services to 28 fee-for-service counties.

DMHC has indicated that it is working with the Department of Finance to assess the workload impact associated with four health plans (instead of two) being selecting for the expansion of Medi-Cal managed care to rural counties.

Questions. The Subcommittee has requested DMHC respond to the following:

1. Please provide an overview of this budget proposal.

2. When will DMHC have an updated estimate regarding the workload impact from the rural Medi-Cal managed care expansion?

4280 Managed Risk Medical Insurance Board

1. Overview

The Managed Risk Medical Insurance Board (MRMIB) provides health coverage through commercial health plans, local initiatives, and County Organized Health Systems to certain persons who do not have health insurance. The Board also develops policy and recommendations on providing health insurance to uninsured Californians. It administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers *five programs,* as follows:

- Healthy Families Program – The 2012 budget transitioned this program to Medi-Cal in four phases starting January 1, 2013. The final transition phase is required to occur no later than September 1, 2013.
- Pre-Existing Conditions Insurance Program
- Major Risk Medical Insurance Program
- Access for Infants and Mothers Program
- County Children's Health Initiative Matching Program

Healthy Families Program (HFP). Through HFP, children in families earning up to 250 percent (and in select cases up to 300 percent) of the federal poverty level (FPL) receive comprehensive health care coverage that includes dental, vision, and basic mental health care benefits. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children.

Pre-Existing Conditions Insurance Program (PCIP). As a result of the federal Affordable Care Act of 2010, California has a contract with the federal Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013, when the national health reform is set to begin. The program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last six months.

Major Risk Medical Insurance Program (MRMIP). MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP.

Access for Infants and Mothers (AIM). AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax

Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost.

County Children's Health Initiative Matching Fund Program (CHIM). Established by AB 495, Statutes of 2001, this program provides four counties the ability to obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars.

Budget Overview. The budget proposes expenditures of $611.3 million ($21.7 million General Fund) and 104.9 positions for MRMIB. The budget includes a $143.9 million General Fund reduction due to the transition of HFP enrollees to Medi-Cal. See table below for additional information.

Table: MRMIB Program Funding (dollars in thousands)

Program	**2012-13**	**2013-14**	**Change**
Major Risk Medical Insurance Program	$43,000	$42,949	-$51
Access for Infants & Mothers	$128,367	$128,036	-$331
Healthy Families Program	$887,591	$89,371	-$798,220
County Health Initiative Program	$2,210	$2,246	$36
Pre-Existing Conditions Plan (PCIP) Program	$350,982	$348,682	-$2,300
Totals Expenditures	**$1,412,150**	**$611,284**	**-$800,866**
General Fund	$165,508	$21,651	-$143,857
Federal Funds	$643,286	$126,394	-$516,892
Federal Funds—High Risk Health Insurance	$350,982	$348,682	-$2,300
Children's Health & Human Services Special Fund	$140,110	$5,212	-$134,898
Managed Risk Medical Insurance Fund	$43,000	$42,949	-$51
Other Funds	$69,264	$66,396	-$2,868

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested MRMIB respond to the following:

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

2. Phase-Out of MRMIP and PCIP

Budget Issue. The Governor's January Budget Summary indicates the Managed Risk Medical Insurance Program (MRMIP) and the Pre-Existing Condition Insurance Program (PCIP), health coverage programs for individuals with pre-existing conditions, will phase-out with the implementation of the federal Affordable Care Act (ACA) of 2010.

MRMIB has indicated that it is working with the Exchange regarding the transition of MRMIP and PCIP subscribers to the Exchange. However, details regarding this transition, such as the transfer of protected health information between the programs; are still being worked out.

It should be noted that the budget includes full year funding for MRMIP. This is because MRMIB must complete reconciliations for MRMIP. Under current statute, health plans have until December 31, 2014 to submit claim information. MRMIB anticipates that it would take an additional six months (until June 2015) to complete the reconciliations.

Background—MRMIP. MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP.

Background—PCIP. As a result of the ACA, California has a contract with the federal Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013, when the national health reform is set to begin. The program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last six months.

Federal Government Requires Closure to New Enrollment for PCIPs Nationwide. The federal government notified all state administered PCIPs to close to new enrollments after March 2, 2013. As the contractor that operates PCIP in California for CMS, MRMIB has closed PCIP enrollment except for persons coming into California with PCIP from another state and for persons who applied prior to March, but whose application was missing information.

California's PCIP has incurred costs of $529 million of its $761 million allocation.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the transition of MRMIP and PCIP subscribers to coverage under the Exchange.

Questions. The Subcommittee has requested MRMIB respond to the following:

1. Please provide an overview of this budget proposal.

2. What would facilitate a successful transition of MRMIP and PCIP subscribers to the Exchange?

3. Transition Plan for Healthy Families Program Staff

Budget Issue. The 2012 Budget Act and the proposed budget bill requires MRMIB, in conjunction with the Department of Health Care Services (DHCS), to submit a transition plan for the transfer of state administrative functions for the operation of the Healthy Families Program (HFP) to DHCS.

The purpose of the plan is to identify the personnel that would be moved from MRMIB to DHCS as children in the HFP are transitioned to Medi-Cal, identify the steps that will be taken to select the positions, notify staff, and/or advertise for recruitment.

This plan is due to the Legislature no later than January 10, 2013. The transition plan has not yet been received by the Legislature.

Background. AB 1494 (a 2012 budget trailer bill) provides for the transition of approximately 870,000 Healthy Families Program (HFP) subscribers to the Medi-Cal program beginning January 1, 2013, in four phases throughout 2013. See Healthy Families Program Transition item under the Department of Health Care Services for more information on this transition.

Subcommittee Staff Comment—Hold Open. It is recommended to hold this item open as the Legislature has not yet received this transition plan.

Questions. The Subcommittee has requested MRMIB respond to the following:

1. When will the Legislature receive this transition plan?

2. Please provide an overview of the transition plan and the Administration's proposal for further updates to the Legislature on staff transitions.

4260 Department of Health Care Services

1. Overview – Medi-Cal Program

The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

Medi-Cal is: (1) a source of traditional health insurance coverage for low-income children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and (3) a wrap-around coverage for low-income Medicare recipients ("dual" eligibles who receive Medicare and Medi-Cal services).

Medi-Cal Eligibility. Generally, Medi-Cal eligibles fall into four categories of low-income people, as follows: (1) aged, blind, or disabled; (2) low-income families with children; (3) children only; and (4) pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance, out-of pocket expenditures, or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others, at the state's option.

Most Medi-Cal clients are from households with incomes at or below 100 percent of the federal poverty level ($19,530 annually for a family of three).

Enrollment. Estimated average monthly Medi-Cal enrollment for the current year is 8.2 million people and for 2013-14 it is 8.7 million people. This increase in caseload is primarily due to the transition of Healthy Families Program enrollees to Medi-Cal.

Summary of Governor's Budget for 2013-14. As shown in the table below, the Governor proposes total expenditures of almost $59.8 billion ($15.3 billion General Fund, $35.9 billion federal Title XIX Medicaid funds, and $8.6 billion in other funds) for Medi-Cal in 2013-14.

Table: Medi-Cal Local Assistance Funding Summary (dollars in millions)

	2012-13 Revised	2013-14 Proposed	Difference	Percent
Benefits	$56,939.60	$55,901.30	-$1,038.30	-1.8%
County Administration (Eligibility)	$2,769.10	$3,564.40	$795.30	28.7%
Fiscal Intermediaries (Claims Processing)	$337.70	$312.70	-$25.00	-7.4%
Total	**$60,046.40**	**$59,778.40**	**-$268.00**	**-0.4%**
General Fund	$14,897.10	$15,251.10	$354.00	2.4%
Federal Funds	$37,264.20	$35,918.00	-$1,346.20	-3.6%
Other Funds	$7,885.00	$8,609.30	$724.30	9.2%

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested DHCS respond to the following questions:

1. Please provide a brief overview of the Medi-Cal program and major budget proposals.

2. Healthy Families Program Transition to Medi-Cal

Budget Issue. The Administration estimates $129,000 General Fund savings in 2012-13 (compared to $13.1 million General Fund savings in the 2012 Budget Act) and $42.6 million General Fund savings in 2013-14, as a result of the transition of Healthy Families Program (HFP) subscribers to Medi-Cal.

These savings estimates are less than what was reflected in the 2012 Budget Act because of a slower transition of children and updated Medi-Cal managed care rates. See table below for a summary chart.

Table: Summary of Savings from Transition of Healthy Families Program to Medi-Cal

	2012-13 Revised	2013-14 Estimate
General Fund	-$129,000	-$42,645,000
Federal Funds	-$3,212,000	-$81,377,000
Total Funds	**-$3,341,000**	**-$124,022,000**

Background. The Governor's January 2012-13 budget proposed to shift children in the Healthy Families Program to Medi-Cal over a nine-month period beginning in October 2012. The Legislature adopted a modified version of this proposed transition.

AB 1494 (a 2012 budget trailer bill) provides for the transition of approximately 870,000 HFP subscribers to the Medi-Cal program beginning January 1, 2013, in four phases throughout 2013. These phases are:

- **Phase 1A** – Occurred on January 1, 2013 and included about 178,000 children in a HFP health plan that matches a Medi-Cal health plan.
- **Phase 1B** – Occurred on March 1, 2013 and included about 101,000 children in a HFP health plan that matches a Medi-Cal health plan.
- **Phase 1C** – Occurred on April 1, 2013 for approximately 36,000 children in five counties (Kern, Sacramento, San Joaquin, Stanislaus, and Tulare) and two health plans.
- **Phase 1C** – Will occur on May 1, 2013 and includes approximately 63,000 children in Los Angeles and San Diego enrolled in one health plan transitioning on May 1, 2013.
- **Phase 2** – Occurred on April 1, 2013 and includes about 228,000 children in a HFP health plan that is a subcontractor of a Medi-Cal health plan.

- **Phase 3** - Begins no sooner than August 1, 2013 and transitions about 135,000 children enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with a Medi-Cal health plan into a Medi-Cal health plan in that county.

- **Phase 4** - Begins no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.

Additionally, AB 1494 required:

- **Strategic Plan for Transition.** The development of a strategic plan for the transition by the California Health and Human Services Agency (CHHSA), the Managed Risk Medical Insurance Board (MRMIB), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC). This plan was submitted on October 2, 2012.

- **Implementation Plans.** The creation of an implementation plan for each phase prior to transitioning children to Medi-Cal to ensure continuity of care with the goal of ensuring there is no interruption in services and there is continued access to coverage for transitioning individuals. AB 1494 requires the Administration to consult with stakeholders on the development of the implementation plans.

- **Network Adequacy Assessment**. The completion of a managed care health plan network adequacy assessment at least 60 days prior to the transition of children in Phase 1. This assessment must be submitted to the Legislature.

- **Monitoring of Transition.** The submittal of monthly status reports to the Legislature on the transition. These reports must include information on health plan grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment).

Children in the HFP will transition into Medi-Cal's new optional Targeted Low Income Children's Program (TLICP) covering children with income up to and including 250 percent of the federal poverty level (FPL).

Network Adequacy Assessment Findings Lead to Phase 1 Sub-Phases. Prior to implementation of Phase 1 and Phase 2 of the transition, DHCS and DMHC completed network adequacy assessments, addendums to those assessments, and implementation plans for enrollees transitioning in these phases. During those assessments, potential interruptions to continuity of care for some transitioning HFP enrollees were identified.

Consequently, Phase 1 was split out into sub-phases to give more time to ensure no interruptions of care would occur. Additionally, Phase 1C will be implemented on two different dates as the state and CMS felt it was important to provide additional time for outreach to

enrollees is Los Angeles and San Diego counties to assist in selecting a new primary care provider, to the extent necessary.

Federal Approval Required Prior to Phase Transition. The Centers for Medicare and Medicaid Services (CMS) granted federal approval for DHCS to begin the transition via the Bridge to Reform 1115 Demonstration Waiver.

Federal CMS approval is required prior to each phase (and sub-phase). CMS has approved the transitions for Phase 1A, 1B, 1C, and 2.

Continued federal approval is contingent upon compliance to the Special Terms and Conditions (STC) as detailed in the waiver amendments and the state demonstrating the successful provision of coverage to children in previous phases, as well as provider network adequacy to serve the children in subsequent phases, and appropriate plans for maintaining continuity of care.

Transition Monitoring Reports for Phase 1A. AB 1494 and the STC of the waiver require the Administration to report every month on metrics to evaluate the transition and the impact on children and families with regard to maintaining coverage, timely access to care, continuity of care, provider capacity, and consumer satisfaction under each phase.

Two monitoring reports have been submitted. (The first report was submitted on February 15 and the second report was submitted on March 18.) These reports generally indicate that Phase 1A has gone smoothly and no continuity of care issues for medical, dental, mental health, or substance use disorder services have been identified.

Almost every child (99.85 percent) remained with the same health plan, as Phase 1A was only for children in HFP plans that matched Medi-Cal plans and whose provider network was determined adequate for transition. About 1 percent of the transitioning population had to choose a new primary care provider.

Greater Potential for Interruptions in Care for Phases 3 and 4. The risk of children losing access to care and services increases in phases 3 and 4 since the level of plan and provider overlap decreases in these phases. Additional education and outreach will be necessary to ensure that providers, application assistors, and families understand this transition and how it will be implemented in their county and health plan.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending May Revise updated estimates and the submittal of additional transition monitoring reports.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an update on the transition of HFP children to Medi-Cal.

2. Since the likelihood of children having to change providers increases in phases 3 and 4, please describe what additional steps the Administration is taking to ensure access to care and continuity of care.

3. How is the Administration working with providers to educate them about this transition? What more needs to be done? What are some lessons learned regarding provider outreach from the transition of seniors and persons with disabilities to Medi-Cal managed care?

3. Coordinated Care Initiative (CCI)

Enacted as part of the 2012 budget, the Coordinated Care Initiative (CCI) integrates medical, behavioral, long-term supports and services (LTSS), and home- and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties. Additionally, it integrates LTSS into Medi-Cal managed care for Medi-Cal-only individuals.

MOU Signed. On March 27, 2013, DHCS announced that it had entered into a Memorandum of Understanding (MOU) with the federal CMS regarding the state's Duals Demonstration, a component of the CCI. The MOU reflects the procedures under which CMS and the state plan will implement and operate Cal MediConnect, the name of the demonstration project. The project will begin no sooner than October 1, 2013 and continue until December 31, 2016.

Key provisions in the MOU that have changed since the 2012 budget include:

- **Shared Savings.** The CCI, as reflected in the 2012 budget, assumes that the state and the federal government will equally share (50:50) the savings as a result of the CCI. The MOU defines the state's the minimum savings percentages as 1 percent in the first year, 2 percent in the second year, and 4 percent in the third year. Payment rates to the health plans will be determined by applying these savings percentages to the baseline spending amounts.

  The Administration has not yet provided fiscal estimates explaining how these savings percentages affect the total estimated savings from CCI.

- **Timeline.** The MOU calls for implementing Cal MediConnect no earlier than October 2013. This means that the first notices any beneficiaries would receive about these transitions would come no earlier than July 2013. This is a change from the 2012 budget that had a launch date of March 2013.

- **Enrollment Strategies.** Eight counties will implement the Cal MediConnect program: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange and Riverside. Originally, all counties would phase-in enrollment over 12 months. The MOU lays out enrollment strategies for each county. Specifically, assuming an October 2013 start, San Mateo County enrollment will complete enrollment in January 2014 and Los Angeles County enrollment will happen over a 15-month period.

- **No Stable Enrollment Period.** The 2012 budget included an initial six-month stable enrollment period, during which eligible beneficiaries would remain in the same health plan. The MOU contains no language regarding a stable enrollment period. Beneficiaries enrolled in Cal MediConnect can opt out at any time.

- **Home and Community Based (HCBS) Waiver.** The original proposal called for closing most of California's HCBS waivers. Those waivers will now remain open.

- **Size of the Demonstration.** The total number of enrollees allowed under the MOU is estimated at 456,000. This is almost half the size of the number of enrollees (800,000) estimated in the 2012 budget.

- **Number of Participants in Los Angeles County.** The MOU sets a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County. The 2012 budget had no such cap.

Other provisions included in the MOU are:

- **Quality Withhold Measures.** Under the demonstration, CMS and the state will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to the health plan's performance, consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures, as well as state-specified quality measures including behavioral health coordination and planning, and ensuring physical access to buildings, services, and equipment.

- **Risk Corridors.** Limited risk corridors will be established in order to provide a level of protection to the health plan and payers against uncertainty in rate-setting that could result in either overpayment or underpayment.

- **Additional Home and Community Based Services.** Health plans participating in the project will have the ability to provide additional HCBS, including supplemental personal care services, respite care, and nutritional supplements.

- **Dental, Vision, and Transportation Benefits Required.** The benefit package offered under this project must include preventative, restorative, and emergency oral health and vision benefits and must include non-emergency, accessible medical transportation.

- **Evaluation.** CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of this project. The evaluator will assess how the project operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences.

Budget Issue. The budget proposes the following related to CCI:

- **Increased General Fund Savings in Current Year.** As a result of delaying the start date until the budget year, General Fund savings in the current year is $642 million, an increase of $34 million compared to the 2012 Budget Act. This is because the state does not have to pay overlapping Medi-Cal fee-for-service payments and Medi-Cal

managed care rates for the dual eligibles that would have transitioned in the current year.

This current year savings is not impacted by the MOU.

- **Decreased General Fund Savings in Budget Year and Ongoing.** The Governor's budget includes $171 million General Fund savings in 2013-14 and ongoing General Fund savings of $535 million starting in 2015-16 (when enrollment will be complete in all demonstration counties). At the time the 2012 budget was enacted, it was estimated that 2013-14 and ongoing General Fund savings would be $880 million. According to the Administration, the revised savings estimates more accurately reflect the number of people eligible for CCI.

  The MOU will have an impact on the estimated budget year and ongoing savings. Consequently, these estimates will change at May Revise.

Background. SB 208 (Statutes of 2010) requires DHCS to establish a demonstration program to begin enrolling persons who are eligible for both Medi-Cal and Medicare (dual eligible) into coordinated health care delivery models in up to four counties. During the 2010 Bridge to Reform Section 1115 waiver negotiations, CMS requested that California pursue the dual eligible pilots through a new federal initiative rather than as part of the waiver. California was one of 15 states to receive a $1 million design contract from CMS in April 2011.

SB 1008 (a 2012 budget trailer bill) and SB 1036 (a 2012 budget trailer bill) modified the original authority in SB 208 and created the Duals Demonstration Project/Coordinated Care Initiative (CCI). Under the CCI:

- Up to eight counties can participate in the Duals Demonstration Project. These counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. See table below for more information on the demonstration counties.

- Long-term supports and services (LTSS), such as In-Home Supportive Services, are shifted into Medi-Cal managed care for Medi-Cal-only individuals.

Under CCI, the state and CMS will jointly contribute to managed care rates that are designed to lower total Medicare and Medi-Cal spending for dual eligibles. The rates will be determined based on the assumption that by integrating LTSS under managed care, demonstration plans can prevent and substitute nursing facility stays for their members with less costly LTSS.

The rates also assume a reduction in hospital inpatient services under managed care. In future years, when CCI is fully implemented, General Fund savings are expected to result from both (1) LTSS integration, which mainly lowers Medi–Cal costs, and (2) reduced hospitalizations for dual eligibles, which mainly lowers Medicare costs.

SB 1008 contains a "poison pill" in that it requires that if a six-month stable enrollment period is not obtained in the project or the level of savings estimated in the 2012 budget act is not achieved, then the entire CCI project becomes inoperative.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Administration will be providing revised fiscal estimates reflecting the provisions of the MOU. The delayed start date, no stable enrollment period, and cap on participation in Los Angeles County, for example, will impact these estimates.

The revised estimate should be provided prior to May Revision to give the Legislature and stakeholders the opportunity to carefully evaluate and consider how these numbers interact with other proposals in the budget.

Additionally, it is anticipated that changes in statute will be necessary to implement the project, such as changes to the "poison pill." It is recommended that the Administration share, as soon as possible, its proposed changes to law.

DHCS has been working closely with CMS over the last year regarding this project and is intimately familiar with the details of its proposed implementation. The Legislature and stakeholders have not been party to the conversations with CMS; consequently, it is reasonable for stakeholders, including the Legislature, to get details and assumptions as soon as possible to ensure a thorough understanding of the changes and implications.

This project impacts the lives of almost half a million Californians and the solvency of many of the state's business partners (health plans and providers), it is important to ensure that the details are carefully considered.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of the MOU and next steps regarding the project.

2. Please explain how CMS and the state will share the savings from this project.

3. Please provide a brief overview of the proposed risk corridors.

4. What is the Administration's timeline for sharing updated fiscal estimates and proposed trailer bill language regarding this project?

4. CCI Long Term Care Division - Position Request

Budget Issue. DHCS's Long-Term Care Division requests the extension of one full-time limited-term position (a Health Program Manager III) for a three-year term. This position would continue work related to the implementation of the Duals Demonstration Project/Coordinated Care Initiative (CCI).

The cost for this position is $150,000 ($75,000 General Fund and $75,000 federal funds).

Background. SB 208 (Statutes of 2010) directed DHCS to establish pilot projects in up to four counties to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs (the Dual Demonstration). SB 1008 (a 2012 budget trailer bill) authorized CCI and expanded the Dual Demonstration to an additional four counties and included the integration of long-term supports and services (LTSS), including the Multi-Purpose Senior Services Program and In-Home Supportive Services, into a Medi-Cal managed care benefit.

The position requested to be extended in this proposal would help facilitate LTSS integration into managed care health plans participating in the Duals Demonstration. In addition, this position would work with the California Department of Aging and the California Department of Social Services, on developing the universal LTSS assessment process and tool.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as details on CCI are still forthcoming (as discussed in the agenda item above).

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this budget proposal.

5. Emergency Preparedness Audits - Position Request

Budget Issue. DHCS requests three permanent full-time Health Program Auditor IV positions, effective July 1, 2013, to conduct audits of local health departments' use of federal public health emergency funds.

The total cost for these positions is $379,000 and would be funded with reimbursements from the Department of Public Health (who receives federal Centers for Disease Control and Prevention grants for these activities).

Background. DPH does not have audit staff to perform financial and compliance audits of local health department's (LHD) use of federal grant funds on a three year cycle, as required by Health and Safety Code Section 10137(g)(3). Consequently, it has entered into an interagency agreement with the Audits and Investigations (A&I) branch of DHCS to conduct these audits.

The CDC has approved the use of California's public health emergency preparedness funds to finance the LHD audits.

At the March 14, 2013 Subcommittee #3 hearing, this Subcommittee approved related positions at the Department of Public Health for a limited-term of four years to align with the federal grant period.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve these positions on a limited-term basis for four years (until 2016-17) to align with the period of the federal grant that funds these positions. No other issues have been raised.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this budget proposal.

2. Does DHCS have any concerns with making these positions limited-term?

6. California Medicaid Management System (CA-MMIS) Replacement Project - Position Request

Budget Issue. DHCS requests a three year extension of 26 of the previously authorized 34 limited-term positions, to provide continued oversight of the California Medicaid Management Information System (CA-MMIS) Replacement Project through its completion in 2015-16.

The cost to extend 26 positions would be $3.52 million ($839,000 General Fund and $2.69 million federal funds). These positions are funded at a 90 percent enhanced federal funding rate as they support the CA-MMIS system replacement efforts (per federal CMS approval).

Background. CA-MMIS is used to process over 210 million claims annually for payment of medical services provided to Medi-Cal beneficiaries. DHCS contracts with a fiscal intermediary (FI) to maintain and operate CA-MMIS.

The CA-MMIS system replacement project was originally scheduled to begin in 2010 and end in 2015. However, due to delays in the execution of the FI contract and the assumption of operations by the new FI (Xerox State Healthcare, LLC), the system replacement project was delayed. Project planning began in October 2011 and the project is scheduled to be completed by June 30, 2016. A Special Project Report (SPR) was completed and approved by the California Technology Agency on July 26, 2012, to extend the project timeframe and expenditure plan.

According to DHCS, this information technology project is very important because the existing legacy CA-MMIS is aged, inflexible, and costly to modify. By extending these positions, it will allow for the project to move forward to help reduce waste, improve fraud detection, cost recovery, and support quality assurance activities.

CA-MMIS System Replacement Phases. The system replacement project is divided into four phases:

- Phase I - Replaces pharmacy claims processing drug rebates functionality.
- Phase II – Focuses on pharmacy authorizations.
- Phase III – Encompasses medical authorizations.
- Phase IV – Implements full Health Enterprise system.

Business rule validation is underway for Phase I and just beginning for Phase II. Work on Phases III and IV are expected to begin in 2014

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

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide a brief description of the CA-MMIS system replacement project and timeline.

2. Please provide an overview of this proposal.

7. Continuation of 1115 Waiver Activities - Position Request

Budget Issue. DHCS requests to extend 18 limited-term positions through the end of the 1115 Waiver, which expires on October 31, 2015. DHCS also requests $1 million per year, for three years, in contract funds for actuary services and $10,000 for actuarial and auditing training.

The 2013-14 cost for this proposal is $3.165 million ($1.3 million General Fund, $1.7 million federal funds, and $107,000 reimbursement from counties).

Background. Effective November 1, 2010, CMS approved California's five-year, $10 billion "Bridge to Reform" Section 1115 Waiver proposal. Generally, the waiver expands health care coverage to uninsured adults; provides support for uncompensated care; improves care coordination for vulnerable populations; and promotes public hospital delivery system transformation.

Provisions of the waiver and waiver amendments that relate to this budget proposal are:

- The transition of seniors and persons with disabilities (SPDs) from voluntary to mandatory enrollment in Medi-Cal managed care in a phased-in manner over a twelve-month period commencing June 1, 2011.

- The development and implementation of intergovernmental transfers to allow the transfer of public funds between governmental entities.

- The transition of Adult Day Health Care (ADHC) to Community-Based Adult Services (CBAS).

- The transition of Healthy Families into the Medi-Cal managed care program.

- The expansion of Medi-Cal managed care into rural counties.

These 18 limited-term positions work on activities related to the above-specified provisions of the waiver and waiver amendments. Key activities performed by these positions include:

- **Administration Division (1 position) -** Prepare and analyze managed care reconciliations; analyze and interpret financial data for federal reporting (the adopted waiver requires the accounting federal reporting unit to produce 1,700 additional CMS reports annually to report and draw federal funding); respond to requests from program management and CMS auditors; process invoices for payment, issue and process difference checks; and prepare quarterly summary information.

- **Medi-Cal Managed Care Division (9 positions) -** Update managed care contracts with requirements specific to the Special Terms and Conditions of the 1115 Waiver, monitor the additional contract requirements specific to the 1115 waiver (e.g., SPD

specific network and medical reviews), and complete the 1115 waiver reporting required by the federal government.

- **Capitated Rates Development Division (5 positions) –** Review capitation rate development, provide fiscal analysis and health care plan analysis of the 1115 Waiver, provide oversight for risk adjustment and rate setting, and review the intergovernmental transfer process for public hospitals.

- **Information Technology Services Division (3 positions) –** Support the 1115 Waiver activities in regard to system modifications and enhancements, assist with technical documentation and testing of system changes related to the Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide a brief summary of this proposal.

8. Continuation of LIHP & DSRIP Activities - Position Request

Budget Issue. DHCS requests the extension of 26 limited-term positions and contract funds to continue the workload associated with the Low Income Health Program (LIHP) and Delivery System Reform Incentive Pool (DSRIP) components of the 1115 Bridge to Reform Demonstration Medicaid Waiver.

The cost for this request is $2.7 million ($260,000 General Fund, $1.4 million federal funds, and $1.1 million in reimbursements from counties).

The positions requested to be extended are:

- **Low Income Health Program (18 positions) -** Complete workload associated with the implementation, close-out, and transition of the LIHP to the Medi-Cal program and the Exchange.

- **Delivery System Reform Incentive Pool (3 positions and contract services) -** Complete workload associated with the DSRIP.

- **Hospital Financing Activities (5 positions) -** Complete workload associated with ongoing hospital financing activities, the final reimbursement activities for the Health Care Coverage Initiative, and the transition of the LIHP to the Medi-Cal program and the Exchange.

Background—LIHP. The Low Income Health Program (LIHP) is a voluntary, county-run program to provide a Medicaid-like coverage to low-income individuals who are uninsured. There are 17 LIHPs in operation, covering 52 counties, and each LIHP can have different income eligibility requirements. The County Medical Services Program (CMSP) LIHP includes 35 counties.

The LIHP is authorized under the state's 1115 waiver. The 1115 waiver provides a bridge to implement the ACA and an opportunity for county health departments to improve coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and build the right delivery systems for a uninsured population with a 50:50 match of existing county health spending for the newly-eligible and federal funds.

The terms of this waiver limit operations of LIHP to December 31, 2013, as LIHP enrollees would be eligible for Medi-Cal or coverage offered through the Exchange starting January 1, 2014 (under provisions of the ACA).

The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very low-income adults with incomes under 138 percent of the FPL, and its federal funding through the waiver is uncapped. HCCI is coverage for low-to-moderate income adults with incomes between 138 percent and

200 percent of FPL, and its expenditures are capped. See the table that follows for LIHP enrollment information.

Table: Low Income Health Program (LIHP), November 2012 Monthly Enrollment

LIHP	Medicaid Coverage Expansion			Health Care Coverage Initiative			Total LIHP Enrolled
	Start Date	Upper Income Limit	Number Enrolled	Start Date	Upper Income Limit	Number Enrolled	
Alameda*	07/01/2011	133% of FPL	38,773	07/01/2011	200% of FPL	8,698	47,471
CMSP (County Medical Services Program)	01/01/2012	100	56,542			0	56,542
Contra Costa*	07/01/2011	133	9,726	07/01/2011	200	2,072	11,798
Kern	07/01/2011	100	6,322			415	6,737
Los Angeles	07/01/2011	133	212,916			185	213,101
Orange*	07/01/2011	133	34,030	07/01/2011	200	9,872	43,902
Placer	08/01/2012	100	2,164			0	2,164
Riverside	01/01/2012	133	24,594			0	24,594
Sacramento	11/01/2012	67	1,394			0	1,394
San Bernardino	01/01/2012	100	26,081			0	26,081
San Diego	07/01/2011	133	33,278			76	33,354
San Francisco	07/01/2011	25	9,383			1,072	10,455
San Joaquin	06/01/2012	80	1,769			0	1,769
San Mateo	07/01/2011	133	8,555			174	8,729
Santa Clara	07/01/2011	75	12,771			745	13,516
Santa Cruz	01/01/2012	100	2,163			0	2,163
Ventura*	07/01/2011	133	8,605	07/01/2011	200	2,997	11,602
TOTAL			**489,066**			**26,306**	**515,372**

*These programs are not currently operating an HCCI, the enrollment numbers reflect legacy program caseload.

Monterey implemented a LIHP in February 2013. Tulare implemented a LIHP in March 2013. According to DHCS, LIHPs in Stanislaus and Santa Barbara will likely not be established. Fresno, Merced, and San Luis Obispo have withdrawn their interest in creating a LIHP.

Transition of LIHP Enrollees to Medi-Cal. On January 1, 2014, LIHP enrollees will automatically transition to Medi-Cal or the Exchange. Welfare and Institutions Code Section 15910(c) requires that LIHPs be designed and implemented with the system and program elements that are necessary to facilitate the transition of LIHP enrollees to Medi-Cal coverage. Additionally, the Special Terms and Conditions of the Waiver requires implementation of a

simplified, streamlined process for transitioning eligible enrollees from LIHP to Medi-Cal or the Exchange in 2014 without need for additional determinations of enrollees' eligibility.

Background—DSRIP. The Delivery System Reform Incentive Pool (DSRIP) Program was created to support the efforts of California's Designated Public Hospitals (DPHs) to transform their health care delivery systems in order to enhance the quality of care and the health of the patients they serve. The program involves the development of hospital plans that include specific work efforts to encourage and create systems to prepare for implementation of federal health care reform.

The funding for DSRIP is $3.3 billion in federal funds ($6.6 billion total as counties use intergovernmental transfers to finance DSRIP projects) over a five-year period (November 1, 2010 – October 31, 2015) and is allocated among the 17 DPH systems. The focus in years one and two of the program is on building infrastructure and systems and the focus in years three through five of the program is on outcomes.

DSRIP projects fall within five distinct categories:

- **Category 1 - Infrastructure Development.** Lays the foundation for delivery system transformation through investments in people, places, processes and technology. Projects include implementing disease management registries, expanding primary care capacity and increasing training of the primary care workforce.

- **Category 2 - Innovation & Redesign.** Includes the piloting, testing and replicating of innovative care models. Many plans include projects to expand medical homes, integrate physical and behavioral health care, expand chronic care management models, redesign primary care and improve patient experience.

- **Category 3 - Population-Focused Improvement.** Requires all public hospital systems to report on the same 21 measures across four domains: (1) the patient's experience, (2) the effectiveness of care coordination (e.g., measured by hospitalization rates for heart failure patients), (3) prevention (e.g., mammogram rates and childhood obesity), and (4) health outcomes of at-risk populations (e.g., blood sugar and cholesterol levels in patients with diabetes).

- **Category 4 - Urgent Improvement in Care.** Requires public hospital systems to achieve significant improvement in targeted quality and patient safety measures that are particularly meaningful to safety net populations and have a strong base of evidence.

- **Category 5 – HIV Transition Projects.** Enables public hospital systems to implement infrastructure, program design, and clinical and outcome projects related to health care practices that support continuity of care for those LIHP enrollees who have been diagnosed with HIV, and who received their care formerly through Ryan White programs.

See table below for categories and projected allocation of funding. (Payments have been made through 2011-12.)

Table: DSRIP Project Category Projected Funding Allocations (in thousands)

Category	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Infrastructure Development	$463,698	$420,949	$354,442	$160,343	$54,660	$1,454,093
Innovation & Redesign	459,671	415,085	315,697	144,867	68,085	1,403,407
Population-Focused Improvements	-	297,103	396,138	594,207	693,242	1,980,693
Urgent Improvement in Care	83,430	166,860	333,721	500,581	584,011	1,668,605
HIV Transition Projects	-	-	110,000	55,000	-	165,000
Total	**$1,006,800**	**$1,300,000**	**$1,510,000**	**$1,455,000**	**$1,400,000**	**$6,671,800**

Subcommittee Staff Comment and Recommendation—Hold Open. Staff had requested information on the planning for the transition of LIHP enrollees to Medi-Cal or the Exchange prior to this hearing. This information has not yet been received. It is recommended to hold this item open until the subcommittee receives more information regarding this transition.

Questions. The Subcommittee has requested DHCS respond to the following question:

1. Please provide a brief summary of this proposal.

2. Please provide an update on the planning for the transition of LIHP enrollees to Medi-Cal or the Exchange.

9. Assisted Living Waiver – Position Request

Budget Issue. DHCS requests to extend two limited-term positions for three years to work on the Assisted Living Waiver (ALW) program. These positions are set to expire on June 30, 2013. The total cost of these positions is $235,000 ($117,000 General Fund and $118,000 federal funds).

The two positions requested are:

- Health Program Manager I (HPM I) – This position would direct the expansion and administration of the waiver. This position would be responsible for executing the requirements of the waiver, conducting outreach and providing technical assistance to external partners, resolving all internal policy and system issues, overseeing financial audits, and monitoring the quality and effectiveness of the waiver.

- Research Analyst II (RA II) – This position would ensure that the fiscal oversight process is in compliance with the fiscal intermediary, which is required for this waiver by CMS and contingent upon renewal of this waiver.

Background. The ALW offers assisted living services in two settings: Residential Care Facilities for the Elderly and publically subsidized housing. Qualified participants have full-scope Medi-Cal benefits with zero share of cost and are determined to meet the Skilled Nursing Facility Level of Care, A or B.

The ALW expires February 28, 2014. The waiver extension application is currently in development (the application would extend the project through February 2019).

The ALW was preceded by the Assisted Living Waiver Pilot Project (ALWPP) which was created by AB 499 (Statues of 2000). It tasked DHCS to test the efficacy of assisted living as a Medi-Cal benefit and as an alternative to long-term nursing home placement. The ALWPP was tested in three counties: Sacramento (representing urban, northern California-350 beneficiaries); San Joaquin (representing rural, central California-50 beneficiaries); Los Angeles (representing urban, southern California-600 beneficiaries).

On March 1, 2009, CMS approved a statewide ALW, and granted it a five year waiver cycle. As of October 2012, approximately 1,840 individuals are enrolled in this program.

Medi-Cal enrollees interested in applying to the ALW do so through a Care Coordinator Agency (CCA), which initially ascertains eligibility through the Medi-Cal provider website and through a nursing assessment conducted by a CCA nurse. Final eligibility for the ALW is determined by DHCS's Long-Term Care Division. The allocation of waiver slots is limited to 60 waiver slots per county, per year, and is dependent upon CMS approval and state appropriations.

DHCS finds that these two positions would permit DHCS to significantly increase nursing facility transitions and develop the necessary community resources to enable thousands of additional Medi-Cal beneficiaries in several different counties to participate in these projects. The ALW results in potential savings for both Medicare and Medi-Cal as individuals are placed in a more cost effective placement.

LAO Findings and Recommendation. The LAO finds that there has been insufficient workload justification to support continuing the Health Program Manager (HPM) position. Specifically, the LAO finds that the workload data provided by DHCS related to the HPM position appears overstated. Therefore, the LAO recommends rejecting the request for the HPM position, resulting in $124,000 in savings ($62,000 General Fund).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DHCS respond to the following question:

1. Please provide a brief summary of this proposal and how DHCS proposes to expand the ALW.

2. What is DHCS's estimate as to the potential savings that could be realized if the ALW was expanded as proposed?

10. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

Budget Issue. DHCS requests one full-time permanent Associate Governmental Program Analyst (AGPA) to operate the Public Assistance Reporting Information System (PARIS) Interstate program on a statewide basis.

This proposal does not seek new General Fund resources as funding for the new staff will come from redirection of program savings of $102,000 ($51,000 General Fund and $51,000 federal funds) resulting from the implementation of PARIS Interstate.

Background. On July 1, 2009, DHCS began participation in the PARIS data match process with three pilot programs to improve program integrity. PARIS is an information-sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances affecting Medicaid program eligibility. PARIS includes three different data matches:

PARIS Data Match Type	Where Implemented?	2013-14 General Fund Savings
PARIS-Veterans allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs.	Implemented in 10 counties.	$519,350
PARIS-Federal allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14.	$332,400
PARIS-Interstate allows states to compare their beneficiary information with other states.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14.	$1,474,000

PARIS-Interstate. DHCS' PARIS-Interstate program began with three counties; and currently has 30 participating counties; however, Los Angeles County is not yet included. Under PARIS-Interstate, DHCS sends residency verification letters to a limited number of Medi-Cal beneficiaries identified by PARIS-Interstate as receiving public assistance in another state. The residency verification letter requires a response from the beneficiary within ten days. If no response is received, or if the beneficiary responds, confirming they are not residents of California, DHCS considers the individual an ineligible, nonresident beneficiary and their benefits are discontinued. DHCS sends the list of discontinued, ineligible, nonresident beneficiaries to the county offices and the county workers update case files.

During quarterly PARIS-Interstate matches, DHCS identified approximately 1,300 ineligible nonresident beneficiaries on Medi-Cal in 2009-10, 2,700 in 2010-11, and 4,000 in 2011-12

The May 2012 Medi-Cal Estimate includes savings for PARIS-Interstate and PARIS-Federal of $8.5 million ($4.2 million General Fund) for 2011-12, and $17.7 million ($8.9 million General Fund) for 2012-13. These cost savings were achieved by avoiding actual managed care capitation payments through the identification of nonresident ineligible beneficiaries.

DHCS notes that if given the resources to expand PARIS-Interstate, DHCS will likely achieve double the savings as it is estimated that there are 957,334 Medi-Cal beneficiaries in Los Angeles County, who would be included in the PARIS file.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised in regards to this proposal for additional resources related to PARIS – Interstate. However, as noted in the chart above, PARIS-Veterans is only in 10 counties. Staff is working with Senate Subcommittee #4 and the California Department of Veterans Affairs to explore options to expand PARIS-Veterans into more counties.

According to a DHCS PARIS report submitted to the Legislature in April 2012, other states have more aggressively maximized the PARIS-Veterans data match and have shown substantial cost avoidance/savings results. For example, Pennsylvania estimated annualized cost avoidance/savings of approximately $27.8 million from a period covering nine quarters. Pennsylvania worked 40,769 cases resulting in reducing 4,448 cases from Medicaid.

Given the potential increase in General Savings, it is recommended to hold this item open to evaluate how California could maximize its use of PARIS data matches.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this proposal.

2. Has DHCS had any discussions with the California Department of Veterans Affairs regarding the expansion of this data match into more counties?

11. Security Oversight of MEDS – Position Request

Budget Issue. DHCS requests the authority to establish five permanent, and two limited-term, full-time positions for $822,000 ($371,000 General Fund and $451,000 federal funds) to provide Medi-Cal Eligibility Data System (MEDS) program and systems management oversight authority, of county California Department of Social Services (CDSS) program administrators, as well as quality control to ensure compliance with federal requirements.

The request is for seven new positions, four Associate Governmental Program Analysts (AGPA), one Staff Information Systems Analyst (SISA), one Systems Software Specialist, and one Staff Programmer Analyst.

These positions will perform authorization, maintenance, and tracking of approximately 10,000 CDSS MEDS accounts; enter into county security agreements with CDSS' business partners; and to perform periodic assessments in the counties to ensure that counties are in compliance with SSA requirements regarding the safeguarding of information.

Background. CDSS has access to MEDS, a database maintained by DHCS. Some of the data in this database comes from the federal Social Security Administration (SSA). The SSA imposes strict requirements on any entity that has access to SSA data, and it required CDSS to submit a Corrective Action Plan (CAP) specifying its steps in maintaining the acceptable and sufficient level of security oversight.

Effective January 1, 2010, SSA executed an Information Exchange Agreement (IEA) with CDSS. The IEA requires CDSS to perform a range of security and privacy activities. The IEA focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

SSA required CDSS recertify compliance with the IEA on June 30, 2012. The IEA recertification process revealed a number of deficiencies in the areas of management and oversight, computer security safeguards and physical security. CDSS was required to submit a CAP to the SSA because it was found that CDSS was inappropriately allowing county Adult Protective Services (APS) workers access to the SSA data within MEDS.

In order to satisfy the CAP and to strengthen the State's management oversight capabilities, DHCS will assist CDSS with authorizing access for county employees, reviewing and signing county security agreements, conducting periodic security assessments, responding to breach notifications, quality control, and ensuring compliance with federal requirements. DHCS currently works with county welfare agencies to provide this type of access assistance and oversight for the Medi-Cal program.

DHCS is requesting the position authority to establish the positions necessary to carry out the new work load that is required to ensure that CDSS programs are in compliance with SSA requirements, and for all the activities stated above.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DHCS respond to the following questions.

1. Please provide an overview of this proposal.

12. Women, Infant, and Children (WIC) Appeals – Position Request

Budget Issue. DHCS requests one new permanent full-time Health Program Auditor IV position and to convert one existing limited-term Administrative Law Judge position into a permanent full-time position. These positions would conduct the increasing number of Women, Infants and Children's (WIC) appeal hearings as a result of WIC's increased efforts to disqualify vendors that have failed to adhere to program policies and procedures.

These positions are funded through reimbursement funding from the Department of Public Health (DPH) at a total cost of $293,000.

Background. DPH administers the WIC Program which provides nutritious supplemental foods, nutrition education, and referrals to health and social services for low-income women, infants and children who are at nutritional risk. DPH contracts with DHCS's Office of Administrative Hearings and Appeals (OAHA) for the appeal functions related to WIC.

Over the last several years, the United States Department of Agriculture (USDA) has enhanced federal regulations governing the WIC Program to increase accountability. Specifically, federal WIC regulations require states to 1) conduct compliance activities on authorized grocers, 2) ensure grocers do not sell their stores to circumvent a State sanction for program violations and 3) deny authorization to grocers lacking business integrity. The federal regulations provide for stricter sanctions for grocers who violate program rules. In addition, federal regulations contain new requirements for more extensive monitoring of grocers.

In 2011-12, WIC denied 239 out of 534 new vendor applications due to stringent stocking requirements and a moratorium on new vendors. The WIC program has contracted with the State Controller's Office to conduct 200 audits of the vendors and agencies. In addition to the audits, the program routinely monitors over 250 vendors through undercover investigations and compliance buys. All these actions create appeal workload for DHCS when the actions are taken against the vendors and agencies.

The appeals workload has increased by over 50 percent from 2010-11 and over 400 percent from 2008-09. The increase in the number of WIC appeals has created a significant backlog and OAHA cannot meet the 120 day time frame for completing the first level appeal process. The staff requested in this proposal will be used to meet the appeal requirements mandated by the federal government.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of this proposal.

13. HIPPA – Position Request

Budget Issue. DHCS requests the establishment of three permanent and two limited-term positions (three-year) in the Office of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance (OHC).

The total cost for these positions is $682,000 ($235,000 General Fund and $447,000 federal funds).

The following positions are requested:

- **Two Staff Information Systems Analyst (Limited-Term)** - Support the HIPAA ICD-9 conversion to HIPAA ICD-10. These two positions will work specifically on ICD-10 project management tasks, processes, documentation, and the development of best practices. The effective implementation date of this rule is October 1, 2014.
- **One Systems Software Specialist II (Permanent) and One Senior Information Systems Analyst (Permanent)** – Support and implement future HIPAA initiatives and enhancements related to the Short-Doyle Medi-Cal system for the behavioral health and substance abuse claims adjudication system that processes claims for all Mental Health Counties and Drug Program Direct Providers.
- **One Staff Information Systems Analyst (Permanent)** – Maintain and implement HIPAA compliant security solutions and perform mandated activities that will further protect the protected health information of millions of beneficiaries in DHCS programs.

These positions would address the anticipated workload attributed to health care reform, new federal HIPAA regulations, and the integration and expansion of technological systems.

Background. In 1996, the federal government enacted HIPAA to help beneficiaries maintain group health insurance coverage when they change jobs. The law also outlined a process to achieve uniform national health data standards and health information privacy in the United States. These provisions require all covered organizations to standardize the way they transmit and code health information for billing and record keeping purposes, and to protect the privacy and security of that information.

The Affordable Care Act (ACA) includes HIPAA-related changes, such as:

- More frequent HIPAA updates: New standards and operating rules can change every two years while the previous process resulted in only one significant update in ten years.
- New transaction standards: New HIPAA standards and compliance dates for:
  - National Health Plan Identifier (NHPI) by October 1, 2012
  - Electronic Funds Transfer by January 1, 2014
  - Claims attachment standards and operating rules by January 1, 2016

- New health plan certification requirements: Health plans will need to certify (i.e., document and test) their compliance with every HIPAA transaction and standard operating rule.
- Privacy and Security Requirements: HIPAA privacy and security requirements are exponentially increased for electronic health records and health information exchange, creating more exposure of protected health information with each exchange of information.
- Higher penalties for non-compliance: Penalties of $1 per covered life per day not certified compliant, up to a maximum of 20 days (approximately $200 million annually for Medi-Cal). Penalties are doubled if false statements are submitted with certification documents; penalty amounts are based on the number of beneficiaries.

According to DHCS, failure to maintain or achieve HIPAA compliance by established federal deadlines has several implications for DHCS, including additional administrative burdens for Medi-Cal providers, increased risk of federal penalties (monetary, and the withholding of federal funds), loss of support to HIPAA-implemented solutions, and additional breach reporting costs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

Questions. The Subcommittee has requested DHCS respond to the following:

1. Please provide a brief summary of this proposal.

14. Medi-Cal Electronic Health Records – Position Request

Budget Issue. DHCS' Office of Health Information Technology (OHIT) requests the extension of 11 limited-term positions for the administration of the Medi-Cal Electronic Health Record (EHR) Incentive Program.

Total cost for these positions is $1.3 million ($1.2 million federal funds and $93,000 reimbursement from outside entities, and [$38,000 General Fund]). DHCS is not requesting any additional General Fund in this proposal, as the $38,000 General Fund cost associated with these positions is covered by the General Fund support specified in AB 1467 (a 2012 budget trailer bill) for support costs associated with this program.

The positions requested to be extended are:

Two-Year Extension – July 1, 2013 to June 30, 2015 (8.0 positions)

- Two Staff Services Manager I
- Three Research Program Specialist II
- Three Associate Governmental Program Analyst

Three-Year Extension – July 1, 2013 to June 30, 2016 (3.0 positions)

- One Research Program Specialist II
- Two Health Program Auditor IV

Background. The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011, and will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has paid over 1,600 providers over $272 million in federal incentive payments.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes $45 billion for federal Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records (EHRs). The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems. The use of EHR technology in this manner includes the use of electronic prescribing (e-prescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information between DHCS and its providers to improve the quality of patient care.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid EHR Incentive Programs. The programs will lead the efforts to advance patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way.

On October 26, 2009, DHCS submitted a funding request to the federal Centers for Medicare and Medicaid Services (CMS) that was approved for $2.8 million to establish the OHIT and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. The department completed and received approval of the SMHP and Implementation Advance Planning Document on September 30, 2011.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. The department indicates that it has not yet secured agreements for the $93,000 in reimbursements from outside entities. It indicates that it is currently exploring opportunities for this funding.

Questions. The Subcommittee has requested the DHCS respond to the following:

1. Please provide a brief summary of this proposal.

2. What is the status of the department's efforts to secure outside funding for this proposal? When does the department anticipate agreements may be reached?