SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 21, 2013

9:30 AM

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

Agenda Part 1
(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

0530 Office of Systems Integration

1. CalHEERS Adjustment (DOF Issue 444)

Budget Issue. The May Revision requests an increase of $3.7 million in reimbursement authority to provide project management services for the design, development, implementation, and operation and maintenance for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) project. The increase reflects changes in state/program partner personnel costs, negotiated service center costs, and expanded system costs for CalHEERS.

Subcommittee Staff Comment and Recommendation—Approve.

4140 Office of Statewide Health Planning and Development

1. Mental Health Reappropriation (DOF Issue 304 and 306)

Budget Issue. The May Revision requests a reappropriation of previously approved Mental Health Services Act Workforce, Education, and Training (WET) funds ($7.8 million). These funds are requested to be reappropriated through 2017-18; consistent with the Mental Health Services Act. Of these funds, $7.5 million will be used for purposes identified in the WET five-year plan that is in development and about $330,000 will be used for scholarship and loan repayment programs.

Subcommittee Staff Comment and Recommendation—Approve.

4150 Department of Managed Health Care (DMHC)

1. 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).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. No issues have been raised.

3. 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.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. The Administration addressed Subcommittee staff concerns with a supplemental request, described in the next agenda item.

4. Medi-Cal Managed Care Rural Expansion Supplemental – May Revision (DOF Issue 501)

Budget Issue. DMHC requests a 0.8 two-year limited term position and $298,000 for 2013-14 and $290,000 for 2014-15 to address workload attributable to an additional three plans that are now part of the Medi-Cal managed care expansion into 28 rural counties. This request includes $195,000 for consultant services to perform annual medical surveys of the three additional plans.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services seeking the federal match. The position requested would be assigned to the Help Center and assist with annual medical surveys of the

five plans for the first two years. The DMHC is asking for a 0.8 limited-term position to augment the previously requested permanent positions listed in the agenda item above.

Subcommittee Staff Comment and Recommendation—Approve. The Governor's January budget included a request to address workload based on providing consumer assistance and conducting annual medical surveys of two plans for the Medi-Cal Managed Care Rural Expansion (see previous agenda item).

Subsequently, DMHC learned that DHCS has contracted with an additional three plans, for a total of five plans. Accordingly, this limited-term supplemental proposal augments DMHC's previously submitted request to allow the DMHC to conduct five surveys annually during the first two years.

4260 Department of Health Care Services

1. Medi-Cal Estimate Update – Technical Adjustments (DOF Issue 200)

May 2013 Medi-Cal Estimate. It is requested that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

1. Item 4260-101-0001 be increased by $579,114,000 and reimbursements be decreased by $907,993,000
2. Item 4260-101-0236 be decreased by $30,000
3. Item 4260-101-0890 be increased by $4,353,324,000
4. Item 4260-101-3168 be increased by $1,419,000
5. Item 4260-101-3213 be increased by $436,646,000
6. Item 4260-104-0001 be increased by $3,531,000
7. Item 4260-105-0001 be decreased by $29,140,000
8. Item 4260-106-0890 be decreased by $8,202,000
9. Item 4260-107-0890 be decreased by $164,000
10. Item 4260-113-0001 be increased by $28,086,000
11. Item 4260-113-0890 be increased by $41,275,000
12. Item 4260-117-0001 be increased by $2,317,000
13. Item 4260-117-0890 be increased by $4,709,000

Subcommittee Staff Comment & Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

2. 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).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. No issues have been raised.

3. 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).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

4. 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).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

5. 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

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.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

6. 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).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

7. 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.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. Additionally, DHCS now anticipates implementing PARIS-Federal and PARIS-Interstate on a statewide-basis starting January 1, 2014.

8. 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.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

9. Lock-In at Annual Open Enrollment for Medi-Cal Managed Care

Budget Issue. The DHCS is proposing trailer bill language that would change the enrollment model for certain Medi-Cal managed care enrollees who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; whereby, an enrollee could only change plans once a year.

This proposal would only apply to those beneficiaries in the Family and Child aid code categories. It would not apply to Seniors and Persons with Disabilities (SPDs) and beneficiaries dually eligible for Medicare and Medi-Cal (duals). However, DHCS would have the option of adding additional Medi-Cal managed care populations in future years.

Subcommittee Staff Comment and Recommendation—Reject. This proposal was discussed at the May 2nd Subcommittee hearing. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time, to ensure that his or her health needs are met. This is still the case and potentially even more important given that there are still ongoing managed care transitions (e.g., the Healthy Families Program transition to Medi-Cal and the rural managed care expansion).

Additionally, the proposed trailer bill language provides DHCS with substantial authority to determine if this policy should be implemented for seniors and persons with disabilities.

10. Diagnosis Related Groups Payment System – Position Request

Budget Issue. DHCS requests conversion of one limited-term position to permanent in order to meet the workload requirements for the Diagnostic Related Groups Payment Systems Program (DRG), which will be implemented on July 1, 2013. The total cost of this position is $121,000 ($61,000 General Fund).

This position will be responsible for researching and developing DRG studies and analyses, as well as monitoring DRG base rates, developing reconciliation processes and providing information to providers and stakeholders.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on May 2, 2013.

11. Breast and Cervical Cancer Treatment Program Resources – Position Request (DOF Issue 006)

Budget Issue. The May Revision requests the extension of six full-time limited-term positions for the Breast and Cervical Cancer Treatment Program (BCCTP), until December 31, 2014. (These positions expire December 31, 2013.)

The total cost of these positions would be $369,000 ($185,000 General Fund and $184,000 federal funds).

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 14,500 active cases as of March 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.

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.

Subcommittee Staff Comment and Recommendation—Approve.

12. Federal Authority for Mental Health Services Technical Adjustment (DOF Issue 008 and 108)

Budget Issue. The May Revision requests a technical adjustment to align federal fund authority for mental health services grants with the actual amount of grant funding received from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This is a technical adjustment.

Subcommittee Staff Comment and Recommendation—Approve.

13. Family Health Programs Adjustments (DOF Issue 211)

Budget Issue. The May Revision requests adjustments to the California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), and the Genetically Handicapped Person's Program (GHPP).

These changes reflected revised expenditure estimates based on caseload adjustments, the use of federal Safety Net Care Pool funding and medical rebate funding, to offset General

Fund, and other technical changes in program expenditures. (Approximately $65 million is still available for Designated State Health Programs in the Safety Net Care Pool.)

Caseload projections are estimated to be 20,062 for CCS (a 44.6 percent decrease over the revised current year forecast), 26,547 for CHDP (a 12.7 percent increase over the revised current year forecast), and 944 for GHPP (a 4.9 percent increase over the revised current year forecast).

Subcommittee Staff Comment and Recommendation—Approve.

14. Drug Medi-Cal Legal Representation – Position Request

Budget Issue. DHCS requests to make one limited-term staff counsel position permanent to provide ongoing legal services to the Drug Medi-Cal (DMC) Program.

The cost of this position is $182,000 ($73,000 General Fund and $109,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 18, 2013.

15. Long Term Care Quality Assurance Fund – Borrowable for Cash Flow

Budget Issue. The May Revision proposes trailer bill language to make the funds available in the Long Term Care Quality Assurance Fund borrowable for General Fund cash flow purposes.

The Administration notes that this is common practice and assists with General Fund cash flow management.

Subcommittee Staff Comment and Recommendation—Approve.

4265 Department of Public Health

1. Genetic Disease Screening Program (DOF Issue 504)

Budget Issue. The May Revision requests a technical adjustment to reflect a rate increase for contracted laboratories, offset by lower costs, to provide follow-up services in the Prenatal Screening Program.

Subcommittee Staff Comment and Recommendation—Approve.

2. Nursing Home Administrator's State License Examining Fund (DOF Issue 502)

Budget Issue. The May Revision proposes to abolish the Nursing Home Administrator's State License Examining Fund and shift expenditures to the Licensing and Certification Fund, as required by AB 1710 (Yamada, Statutes of 2012).

Background—AB 1710. AB 1710 eliminates the Nursing Home Administrator's State License Examining Fund and shifts expenditures to the Licensing and Certification Fund in order to integrate nursing home administrator fees into the L&C's fee and workload methodology.

Subcommittee Staff Comment and Recommendation—Approve.

4280 Managed Risk Medical Insurance Board

1. Caseload Updates (Technical Adjustments)

Budget Issue. The May Revision requests the following:

- **County Health Initiative Matching (CHIM) Caseload Update (DOF Issue 106)** – An increase of $45,000 in the CHIM fund and $88,000 in federal funds due to a slight increase in projected enrollment. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 400 percent of the federal poverty level (FPL) and who otherwise meet federal eligibility criteria.

- **Healthy Families Program Caseload Update (Issue 104)** – A net increase of $6.7 million General Fund (and other technical budget adjustments) as a result of the increased enrollment months for infants linked to the Access for Infants and Mothers (AIM) program, the transfer of Single Point of Entry related costs to the Department of Health Care Services (DHCS), and increased Healthy Families Program (HFP) administrative vendor costs.

- **Access for Infants and Mothers Program Caseload Update (Issue 105)** - An increase in $2.2 million federal funds (and corresponding technical adjustments) to reflect the net effect of a decrease in estimated caseload, an increase in administrative vendor costs, an increase in capitation and lump-sum birth event and post-partum rates, and an increase in costs associated with covering beneficiaries under a single statewide health care service plan.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding these adjustments.

4560 Mental Health Services Oversight and Accountability Commission

1. Proposition 63 Evaluation Master Plan (DOF Issue 001)

Budget Issue. The May Revision requests $947,000 and six positions to begin implementation of the Mental Health Services Act (MHSA, Proposition 63) Evaluation Master Plan.

The MHSOAC is mandated to evaluate the outcomes of investments made through the MHSA. On March 28, 2013, the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a three to five year course of action.

The MHSOAC Evaluation Master Plan is the result of findings from interviews with approximately 40 key informants, along with county visits. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize those and future evaluation activities; and identifies strategies for successful completion of all items described and prioritized in the plan. While the major focus of the plan is on the MHSA, the scope of the plan is broader.

Subcommittee Staff Comment and Recommendation—Approve. These needed resources were discussed in detail at the April 18th Subcommittee hearing. No issues have been raised.

ISSUES FOR DISCUSSION

4280 Managed Risk Medical Insurance Board (MRMIB)

1. Pre-Existing Condition Insurance Plan (PCIP) Update

Issue. MRMIB has recently been notified that the federal government plans to take over the administration of PCIP on July 1, 2013. MRMIB is in the process of assessing the implication of this change. Its preliminary assessment indicates that deductibles under the federally-administered program will be higher and there will be a change in premiums (some individuals may have a lower premium and some individuals may have a higher premium). MRMIB anticipates sending notices to PCIP subscribers by the end of this week.

Background. As a result of the federal Affordable Care Act (ACA), California, via MRMIB, 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. After that date, there will no longer be a need for high-risk pools because federal rules will not allow insurers to reject persons with pre-existing conditions or charge them higher rates than those without such conditions.

The federally-funded 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. The California PCIP is run by the Managed Risk Medical Insurance Board (MRMIB).

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.

Approximately 16,500 individuals are enrolled in PCIP. California has the largest PCIP program in the nation. California's PCIP has incurred costs of about $529 million of its $761 million allocation.

Subcommittee Staff Comment—Informational Item.

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

1. Please provide an overview of this issue and its implications.

2. How is MRMIB planning for the transition of these subscribers?

4140 Office of Statewide Health Planning and Development

1. Grant for Workforce Development (DOF Issue 303 and 305)

Budget Issue. The California Endowment (TCE) has committed $52 million, over four years, to OSHPD for health care workforce development programs. The May Revision proposes that these funds be allocated to (1) $31 million ($14 million in 2013-14, $9 million in 2014-15, $7.9 million in 2015-16, and $82,000 in 2016-17) and one staff person for the Health Professions Education Foundation for health professional scholarship and loan repayments and (2) $21 million ($7 million dollars in 2013-14, 2014-15 and 2015-16) for the Song-Brown Program to provide funding to health professional training institutions to train Family Practice Physicians, Family Nurse Practitioners, and Primary Care Physician Assistants.

Background. On January 18, 2013, TCE announced its commitment of $225 million to help California implement the Affordable Care Act (ACA). TCE is dedicating $90 million to "fund efforts to expand the primary care health workforce" and of that, TCE is investing $52 million in OSHPD healthcare workforce development programs.

As a result of the TCE's grant to OSHPD, the Health Professions Education Foundation will award approximately 625 more scholarships and loan repayments to students and practitioners providing direct patient care in underserved communities over 2013-14, 2014-15 and 2015-16, and Song-Brown will fund 68 health professions programs that will result in 4,166 physicians, family nurse practitioners (FNP) and physician assistants (PA) trained in primary care and providing direct patient care in underserved communities each year in 2013-14, 2014-15 and 2015-16.

The Health Professions Education Foundation was established in 1987, it is the state's only non-profit, public-benefit corporation statutorily created to provide financial assistance to students and providers in exchange for providing direct patient care in a California medically underserved area (MUA). Housed in OSHPD, the Foundation supports the participation of Californians from underserved and economically disadvantaged communities and increases access to health providers in those communities.

The Song-Brown Program provides grants to California health professions education institutions (HPEIs) providing clinical training to family practice medical residents, and primary care family nurse practitioners and physician assistant students. Residents and students of Song-Brown funded HPEIs are required to complete training in underserved areas, such as health professional shortage areas, medically underserved areas, medically underserved populations, and primary care shortage areas, as well as multicultural and rural communities.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an overview of this proposal.

4265 Department of Public Health (DPH)

1. AIDS Drug Assistance Program (ADAP) Caseload and Estimate Update (DOF Issue 506)

Budget Issue. The May Revision updates expenditures for the ADAP program. See table below.

Table: Comparison of January and May Estimates for ADAP for Budget Year
(dollars in thousands)

Fund Source	January Budget	May Revise	Difference
AIDS Drug Rebate Fund	$264,158	$243,809	-$20,349
Federal Funds – Ryan White	105,179	79,141	-$26,038
Reimbursements-Medicaid Waiver	66,339	66,339	-
Total	**$435,676**	**$389,289**	**-$46,387**

Two issues impacting the ADAP program are:

a. **ADAP and Health Care Reform.** The transition of ADAP clients to Medi-Cal or Covered California as a result of the federal Affordable Care Act (ACA).

b. **Changes to OA-Pre-Existing Condition Insurance Plan (PCIP).** The implications of the transition of the administration of the Pre-Existing Conditions Insurance Plan from the state to the federal government.

ADAP and Health Care Reform. For the most part, the May Revision projects a reduction in expenditures for ADAP a result the movement of ADAP clients to the Low Income Health Program (LIHP) and the movement of ADAP clients to Medi-Cal expansion and Covered California, under implementation of the federal Affordable Care Act (ACA). See following tables for details.

Table: DPH Projection of ADAP Client Transition to Medi-Cal (in millions)

Client Population	Clients	Estimated Savings	Notes
ADAP to LIHP to Medi-Cal Expansion	9,140	$84.3	Assumes 85% of ADAP clients who transition to LIHP prior to December 31, 2013 will transition to Medi-Cal Expansion on January 1, 2014, and the remainder will return to ADAP.
ADAP-only directly to Medi-Cal Expansion	612	$6.0	Assumes approximately 64% (85% of 75%) of ADAP-only clients who are eligible for Medi-Cal Expansion transition to Medi-Cal in 2013-14. Assumes that those who transition will apply on their birth month starting October 2013-June 2014.
OA-PCIP to Medi-Cal Expansion	101	$1.0	Assumes 85% of OA-PCIP clients will transition to Medi-Cal Expansion on January 1, 2014, and the remainder will become ADAP-only clients.
Total	**9,853**	**$91.3**	

Table: DPH Projection of ADAP Client Transition to Covered California (in millions)

Client Population	Clients	Estimated Savings	Notes
ADAP to LIHP to Covered California	225	$2.0	Assumes 85% of ADAP clients who transition to LIHP prior to December 31, 2013 will transition to Covered California on January 1, 2014, and the remainder will return to ADAP.
ADAP-only directly to Covered California	195	$1.5	Assumes 3.4% (85% of 4%) of ADAP-only clients who are eligible for Covered California transition in 2013-14. Assumes that 50% of those who transition will do so as of January 31, 2014, another 25% will transition in February 2014 and the remaining 25% will transition in March 2014.
OA-PCIP to Covered California	159	$1.3	Assumes 85% of OA-PCIP clients will transition to Covered California on January 1, 2014, and the remainder will become ADAP-only clients.
Subtotal	**579**	**$4.8**	
Admin Cost		~$1	Cost for contractor to administer premium payment workload for 2,692 OA-HIPP clients.
Total	**579**	**$4.1**	

Changes to OA-Pre-Existing Condition Insurance Plan (PCIP). OA-PCIP was implemented in November 2011 to pay monthly PCIP premiums. Clients who co-enroll in OA-PCIP and ADAP also receive assistance with drug co-pays and deductibles. OA-PCIP was implemented as a cost-containment measure because it is cheaper to pay monthly insurance premiums and medication co-pays and deductibles than the full-cost of a client's HIV-related medication.

The Managed Risk Medical Insurance Board (MRMIB) has recently been made aware that the federal government does not plan to renew its contract with MRMIB to administer the PCIP program. Consequently, it appears that current PCIP clients would transition to a federally-administered PCIP program. It is likely that the premiums, medication co-pays, and deductibles under the federally-administered program will be higher than under MRMIB's administered PCIP program. Consequently, OA-PCIP expenditures would be higher.

Subcommittee Staff Comment and Recommendation—Adjust expenditures and adopt placeholder trailer bill language. It is recommended to adjust ADAP expenditures to reflect that only 70 percent of ADAP clients (instead of 85 percent) would transition to Medi-Cal or Covered California in the budget year.

As discussed in previous Subcommittee hearings, there is much uncertainty regarding the rate at which individuals would transition to Medi-Cal or Covered California. Given the state's experience with take-up into new health care coverage programs (it took five-years for the Healthy Families Program to achieve its enrollment), it is prudent to ensure that ADAP has expenditure authority to continue to provide assistance.

Additionally, because of this and the uncertainty with OA-PCIP related-costs, it is recommended to adopt placeholder trailer bill language to keep the Legislature informed of any potential risk of the ADAP program's inability to provide services within its appropriation:

> Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to Medi-Cal or other health insurance coverage, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2013 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2013, and ADAP is unable to provide services to eligible ADAP clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

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

1. Please provide an overview of this proposal.

2. Please provide an update on discussions regarding the implications of the transition of the administration of the Pre-Existing Conditions Insurance Plan from the state to the federal government.

2. Licensing and Certification (L&C) – Position Request (DOF Issue 502)

Budget Issue. The May Revision proposes an increase of 21 positions that would be supported with existing budget resources and would assist with the state survey workload.

Additionally, L&C proposes to contract for an organizational assessment of its effectiveness and performance. The assessment would evaluate L&C's resources, workload mandates and performance, workload management processes, organizational culture, and propose opportunities for L&C to implement operational efficiencies and best practices.

Background—CMS Concerns with L&C. On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds."

In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

Subcommittee Staff Comment and Recommendation—Approve. As discussed at the March 14th Subcommittee hearing, concerns have been raised by the federal CMS and consumer advocates indicating that L&C has insufficient staff to address its workload. It is recommended to approve these positions and to request L&C keep the Subcommittee updated on its organizational assessment.

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

1. Please provide an overview of this proposal.

2. Please provide an update on the L&C's efforts to address CMS's concerns.

3. Infant Botulism Program / BabyBIG Program

Issue. In December 2011, the Governor issued and executive order, which directed the Department of Finance (DOF) to modify the budget process to increase efficiency and focus outcomes. In May 2012, DOF selected DPH as one of four state departments to pilot zero-based budgeting (ZBB) for 2013-14. DPH initiated its ZBB efforts in September 2012, focusing on three of its programmatic areas: (1) the Women, Infants and Children (WIC) Division, (2) the BabyBIG program, and (3) DPH contracting functions.

Background—Zero Based Budgeting (ZBB). DPH took a hybrid approach to its ZBB efforts by combining different elements of traditional, performance-based, and zero-based budgeting methods. As a starting point, the ZBB teams used prior year and current year budget information to build a "baseline budget." Each ZBB team also identified performance goals or metrics so it could better link program spending with program outcomes. Finally, the ZBB teams identified the various functions performed in their respective programs and calculated the cost to perform these functions.

Background—BabyBIG. The Infant Botulism Treatment and Prevention Unit (BabyBIG program) was established under Chapter 674, Statutes of 1995, to ensure the production and distribution of the orphan drug BabyBIG, which is a human-derived botulism antitoxin approved by the U.S. Food and Drug Administration (FDA) for the treatment of infant botulism. This orphan drug (i.e., medication for treatment of a rare medical condition) was originally developed by DPH staff, who now work with several contractors to produce, test, and distribute BabyBIG across the country and internationally.

ZBB BabyBIG Findings. The ZBB effort identified the following preliminary findings regarding the BabyBIG program:

- ***Need to Consider Entire Product Cycle Costs*** – The BabyBIG production cycle takes roughly five years from pre-production to post-production activities. During this period, the program's operating costs fluctuate significantly depending on the type of activities performed during the fiscal year. BabyBIG has an annual appropriation which remains largely fixed; any increase or decrease to the program's appropriation requires an approved budget change request. Ideally, the appropriation covers all anticipated costs associated with the expenditures incurred during a peak production year, eliminating the need for ongoing budget change requests.

- ***BabyBIG Expenses Must Be Carefully Monitored*** – Since BabyBIG's production costs fluctuate significantly, but its annual appropriation does not, it is absolutely critical for BabyBIG to carefully monitor spending and stagger costs from one budget cycle to the next.

- ***Pre-Production and Production Costs Have Increased Significantly*** – In the course of their analysis, the BabyBIG ZBB Team determined that the cost to produce Lot 6 will be 83 percent greater than that of Lot 5, which was produced in 2010. Without the ZBB

process, the BabyBIG program would not have been able to explain the reasons why production costs increased or whether these cost increases were justifiable.

- ***The Current BabyBIG Fee Will Not Cover Production Costs*** – In the course of their analysis, the BabyBIG ZBB Team calculated that the current fees cannot cover the cost to produce Lot 6. The department will need to raise its current fee, as the actual cost per treatment is anticipated to increase significantly with the production of Lot 6.

- ***Collection of More Blood Plasma Is Critical*** – The amount of BabyBIG produced is limited by the volume of the raw material (human plasma from vaccinated donors) collected. While there are numerous barriers in identifying and obtaining additional donors, the BabyBIG ZBB team identified some options that can be explored to increase plasma collection.

- ***Demand for BabyBIG May Exceed Vaccine Supply*** – The ZBB Team's analysis of BabyBIG utilization suggests that the amount produced in Lots 5 and 6 may be insufficient to meet BabyBIG demand.

- ***Prevention Efforts Could Be Cost-Effective*** – BabyBIG treatment is expensive; however, treatment with BabyBIG saves money. The BabyBIG ZBB Team's analysis suggests that a relatively small investment in prevention activities could reduce the incidence of infant botulism. Increased program activity to identify and implement effective prevention strategies may be warranted.

ZBB Recommendations – The BabyBIG ZBB Team has the following recommendations:

- ***Strengthen Administrative Support*** – Currently, the BabyBIG program is largely administered by the scientists who developed BabyBIG. These same scientists are responsible for contract negotiation with pharmaceutical firms, budgeting, fiscal forecasting, and trend analysis. The BabyBIG ZBB Team recommends that the program reallocate one of its vacant positions for quality control to focus on program administration, particularly in the area of contract negotiation and execution.

- ***Raise BabyBIG Vaccine Fee*** – BabyBIG should increase its vaccine fee to cover the anticipated cost to produce Lot 6. As a result of its in-depth fiscal analysis, the BabyBIG ZBB Team has determined that implementation of a fee increase in 2013 can be done with a two-phased approach. Specifically, the BabyBIG ZBB Team recommends an initial 20 percent fee increase in 2013, followed by another fee increase once the full cost of Lot 6 production is calculated. This phased approach will help payers adjust to the rising cost and will ensure continuity of product development regardless of external, inflationary costs that CDPH cannot control.

- ***Produce More Blood Plasma*** – The BabyBIG ZBB Team recommends that the BabyBIG program actively take measures to identify ways to collect more blood plasma. The collection of more blood plasma may sharply reduce the average cost per vaccine and will help ensure that supply keeps up with demand.

- ***Monitor Utilization*** – Given the recent spike in BabyBIG utilization, the program must carefully monitor utilization at the statewide, national, and international levels to determine if the increase last year was an anomaly or part of a new trend. This utilization review should be conducted quarterly as part of an internal estimate process.

- ***Develop Criteria and Policies for BabyBIG Distribution*** – Currently, BabyBIG is distributed on a first-come, first-serve basis. Given the risk that Lot 6 may not produce a sufficient supply of BabyBIG vaccine, the BabyBIG ZBB Team recommends that the program identify some criteria or policies to determine how it will distribute BabyBIG. The program may choose to continue its first-come, first-serve policy, but it may also want to investigate other options, including (1) prioritization for domestic use over international use, (2) severity of symptoms, (3) lower dosage, or (4) other considerations.

- ***Increase Prevention Efforts Through Partnerships*** – The BabyBIG ZBB Team recommends that the program collaborate with federally-funded programs like the Maternal Child Adolescent Health (MCAH); Women, Infant & Children, and Nutrition Education & Obesity Prevention (NEOP) programs to identify ways to educate parents on the ways to prevent infant botulism.

- ***Investigate Handling Fee*** – Federal law prevents BabyBIG from charging a higher fee for residents of other states. However, the BabyBIG ZBB Team recommends that the program investigate whether it may charge a handling or distribution fee to other states. In addition, the BabyBIG ZBB Team recommends that the program consider charging a higher fee to international clients. Taking these measures may mitigate the fee increase for California BabyBIG vaccine users.

- ***Consider Continuous Appropriation for BabyBIG*** – The BabyBIG program is unique insofar as it has a lengthy production cycle in which costs from year-to-year fluctuate significantly. In order to better manage and monitor its production costs and prevent the need for BCPs from year-to-year, the BabyBIG ZBB Team recommends that the program consider a continuous budget appropriation, which would allow it to carry forward unspent monies from one fiscal year to the next.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is apparent that the ZBB efforts regarding the BabyBIG program have identified areas for improvement that could facilitate better policies, improve service delivery, and improve public health outcomes. It is important that these preliminary findings and recommendations be acted upon and not “sit on a shelf.”

Consequently, it is recommended to adopt placeholder trailer bill language requiring DPH to submit a plan to the Legislature on how it will address these findings and implement changes, as it is important to ensure that an adequate supply of the vaccine is available to meet demand.

Questions. The Subcommittee has requested DPH respond to the following question.

1. Please provide a brief overview of the ZBB process and the findings and recommendations for the BabyBIG program.

4. Women, Infants, and Children (WIC) Program (DOF Issue 505)

Budget Issue. For the WIC program, the May Revision projects an expenditure decrease of $62 million as a result of Maximum Allowable Departmental Reimbursement (MADR) rate limitations directed by the US Department of Agriculture (USDA) and a net decrease of $80 million in federal funds as a result of the change in the level of final WIC grants to states. Of this reduction, $44.6 million is due to sequestration.

No change in the number of individuals served by WIC is projected as a result of these expenditure and revenue changes.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by local WIC agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 cash register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent more than prices paid to other vendors.

CA WIC submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment on October 3, 2012. It is still working on a final methodology with USDA and plans to incorporate the methodology in the November 2013 estimate for the 2014-15 fiscal year.

In the meantime, USDA has directed MADR limitations to be 15 percent for 1-2 cash register vendors and 11 percent for 3-4 cash register vendors above the average redemption value charged by vendors with five or more cash registers in the same geographic region.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an update on the WIC estimate and adjustments.

2. Please describe the impact of sequestration on WIC.

4260 Department of Health Care Services

1. ACA Implementation Activities Related to Medi-Cal – Position Request (DOF Issue 010)

Budget Issue. The May Revision requests to make 12 existing limited-term positions permanent and to extend nine existing two-year limited-term positions to continue to support the implementation of the ACA.

The annual cost of the 21 requested positions is $2.3 million ($893,000 General Fund and $1.4 million in federal funds).

Background. DHCS is responsible for California's Medicaid program (Medi-Cal), and is responsible for implementing and maintaining new Medicaid program changes relating to the ACA. The requested positions would be responsible for the following ACA-related workload:

- **Medi-Cal Eligibility Expansion and Interactions with Covered California and Other State Departments**
  - Office of Legal Services (1 position) – Review and respond to federal proposed rulemaking, follow federal case law, establish benchmark benefits, develop parity for mental health services, review eligibility statutes and regulations and amend accordingly, establish protocol and procedures for working with Covered California, contract with counties for new eligibility workload, develop necessary interagency agreements, and contract monitoring.
  - Information and Technology Services Division (1 position) – Provide technical analysis and support information technology changes needed to implement the ACA. This includes changes to MEDS and CalHEERS.

- **Enhancements to California Medicaid Management Information Systems (CA-MMIS)**
  - Information Technology Management Branch (3 positions) – Develop business rules and design, develop, and implement CA-MMIS changes required by the ACA.

- **Changes to Medicaid Drug Rebate Provisions**
  - Pharmacy Benefits Division's Policy Branch (3 positions) - Implement ACA-related changes regarding pharmacy benefits.
  - Pharmacy Benefits Division's Drug Rebate Branch (5 positions) – Implement ACA requirement that the state capture claims data and rebates from managed care organizations for drugs provided to Medi-Cal beneficiaries.
  - Capitated Rates Development Division (1 position) – Analyze, monitor, and respond to the financial impacts that the prescription drug rebate program changes have on the capitation rates paid by DHCS to Medi-Cal managed care plans and assist in the development of capitation rates.

- **Program Integrity – Enhanced Provider Screening**
  - Provider Enrollment Division (5 positions) – Implement enhanced provider screening under the program integrity requirements of the ACA.

- **Cross-Cutting ACA Issues Requiring Rates, Regulations, and/or System Changes**
  - Mental Health Services Division (1 position) – Research, establish, and implement California's mental health and substance use disorder essential health benefits; establish enhanced coordination and integration of mental health, substance use, and primary care services; and implement federal parity requirements.
  - Benefits Division (1 position) – Collaborate with other divisions to ensure implementation of ACA provisions, develop State Plan Amendments, convene stakeholder meetings, and serve as the lead with external partners.

DHCS contends that without the positions noted above, it would not be able to implement the ACA. It also states that it cannot redirect existing positions to perform this workload without impacting other high-priority workload.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an overview of this proposal.

2. Withdraw Managed Care Efficiencies Proposal (DOF Issue 216)

Budget Issue. The May Revision proposes to withdraw the proposal to implement $135 million in General Fund savings as a result of managed care efficiencies.

Background. The Governor's January budget included a decrease of $135 million General Fund in the Medi-Cal program as a result of implementing additional efficiencies in managed care. DHCS proposed to look for new ways to improve quality and the efficiency of the health care delivery system and develop payment systems that promote quality of care and improve health outcomes.

The Administration indicated that this proposal did not require statutory authority, but it did not provide details on how this proposal may be implemented.

Subcommittee Staff Comment and Recommendation—Approve withdrawal of proposal. It is recommended to approve the withdrawal of this proposal and make the corresponding adjustments in the budget. As discussed at the May 2nd Subcommittee hearing, it was unclear how the Administration planned to implement this proposal and it was unclear how this proposal would have impacted quality and access to care.

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

1. Please provide an overview of this issue.

3. ACA - Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

Budget Issue. The May Revision includes $2.5 million General Fund savings associated with an increase in the federal funding percentage for Medi-Cal preventive services and adult vaccines as provided under the ACA. The proposed savings only reflect the Medi-Cal fee-for-service delivery system and does not include the Medi-Cal managed care delivery system.

Additionally, the May Revision proposes trailer bill language to exempt preventive services and adult vaccines from copayment or cost sharing, in order to implement these savings. The ACA ensures that cost sharing cannot be required for these services.

Background. Effective January 1, 2013, the ACA established a one percentage point increase in the Federal Medical Assistance Percentages (FMAP) for Medi-Cal for preventative services and adult vaccines in states that meet certain requirements. In order to qualify for the one percentage point FMAP increase for these services, a state must cover all preventative services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Also, states may not impose beneficiary cost-sharing on such services. The increased FMAP would apply to the applicable services in both fee-for-service (FFS) and managed care.

Medi-Cal currently covers all specified preventive services assigned a grade A or B by the USPSTF and approved adult vaccines recommended by the ACIP and does not impose cost-sharing for these services.

DHCS submitted its state plan amendment (SPA) to the federal government at the end of March indicating that it seeks this FMAP increase. If this SPA is approved, the state would be able to claim the enhanced FMAP retroactively back to January 1, 2013.

Prevention services that would be eligible for this increase in FMAP include: breast cancer screening, colorectal cancer screening, depression screening, HIV screening, and osteoporosis screening, and tobacco use counseling.

Subcommittee Staff Comment and Recommendation—Adjust savings and approve placeholder trailer bill language. The May Revision does not account for the savings in Medi-Cal managed care associated with this increase in federal funding percentage. DHCS acknowledges that these savings are not included and indicates that it is working on developing this estimate.

It is recommended to score an additional $10 million in General Fund savings attributable to the increase in federal funds for these services for Medi-Cal managed care plans. Given that about 80 percent of the Medi-Cal caseload is under managed care, these savings generally reflect a corresponding proportion of savings that should be recognized in the budget.

It is also recommended to adopt the placeholder trailer bill language necessary to exempt these services from cost-sharing in order to be eligible for this enhanced federal funding percentage.

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

1. Please provide an overview of this ACA provision and the proposal.

4. Eliminate Sunset Date for Specialty Provider Contracting

Budget Issue. The May Revision proposes trailer bill language to eliminate the sunset date for specialty provider contracting. The elimination of this sunset date achieves ongoing $6.9 million General Fund savings.

Background. AB 1183 (Statutes of 2008) allows DHCS to enter into contracts with providers who distribute and provide care for specialty drugs and services. This law allows DHCS to restrict payment of specialty drugs and services to a limited number of providers. AB 1183 also included an annual reporting requirement after the first and second years after implementation and a sunset provision of July 1, 2013.

According to DHCS, most chain and non-specialty retail pharmacies are unwilling or incapable of providing the drugs currently provided by specialty pharmacy providers. If the specialty provider contracting provisions sunset, beneficiaries in need of blood factor, drugs used for HIV, cancer, hepatitis, inborn errors of metabolism, pulmonary hypertension, transplants, for example, would be forced to obtain these services through utilization of hospital emergency departments, extended stays in acute and sub-acute care settings, or via increased medical interventions in acute care settings. Additionally, DHCS notes that provision of these services in an outpatient pharmacy setting has been demonstrated to be less costly on the national level.

This proposal would remove the July 1, 2013, sunset date and allow DHCS to continue to contract with providers of specialty drugs and services. Also, the proposal would delete the annual reporting requirements which DHCS has already met.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal.

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

1. Please provide an overview of this proposal.

5. Laboratory Rate Methodology Stakeholder Process Extension

Issue. AB 1467 and AB 1494 (2012 budget trailer bills) allowed DHCS to develop a new rate reimbursement methodology for clinical laboratory and laboratory services. The proposed methodology would develop rates that are based on the lowest amounts other payers are paying for similar clinical laboratory services.

Until the implementation of the new methodology, payments for clinical laboratory services would be subject to an additional 10 percent reduction (on top of the 10 percent payment reductions pursuant to AB 97 (2011)). (The Family Planning, Access, Care, and Treatment Program is exempt from the payment reduction specified in AB 1494.)

As required by AB 1467, DHCS has been working with stakeholders on the development of the new rate methodology; however, this process has taken longer than anticipated and the new rate methodology has not yet been approved by the federal CMS.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to extend the time period for which laboratory service providers have to submit data reports specifying their lowest amounts other payers are paying. This is necessary as the process to develop the new rate methodology has taken longer than anticipated. This proposal has no impact on the General Fund savings anticipated with the change in methodology.

DHCS has indicated that it has no concerns with this proposed trailer bill language.

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

1. Please provide an overview of this proposal.

6. Dense Breast Notification – Medi-Cal and Every Woman Counts Program (DOF Issue 211)

Budget Issue. The budget includes a total of $11.9 million General Fund to implement the dense breast notification and supplemental screening required by SB 1538 (Simitian, Statutes of 2012)--$3.6 million for the Medi-Cal program and $8.3 million for the Every Woman Counts (EWC) program.

Background. SB 1538 requires health facilities, administering mammograms to women 40 years and over, to notify patients whose breasts are categorized as being heterogeneously or extremely dense. The notification informs patients that they may benefit from supplementary screening due to the level of dense breast tissue seen on the mammogram.

Data indicates that about 50 percent of women over age 40 have dense breasts. Of this population, DHCS projects that (1) 50 percent would request a supplementary screening test and (2) 100 percent would require case management services under the EWC program.

Subcommittee Staff Comment and Recommendation—Adjust expenditures. DHCS's assumptions regarding the number of women who would request a supplementary screening test and require EWC case management services are high. For example, Connecticut is the only other state that requires similar dense breast notification. In its first year of implementation, according to a study by the Yale Cancer Center, only 20 percent of women who received the notification requested a supplementary screening.

Additionally, EWC case management services would only be necessary for women who receive a positive screen on their supplementary screening test and not for all women who receive a supplementary screening, as projected by DHCS. Data suggests that only 10 to 15 percent of women who obtain a supplementary screening test receive a positive screen.

Consequently, it is recommended to adjust these program budgets to reflect that only 30 percent of women who receive a dense breast notification obtain a secondary screening and only 10 percent of this population (for the EWC program) requires case management services. This results in about a $5 million General Fund savings.

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

1. Please provide an overview of this proposal.

7. Integration of Medi-Cal Managed Care Screenings and Referrals into EPSDT Performance Outcome System

Issue. DHCS is in the process of developing a performance outcome system for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program mental health services for children, as required by SB 1009 (a 2012 budget trailer bill). As currently designed, this performance outcome system is focusing on the Medi-Cal specialty mental health services provided by the counties.

As discussed at the April 18th Subcommittee hearing, the measuring and evaluating of Medi-Cal managed care plan screenings for mental disorders and referrals (to Medi-Cal fee-for-service providers and county mental health plans) has not been incorporated into the EPSDT performance outcome system.

DHCS has indicated that it agrees that screening and assessments of children and youth for mental health needs is critical and that it is looking at how it can strengthen managed care plans' screenings of children for these needs as well as their referrals for these services.

Background—EPSDT. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's (Medi-Cal in California) comprehensive preventive child health service designed to assure the availability and accessibility of health care services and to assist eligible individuals and their families to effectively use their health care resources.

The EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams), as defined by statute. One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development. Early detection of mental health and substance use issues is important in the overall health of a child and may reduce or eliminate the effects of a condition if diagnosed and treated early. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service.

On March 27, 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin to help inform states about resources available to help them meet the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services.

Background—EPSDT Performance Outcome System. SB 1009 (a 2012 budget trailer bill) requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to

create a plan for a performance outcome system for EPSDT program mental health services for children.

SB 1009 also requires that by no later than September 1, 2012, a stakeholder advisory committee shall be convened for the purpose of developing this plan and requires DHCS to provide a plan, including milestones and timelines for EPSDT mental health outcomes by no later than October 1, 2013.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to incorporate the measuring and evaluating of Medi-Cal managed care plans screenings for mental health needs and their referrals for these services (to both Medi-Cal fee-for-service providers and county mental health plans) into the EPSDT performance outcome system. This effort would be informed by stakeholders and a plan for the incorporation of these factors into the outcome system would be due to the Legislature by October 1, 2014.

Understanding how children are screened and access mental health care is fundamental to understanding how well EPSDT benefits are provided.

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

1. Please provide an overview of this proposal.

8. Behavioral Health Services Needs Assessment and Services Plan

Issue. Concerns have been raised that the process DHCS is using to develop its Behavioral Health Services Plan has not been transparent. Stakeholder involvement is important to ensure that this plan has meaning and accounts for variations across counties.

Background. The state's Medi-Cal Section 1115 "Bridge to Reform" Waiver Special Terms and Conditions requires the state to complete a Behavioral Health Services Needs Assessment that includes an accounting of the services available throughout the state, as well as information on service infrastructure, capacity, utilization patterns, and other information necessary to determine the current state of behavioral health service delivery in California. (Behavioral health includes mental health and substance use disorder services.)

The waiver special terms and conditions also require the completion of a Behavioral Health Services Plan, no later than October 1, 2012. This service plan will describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the state's readiness to meet the projected mental health and substance use disorder needs.

Behavioral Health Services Needs Assessment. DHCS contracted out to conduct a Mental Health and Substance Use System Needs Assessment. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform.

The Needs Assessment was completed in February 2012.

Behavioral Health Services Plan. The Needs Assessment was to facilitate DHCS's development of a Behavioral Health Services Plan. The Services Plan would describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. The Services Plan was due to the federal CMS on October 1, 2012. However, since federal guidance on the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity was not available in October 2012, the state and CMS agreed that the state could submit an outline of the Services Plan in October 2012 and that the state would have until April 1, 2013 to submit the Services Plan.

On April 1, 2013, DHCS submitted a letter to CMS and a draft Medicaid Alternative Benefit Plan Options Analysis prepared by Mercer. This Options Analysis was developed on behalf of DHCS to provide information on the Medicaid expansion benefit options. DHCS has not been able to complete the Services Plan because a decision on the Medicaid benefit package and delivery system has not been made.

DHCS has indicated that it will submit the final Service Plan to CMS by October 1, 2013.

Subcommittee Staff Comment—Adopt placeholder trailer bill language. It is recommended to adopt the following placeholder trailer bill language to require the Administration to consult with stakeholders prior to the submittal of the Behavioral Health Services Plan to the federal CMS:

> Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by the Section 1115 Bridge to Reform Demonstration Special Terms and Conditions paragraph 25.d.

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

1. Please provide an update on the development of the Behavioral Health Services Plan.