SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 23, 2013

Upon Adjournment of Appropriations Committee

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

Agenda Part 2
(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

4150 Department of Managed Health Care

1. Coordinated Care Initiative

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.

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

4260 Department of Health Care Services

1. Medi-Cal Coverage of County Medical Parole and Compassionate Release

Budget Issue. DHCS requests one permanent position to implement SB 1462 (Leno, Statutes of 2012), which provides Medi-Cal to eligible county inmates on medical parole and inmates granted compassionate release. The annual cost for this position is $103,000 total funds ($51,000 reimbursement from counties, and $52,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve and adopt placeholder trailer bill language. It is recommended to approve the position and adopt placeholder trailer bill language to ensure the cost neutrality (i.e., no General Fund impact) of SB 1462.

This issue was heard on May 9, 2013.

2. Non-Designated Public Hospital Program – Position Request

Budget Issue. DHCS requests permanent expenditure authority and the conversion of six limited-term 1115 Bridge to Reform Waiver positions to permanent to implement and maintain the new Non-Designated Public Hospital (NDPH) program, implemented as part of the 2012 budget. The six positions requested are existing limited-term positions that were originally approved to work on the 1115 Bridge to Reform Waiver. The cost of these positions is $827,000 ($414,000 General Fund and $413,000 federal funds).

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this request since the Administration is not proceeding with changes to the NDPH program because federal CMS approval was not obtained (this issue is discussed in more detail later in the agenda). This position request was heard on May 2, 2013.

3. Eliminate Physician and Clinic Seven Visit Cap

Budget Issue. The Administration has indicated that it is withdrawing its state plan amendment (SPA) that caps the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary, at seven per year, as it became apparent that the federal CMS would not approve this SPA. It made the decision to withdraw the SPA after the May Revision.

Background. AB 97 (a 2011 budget trailer bill) capped the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary, at seven per year. The cap on the number of physician and clinic visits is for adults, 21 years of age or older, that do not meet the statutory exemptions or exceptions criteria.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to remove this cap in statute since it would not be approved by the federal CMS.

4. Eliminate Contractor Costs to Survey Drug Price Information

Budget Issue. The May Revision includes $500,000 General Fund to hire a contractor to survey drug price information from Medi-Cal pharmacy providers and update maximum allowable ingredient costs and average acquisition costs on an ongoing basis. AB 102 (a 2011 budget trailer bill) authorizes DHCS to develop a reimbursement methodology for drugs based on a new benchmark. To assist in developing this benchmark, DHCS had anticipated hiring a contractor to conduct surveys.

On May 15th, DHCS notified stakeholders that it has placed on hold the procurement for an average acquisition cost study vendor while it awaits and considers further federal CMS guidance regarding national pricing benchmarks.

Subcommittee Staff Comment and Recommendation—Reduce "Other Administration" expenditures by $500,000 General Fund. Since the state has put the procurement for a survey on hold, it is recommended to reduce DHCS's other administration expenditures by $500,000.

5. 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—Approve.

4560 Mental Health Services Oversight and Accountability Commission

1. Guidelines for Prevention and Early Intervention Projects

Issue. The Mental Health Services Oversight and Accountability Commission (OAC) is responsible for developing guidelines for prevention and early intervention (PEI) projects.

AB 1467 (a 2012 budget trailer bill) implemented changes to the Mental Health Services Act (MHSA, Proposition 63) and gave the Department of Health Care Services authority to issue

regulations regarding the MHSA. This is technical clean-up language regarding last year's trailer bill that transferred and consolidated community mental health.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to clarify the responsibility of OAC regarding PEI guidelines.

ISSUES FOR DISCUSSION

4260 Department of Health Care Services

1. Medi-Cal Baseline Caseload and Budget – May Revision Update

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

Governor's May Revision. The May Revision proposes total expenditures of $69.2 billion ($16.1 billion General Fund) for 2013-14 which represents *an increase* of $9.4 billion (total funds), or 15.7 percent more than the current-year.

Medi-Cal caseload is projected to be 9,117,000, which represents a 15.5 percent increase compared to current year (and reflects the Administration's assumptions on take-up regarding Medi-Cal expansion).

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

	2012-13 Revised	2013-14 Proposed	Difference	Percent
Benefits	$55,901.3	$64,829.5	$8,928.2	16%
County Administration (Eligibility)	3,564.4	3,976.9	412.5	11.6%
Fiscal Intermediaries (Claims Processing)	312.7	355.7	43.3	13.8%
Total-Local Assistance	**$59,778.4**	**$69,162.1**	**$9,383.7**	**15.7%**
General Fund	$15,251.1	$16,072.3	$821.1	5.4%
Federal Funds	$35,918.0	$42,325.4	$6,407.4	17.8%
Other Funds	$8,609.3	$10,764.3	$2,155.0	25.0%

LAO Comment. Based on its review of recent caseload data, the LAO finds that the Administration's revised estimates of Medi-Cal caseload, which are unrelated to the federal Affordable Care Act, are reasonable.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve adjustments in caseload and budget, with any changes to technically conform as appropriate to other actions that have been or will be taken.

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

1. Please provide a high-level overview of the changes to the Medi-Cal budget from the January budget.

2. ACA – "Optional" Medi-Cal Expansion

Special Legislative Session on Health Care Reform. The Legislature has special session bills SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) that implement the expansion of Medi-Cal coverage in California to low-income adults with incomes between 0 and 138 percent of the federal poverty level (FPL), establishes the Medi-Cal benefit package for this expansion population, and requires the existing Medi-Cal program to cover the essential health benefits (EHB) contained in the federal Affordable Care Act (ACA). Additionally, these bills implement a number of Medi-Cal ACA provisions to simplify the eligibility, enrollment, and renewal processes for Medi-Cal. (SBX1 1 and ABX1 1 are identical bills.)

Budget Issue. In the May Revision, the Administration has finally made a proposal regarding the "optional" Medi-Cal expansion for newly eligible childless adults, with incomes up to 138 percent of the federal poverty level, as provided under the federal Affordable Care Act (ACA):

- **State-Based Expansion.** The Governor has concurred with the Legislature (as specified in SBX1 1 and ABX1 1) to implement this expansion on a statewide-basis. The Governor's January budget proposed two-options, a state-based option and a county-based option.

- **Benefit Package.** The Administration proposes that Medi-Cal benefit package for these newly eligible individuals would be the same as the current Medi-Cal benefit package, including county-administered specialty mental health services and county-supported substance use disorder services.

  Long-term care services would be covered, provided that the federal government approves the retention of an asset test for these services. At a county's option, existing enrollees and newly eligible individuals could receive an enhanced benefit package for substance use disorders.

  In contrast, SBX1 1 and ABX1 1 provide a more comprehensive benefit package in that these bills propose that the Medi-Cal benefit package cover the EHB contained in the ACA. For example, SBX1 1 and ABX1 1 provide enhanced substance use disorder services as part Medi-Cal. Whereas, the Administration's proposal allows counties to provide enhanced substance use disorder and could lead to county differences in these services.

- **Mechanism to Capture County Savings.** The May Revision estimates that counties would save $300 million in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 as individuals who were previously uninsured would gain health coverage through Medi-Cal expansion or through health coverage available through Covered California (California's Health Benefit Exchange).

  The Administration indicates that these are only estimates and it proposes that a mechanism be developed to determine the level of county savings based on *actual*

experience. These savings would be withheld from counties health realignment funding and would be "trued-up" once actual data became available. This mechanism is discussed in more detail below.

- **County Savings on Indigent Care Redirected to Support Human Services Programs at the Local Level.** The May Revision proposes to redirect the previously specified county savings on indigent care to support human services programs at the local level. These programs include CalWORKs, CalWORKs-related child care programs, and CalFresh (formerly Food Stamps). This issue was discussed at the Subcommittee hearing on May 20th.

- **Pregnant Women Shift to Covered California.** The May Revision includes a decrease of $26.4 million General Fund in 2013-14 to reflect that pregnant women with incomes between 100 percent and 200 percent of the federal poverty level, who are currently eligible for Medi-Cal, would instead receive health coverage through Covered California, beginning in 2014.

  The May Revision proposes for the state to cover all cost sharing not covered by the federal advance premium tax credits and any Medi-Cal benefits that are not provided under the coverage obtained via Covered California.

- **Newly Qualified Immigrants Shift to Covered California.** The May Revision includes a decrease of $5.4 million General Fund in 2013-14 to reflect that individuals, who would otherwise have been eligible under Medi-Cal as newly qualified immigrants, would instead receive coverage through Covered California, beginning in 2014.

  The May Revision proposes for the state to cover all cost sharing not covered by the federal advance premium tax credits and any Medi-Cal benefits offered under the expansion benefit package that are not provided under the coverage obtained via Covered California.

- **County Administrative Costs.** The May Revision includes an increase of $71.9 million in 2013-14 for increased county costs to implement the ACA. This includes additional resources to process new applications and redeterminations, develop training materials, train county eligibility workers, and support planning and implementation activities. The Administration proposes to base future appropriations on a time study of resource needs, beginning in 2015-16. This item will be discussed in more detail later in the agenda.

The cost to implement this expansion is $1.5 billion ($21 million General Fund and $1.5 billion federal funds) in 2013-14. Under the ACA, the federal government will pay for 100 percent of the costs for this population for the first three years (2014-2016), with funding gradually decreasing to 90 percent in 2020.

Mechanism to Determine County Savings. The Administration proposes to establish a single mechanism to determine the level of county savings resulting from implementation of the ACA that is based on actual experience.

This mechanism will determine savings on a county by county basis. Each county's savings will be determined by measuring actual county costs for providing Medi-Cal and uninsured services and the revenues received for such services, including federal funds, as well as an established baseline of health realignment and other county contribution to health services. To the extent that the combination of revenues for services and realignment/county contribution exceeds the county's costs, the amount of that excess will be considered savings and will be redirected to human services programs.

Additionally, given the cost-basis of this mechanism, the Administration proposes to include appropriate incentives for cost containment and maximizing enrollment into coverage for counties. Therefore a cap on cost growth will be included in the determination of county costs used in this calculation; this cap will be based on historical county cost trends.

The intention of this mechanism is that the counties maintain funding for services to the uninsured at today's level of service and reimbursement, since other support for the safety net will be provided through the coverage expansion at the state level.

Finally, it is proposed that this mechanism be time-limited until such point that stability has occurred with respect to the shifting health care costs and responsibilities between the counties and the state at which time the shift of county fiscal and programmatic responsibility for human services will be finalized. The Administration estimates that this could be in eight to ten years.

Maintaining County Safety Net. The Administration acknowledges that the state has an interest in maintaining a strong public safety net to ensure access to health care services, particularly in the Medi-Cal program. As a part of the optional Medi-Cal expansion, the Administration indicates that it will work with the county safety net in an effort to ensure that those providers have a viable patient base of beneficiaries as well as adequate rates for services provided to that population. In addition, the Administration has committed to maximizing federal funding through the development and procurement of a future Medicaid Waiver to replace the existing Waiver that expires in 2015.

Subcommittee Staff Comment and Recommendation—Hold open. It is recommended to hold this item open. Significant concerns have been raised by various stakeholders regarding this proposal and the withholding of $300 million in county realignment funds in the budget year.

Counties and other stakeholders contend that there are too many unknowns in regards to how individuals might receive coverage and counties need to maintain adequate funding for ongoing indigent care, public health responsibilities, and infrastructure development.

Additionally, concerns have been raised that the proposed mechanism treats all counties in the same manner regardless of if they have a public hospital (12 counties), are a County Medical Services Program (CMSP) county (35 counties), or provide indigent care under a different system (11 counties).

This proposal is unclear and there are many unanswered questions. No data has been provided to support withholding $300 million in county indigent care realignment funding in the budget year. Additionally, trailer bill language to implement this proposal has not yet been received.

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

1. Please provide an overview of this proposal.

2. What is the timeline for finalizing the details of this mechanism?

3. What is the basis of the $300 million in county savings on indigent care?

3. ACA – MAGI Income Conversion – State True-Up on General Fund Savings

Issue. The state is currently developing its modified adjusted gross (MAGI) income conversion standard. This standard will define what Medi-Cal population would be eligible for claiming enhanced federal funding (100 percent starting in 2014 for three years and decreasing to 90 percent in 2020).

It is anticipated that certain currently eligible individuals (in the parent/caretaker relative eligibility category) could be eligible for claiming of enhanced federal funding depending on where the income conversion standard is set, and; consequently, the state could achieve General Fund savings as federal funds cover a higher percentage of these costs.

Background—MAGI Conversion Standard. The Affordable Care Act (ACA) changes the way income will be counted for determining Medi-Cal eligibility. Historically, states have calculated eligibility using net income standards incorporating various disregards. Disregards vary by state, eligibility category, and income source. For example, when counting income for parents and children, states typically disregard $90 of earnings per worker in a household and disregard at least $50 in child support payments received.

In addition to income disregards, states may also deduct certain expenses from counted income and may augment these deductions. In the case of determining eligibility for parents and children, states commonly deduct between $175 and $200 of monthly child care expenses (based on the age of the child) from counted income.

After 2014, states will assess eligibility using MAGI for most populations, and current state-specific disregards will be replaced by a general disregard of five percent of the current federal poverty level (FPL) for the applicable family size.

The transition to MAGI involves converting current net income eligibility standards to MAGI standards. Federal guidance sets out two options for a state to use a standardized MAGI conversion methodology (1) a federal methodology using state-adjusted data or (2) a state-developed alternative methodology that must be approved by CMS.

As explained in CMS guidance, the primary objective in establishing a methodology to convert from the current net income standard and eligibility group to the converted MAGI standard and eligibility group is to produce no change in aggregate eligibility, though some individuals will likely gain or lose eligibility, or move from one eligibility group to another. The conversion process should not systematically increase or decrease eligibility overall.

Implications of MAGI Conversion Standard. The MAGI conversion standard will define the "entry point" to where the state can claim enhanced federal financial participation (100 percent starting in 2014) for the newly eligible individuals. Importantly, the state may be able to set the MAGI conversion standard at a level that could allow the state to claim enhanced federal funding (100 percent) for certain currently eligible parent/caretaker relatives.

Consequently, the state would receive enhanced federal funding (100 percent) for this already eligible population.

This conversion level would be effective January 1, 2014 and would immediately be applied to the state's claiming for federal financial participation.

Develop State True-Up Mechanism to Keep General Fund Savings in Health Programs. It is estimated that there are over a million individuals eligible under the parent/caretaker relative category.

If a portion of these individuals exceed the MAGI conversion standard and are eligible for enhanced federal funding the state could achieve hundreds of millions of dollars in General Fund savings as federal funds cover a greater share of the Medi-Cal costs for these individuals.

It is critical that the Legislature maintain oversight of the implications of this conversion standard and direct the resulting state savings to health, mental health, and substance use disorder services.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is too soon to tell at what level California's MAGI conversion standard will be set. However, it is likely that it would be set at a level that would include some individuals (in the parent/caretaker relative eligibility category) that are currently receiving Medi-Cal.

It is recommended to adopt placeholder trailer bill language to require the Administration to develop a "true-up" mechanism to identify the General Fund savings as a result of the state receiving an enhanced federal matching rate for currently enrolled individuals that exceed the MAGI conversion standard. This language would direct the General Fund savings to be used to invest in health, mental health, and substance use disorder services.

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

1. Please provide an overview of this proposal.

2. When does the Administration plan to submit its proposed MAGI conversion standard methodology to CMS?

4. ACA – County Eligibility Processing Costs

Budget Issue. The budget includes three components (for a total of about $100 million General Fund) to address the increased county costs as a result of the ACA-related workload at county human services departments:

1. The May Revision includes an increase of $143.8 million ($71.9 million General Fund) in 2013-14 for increased county costs to implement the ACA. This includes $65 million to process new applications and redeterminations, $4 million to develop training materials, train county eligibility workers, and $2.9 million support planning and implementation activities. The Administration proposes to base future appropriations on a time study of resource needs, beginning in 2015-16.

2. A $30.8 million ($15.4 million General Fund) cost of doing business increase for county staff who perform tasks as part of the Medi-Cal Eligibility process.

3. The ability to rollover unspent funding from the current year. It is estimated that $15 to $35 million General Fund might be available from the current year for the budget year.

Background. The state delegates various administrative functions to counties, such as intake and eligibility determinations of new Medi-Cal applications and ongoing eligibility case management activities. Generally, the state allocates funds to counties based on expected workload and costs.

County human services departments will play an important role in ensuring the successful implementation of health care reform. Starting in October, these departments will begin early enrollment of individuals and families into the new Medi-Cal expansion program as well as the coverage offered under Covered California. Counties anticipate receiving walk-in traffic at county offices throughout the state, as well as an increase in direct phone calls and applications through our online systems. Additionally, 32 counties will be receiving calls transferred from the main Covered California service center when the caller is identified as likely Medi-Cal eligible. The goal of all of these efforts is to maximize customer-friendly service and provide real-time enrollment decisions to as many applicants as possible.

LAO Findings. The LAO has expressed concerns regarding the proposed increase in funding for county eligibility processing given the uncertainty of how the simplification of the eligibility determination process (as required by the ACA) might reduce the average cost per enrollee across the entire Medi-Cal population. Additionally, the LAO notes that the Administration has provided very little detail to support these proposals.

Subcommittee Staff Comment and Recommendation—Modify. Concerns have been raised that county human services departments need additional funding, beyond what is proposed in the May Revision, to ensure a successful implementation of the ACA and to meet performance requirements for processing Medi-Cal applications.

The County Welfare Directors Association (CWDA) conducted its own cost analysis related to ACA implementation and believes that counties will need $120 million in order to implement the ACA efficiently and in a timely manner. Therefore, although CWDA supports the May Revision, they also believe that an additional approximate $20 million will be necessary for counties. In order to achieve this additional $20 million, CWDA request a one-time rollover of potential unspent funds from the current year CalWORKs single allocation, up to a maximum of $120 million General Fund, to county administration.

Counties have not received a cost-of-living adjustment for five years. They are key partners in ensuring the successful implementation of the ACA and the enrollment of millions of new individuals into Medi-Cal.

Consequently, it is recommended to do the following:

- **Approve** the proposed May Revision increases specified above for county administrative costs associated with the implementation of the ACA.

- **Adopt budget bill language** to allow a one-time rollover of potential unspent funds from the current year CalWORKs single allocation to county administration, up to a maximum of $120 million General Fund from all county administration proposals discussed in this item

- **Adopt uncodified placeholder trailer bill language** requiring the Department of Social Services to work together with counties, advocates for clients, and Legislative staff to ensure that there is no unintended impact of this action on clients' access to employment services or child care.

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

1. Please provide an overview of this proposal.

5. Managed Care Organization Tax

Budget Issue. The May Revision proposes a permanent reauthorization the managed care organization (MCO) tax, a tax on Medi-Cal managed care plans:

- In 2012-13, the tax rate would be equal to the gross premiums tax (2.35 percent) to generate $128.1 million General Fund savings. The current year revenues would be directed to the Healthy Families Program. The proposed trailer bill language also provides for a General Fund loan to the Managed Risk Medical Insurance Board to cover the costs of the Healthy Families Program until MCO tax revenue is received.

- In 2013-14, and beyond, the rate would be equal to the state sales and use tax rate (3.9375 percent) and would generate about $342.9 million in General Fund savings on an ongoing basis.

  In the budget year, it is projected that the MCO tax would generate $644 million in revenue. Half of these funds would be used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans. And the other half of these funds would be used to offset General Fund expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles.

Subcommittee Staff Comment and Recommendation—Hold open. It is recommended to hold this item open. Subcommittee staff and health plans have requested more information regarding managed care plan rates that has not yet been received.

Additionally, as has been previously been discussed in Subcommittee, a permanent extension of this tax does makes is it difficult to periodically evaluate its effectiveness and its impact on Medi-Cal managed care.

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

1. Please provide an overview of this proposal.

6. Coordinated Care Initiative

Budget Issue. The May Revision proposes changes to the Coordinated Care Initiative (CCI) resulting in $119.6 million General Fund savings in 2013-14. See table on following page for a summary of CCI savings.

The May Revision proposes the following changes to CCI:

- Delay the CCI start date from October 1, 2013 to no sooner than January 1, 2014.
- Implement a scheduled phasing-in of CCI enrollment. Los Angeles County would phase-in beneficiaries over 12 months (subject to discussions with the federal government). San Mateo County would enroll all beneficiaries over three months. Orange, San Diego, San Bernardino, Riverside, Alameda, and Santa Clara counties would phase-in over 12 months.
- Reflect a revised number of enrollees estimated at 456,000, which is almost half the size of the number of enrollees estimated in the 2012 budget. This includes a cap of no more than 200,000 participants in Los Angeles County.

The Administration indicates that trailer bill language regarding these changes (and potentially others) is forthcoming.

Background. The Coordinated Care Initiative (CCI) integrates medical, behavioral health, and long-term support and services for individuals who are eligible for both Medi-Cal and Medicare (dual eligibles) through a single health plan. The CCI also enrolls dual eligibles in managed care plans for their Medi-Cal benefits. The CCI is a demonstration project in eight counties. The state and federal government entered into a Memorandum of Understanding (MOU) regarding the CCI on March 27, 2013.

Table: Summary of Projected Coordinated Care Initiative Savings

	2013-14		2014-15 (8 counties)		Annual (8 counties)	
(Whole Dollars)	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
SAVINGS						
Dual Medi-Cal Savings	159,740,728	79,870,364	192,945,500	96,472,750	-164,384,129	-82,192,065
Non Duals Medi-Cal Savings	275,681,883	137,840,942	-626,130	-313,065	-122,678,606	-61,339,303
Total	**435,422,612**	**217,711,306**	**192,319,371**	**96,159,685**	**-287,062,735**	**-143,531,367**
Payment Deferrals						
Defer Managed Care Payment	-437,827,767	-218,913,884	-304,870,977	-152,435,489	0	0
Delay 1 Checkwrite	39,640,925	19,820,463	92,640,370	46,320,185	0	0
Revenue						
Increased MCO Tax from CCI Population	-25,594,590	-25,594,590	-109,388,744	-109,388,744	-160,241,144	-160,241,144
Incremental Increase from shifting to MCO Tax at Sales Tax Rate	-115,180,445	-115,180,445	-124,394,881	-124,394,881	-219,811,908	-219,811,908
Savings Sub-Total	**-103,539,266**	**-122,157,151**	**-253,694,861**	**-243,739,243**	**-667,115,787**	**-523,584,419**
COSTS						
Increased DHCS Costs						
Administrative Costs	5,172,000	2,542,500	5,172,000	2,542,500	5,172,000	2,542,500
Costs Sub-Total	**5,172,000**	**2,542,500**	**5,172,000**	**2,542,500**	**5,172,000**	**2,542,500**
Net Impact to CA - Costs (Savings)	**-98,367,266**	**-119,614,651**	**-248,522,861**	**-241,196,743**	**-661,943,787**	**-521,041,919**

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- **Adopt revised savings.** It is recommended to adopt the revised CCI savings.

- **Take no action on proposed trailer bill language.** Trailer bill language regarding this proposal has not yet been received. Consequently, since CCI has been delayed until no sooner than January 1, 2014, it is recommended that these changes be worked out via policy bill.

- **Adopt placeholder trailer bill language** regarding the extension of certain Medicare contracts (MIPPA/D-SNP/FIDE-SNP) with the federal CMS. Since the CCI implementation date has been delayed until at least January 1, 2014, it is important to maintain continuity of care for these dual eligibles. If these Medicare contracts are not extended then dual eligibles covered by these Medicare plans may have their care interrupted. Since these contracts must be extended by June 30, 2013, it is recommended to adopt placeholder trailer bill language.

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

1. Please provide an overview of the proposed changes to CCI.

2. Please discuss the revised CCI savings.

7. Healthy Families Program Transition to Medi-Cal

Budget Issue. As has been discussed in previous Subcommittee hearings, the state is in the process of transitioning children in the Healthy Families Program to Medi-Cal. The table below reflects the May Revision projected savings from this transition.

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

	2012-13 Revised	2013-14 Estimate	Ongoing
General Fund	$2,733	-$38,907	-$33,306
Federal Funds	$2,102	-$74,434	-$64,032
Total Funds	**$4,434**	**-$113,342**	**-$97,338**

The Administration is in the process of planning for phases 3 and 4 of this transition:

- **Phase 3** - Begins no sooner than August 1, 2013 and transitions about 111,000 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 40,000 children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.

Phase 3 Network Assessments Not Complete. As part of the transition, the Administration is required by AB 1476 (a budget trailer bill) to provide an implementation plan and network adequacy assessment in advance of a phase. On May 1st, the Phase 3 Implementation Plan and Network Adequacy Assessment Report were submitted to the Legislature. Among the key findings from the network adequacy assessment report are that of the 23 counties (included in the report) that would be transitioning in Phase 3:

- 11 counties require follow-up network adequacy assessments
- 7 counties still are working on subcontracting with a health plan. If this subcontract does not occur, additional follow-up would be necessary.
- 5 counties require no additional follow-up as the departments have deemed the Medi-Cal networks adequate

DHCS and the Department of Managed Health Care (DMHC) indicate that follow-up information is expected from the plans by early June and that DMHC would likely develop an addendum to this assessment prior to the transition.

Phase 4 Interaction with Rural Managed Care Expansion. Phase 4 of this transition is targeted to occur on the same date as Medi-Cal managed care is expanded in 28 counties. The rural managed care expansion was delayed from June 2013 to September 2013. The

delay was necessary to allow for all readiness activities to be completed, including the each health plans development of a sufficient provider network.

Subcommittee Staff Comment and Recommendation—Approve updated fiscal estimates. It is recommended to approve the updated estimates regarding the transition.

There is greater potential for interruptions in care for phases 3 and 4 of this transition. This is because the level of plan and provider overlap decreases in these phases. Since there is great uncertainty regarding the networks in phases 3 and 4 as Administration has not yet been able to confirm the adequacy of plan networks in 11 of the 23 counties transitioning in Phase 3 and expansion of rural managed care has already been delayed, it is important the Administration proceed cautiously in the final phases of this transition.

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

1. Please provide an update on the planning for Phases 3 and 4 of this transition.

2. Since the April Subcommittee hearing on this transition, how has the Administration worked with providers to educate them about this transition? What more needs to be done?

8. Add Applied Behavioral Analysis (ABA) Services to Medi-Cal Managed Care

Issue. In the fall of 2012 during the planning for the Healthy Families Program (HFP) transition to Medi-Cal, questions about the provision of Applied Behavioral Analysis (ABA) services in Medi-Cal for children with autism were raised.

Stakeholders requested specific information regarding the differences in services provided by HFP and Medi-Cal in order to identify issues prior to any transition and plan for their remedy. Senator Steinberg sent a letter to the California Health and Human Services Agency on November 29, 2012 requesting this specific information. However, the Administration did not respond to Senator Steinberg and did not provide stakeholders a clear representation for how the eligibility for this service differed between HFP and Medi-Cal.

On April 1, 2013 as HFP children in some counties were transitioned to Medi-Cal, families were given very short notice that their children would no longer be able to access ABA services once enrolled into a Medi-Cal managed care plan. This was in spite of months of awareness of this concern and clear feedback from consumer advocates that there was still confusion about this issue. Since April, it appears that DHCS may have addressed this on a case-by-case basis, but a thoughtful, systematic, and planned approach has not occurred.

Background. Pursuant to AB 88 (Thomson, Statutes of 1999) and SB 946 (Steinberg, Statutes of 2011), commercial insurance plans including HFP were required to pay for behavioral services (e.g., ABA) while health plans contracted with Medi-Cal were exempt from these provisions. Consequently, Medi-Cal does not currently have a set of services designated as "ABA." Currently, Medi-Cal pays for behavioral services for children under the Department of Developmental Services' Home and Community Based waiver provided through the regional centers. Not all HFP children receiving behavioral services qualify for these services in the regional centers because of eligibility and medical necessity criteria.

ABA is an intensive behavioral intervention therapy which is designed to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Subcommittee Staff Comment and Recommendation—Add ABA services to Medi-Cal managed care for children. It is recommended to augment the Medi-Cal budget by $50 million General Fund and adopt placeholder trailer bill language to add ABA services to Medi-Cal managed care for children ineligible for regional center services. This funding is intended for the budget year as a short-term solution to ensure that services are maintained from July through June 30, 2014. This is necessary to ensure that these services are appropriately continued during the transitions and changes to Medi-Cal under federal health care reform so as to not impact families (again) as transitions occur.

As specified in AB 1494 (a 2012 budget trailer bill), the Legislature intended for no disruptions in services for children transitioning from HFP to Medi-Cal and required that implementation

plans to be developed to ensure continuity of care. This did not occur as ABA services were disrupted.

In the long-term, SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) propose to make the current Medi-Cal benefit package for existing enrollees comparable to the Medi-Cal benefit package for the Medi-Cal expansion. Federal law requires that the benefit package for the Medi-Cal expansion include the Essential Health Benefits, which includes behavioral services.

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

1. Please provide an overview of this proposal.

9. Transition of AIM-linked Infants (DOF DHCS Issue 007 and MRMIB Issue 107)

Budget Issue. The May Revision proposes to transfer the AIM-linked infants, born to women whose income is from 250 to 300 percent of the federal poverty level (FPL), from the Managed Risk Medical Insurance Board to DHCS. AIM-linked infants, born to women whose income is up to 250 percent of FPL are transitioning, as described below, as part of the Healthy Families Program transition to Medi-Cal.

Children born to women in the AIM program whose income is up to 300 percent of the FPL are eligible for health, dental, and vision services for the first two years as AIM-linked infants. AIM-linked infants, whose mothers have incomes up to 250 percent of the FPL, are scheduled to transition to Medi-Cal beginning on August 1, 2013. The Administration proposes to transfer the remaining AIM-linked infants between 250 to 300 percent of the FPL to the DHCS on October 1, 2013.

It is important to note that because of ACA maintenance of effort requirements, the state must maintain the AIM program until 2019.

Summary of AIM-Linked Infant Transition. The Administration's plan for the transition of AIM-linked infants has multiple components, this includes:

- AIM-Linked Infants up to 250% FPL in Healthy Families Program Transition Phase 1, 2, and 3 Counties Transition to Medi-Cal August 1, 2013 with Phase 3 Counties.

- AIM-Linked Infants up to 250% FPL in Healthy Families Program Transition Phase 4 counties, will transition to Medi-Cal with Phase 4 on September 1, 2013.

- AIM-Linked Infants between 250-300% of FPL in *ALL* Counties will transition to DHCS on October 1, 2013. MRMIB and DHCS will work collaboratively to draft a Title XXI State Plan Amendment to establish a CHIP program under DHCS for AIM-linked Infants.

Table: Number of AIM-Linked Infants by Income Category

Under 200% FPL	200-250% FPL	251% FPL & Above	Total
2,883	6,649	1,886	11,418

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the placeholder trailer bill language regarding the transition of AIM-linked infants (born to women whose income is from 250 to 300 percent FPL.)

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

1. Please provide an overview of this proposal.

10. Family Planning, Access, Care and Treatment Benefit Changes

Budget Issue. The May Revision proposes to implement benefit changes to the Family Planning, Access, Care and Treatment (FPACT) program. These changes result in $32.6 million ($9.7 million General Fund) savings.

Background. FPACT was established by the Legislature in 1996 to fill a gap in health care for underinsured and uninsured. The objectives of this program are to reduce the rate and cost of unintended pregnancies, increase access to publicly funded family planning for low-income Californians, increase the use of effective contraceptive methods by clients, and promote improved reproductive health.

The Office of Family Planning at DHCS conducts on-going monitoring and utilization management of the FPACT program to evaluate the cost-effectiveness of services and identify opportunities to reduce program costs while maintaining the same quality of care.

According to DHCS, this ongoing monitoring and evaluation indicates that changes to the FPACT benefits should be made. Consequently, DHCS proposes to:

- Reduce chlamydia screening of women over 25 years of age,
- Decrease over-utilization of emergency contraception,
- Adopt a Medi-Cal Preferred List for oral contraceptives,
- Eliminate urine culture, and
- Discontinue brand name anti-fungal drugs.

Additionally, effective July 1, 2013, DHCS plans to eliminate mammograms and pregnancy test only benefit to maintain compliance with Federal rules. See following table for projected savings from these benefit changes.

Table: DHCS Proposed Savings as a Result of FPACT Benefit Changes

Benefit	Federal Matching Rate	Total Savings
Chlamydia Screening	90%	$16,586,000
Emergency Contraception	90%	$5,505,000
Medi-Cal List of Oral Contraceptives	90%	$4,000,000
Urine Culture	50%	$335,000
Brand Name Antifungal Drug	50%	$812,000
Pregnancy Test Only	90%	$325,000
Total Savings		**$32,605,000**

Subcommittee Staff Comment and Recommendation—Reject proposed benefit changes. It is recommended to reject this proposed benefit change to FPACT. DHCS has not provided any documentation to support these recommended benefit changes. Nor has it explained why these benefit changes would be cost effective, particularly given the enhanced federal matching rate.

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

1. Please provide an overview of this proposal.

2. Please discuss the evidence and data supporting DHCS's proposed benefit changes.

11. Federal Grant on Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Suicide Prevention Project (DOF Issue 009)

Budget Issue. The May Revision request an increase in federal authority of $928,000 in the budget year as a result of the state receiving a Garrett Lee Smith Memorial Act Grant from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).

This grant is to be used for the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Suicide Prevention Project. The grant provides $479,000 in fiscal year 2012-13, $449,000 in 2013-14, and $450,000 in 2014-15 for prevention, educational, and training resources in high schools to prevent suicide among LGBTQ youth. Due to startup delays, the 2012-13 funds were unspent. However, the SAMHSA has approved the rollover of these funds to 2013-14 for a combined total of $928,000.

According to DHCS, this grant will allow DHCS to build a system of suicide prevention in high schools in five California counties. The project will promote acceptance of culturally diverse students, particularly LGBTQ youth, increase the capacity of peer and adult gatekeepers to recognize warning signs and risk factors of suicide, and increase knowledge and use of LGBTQ resources specific to this target population. This grant will also increase the number of mental health professionals in California trained to recognize and manage suicide risk among LGBTQ youth.

DHCS will contract with three entities to implement the components of the LGBTQ Youth Suicide Prevention Project. These entities include the Trevor Project, Education Development Center, Inc. (EDC) and the Institute for Social Research (ISR) at the California State University, Sacramento.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. It is important for DHCS to coordinate and keep in communication with other state agencies and programs on these efforts as they complement the Office of Health Equity's work on the California Reducing Disparities Project and the LGBTQ community and the Mental Health Services Act' state level prevention programs.

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

1. Please provide an overview of this proposal.

2. How is DHCS working with other partners, including other state agencies, on maximizing coordination and communication on this important issue?

12. Medi-Cal Specialty Mental Health Services – May Revision Update

Budget Issue. The May Revision includes $1.8 billion federal funds and $33.4 million General Fund) for Medi-Cal Specialty Mental Health Services. See following table for funding summary.

Table: Medi-Cal Specialty Mental Health Services May Revision Summary (in millions)

	2013-14 January Budget		2013-14 May Revision	
	General Fund	**Federal Funds**	**General Fund**	**Federal Funds**
Healthy Families	$0	$17,018	$0	$18,77
Children	$39,261	$1,038	$39,385	$1,116
Adults	-$6,000	$672,441	-$6,000	$750,888
Total	**$33,261**	**$1,728**	**$33,385**	**$1,886**

Caseload. In the May Revision, it is projected that 276,466 adults (an 18 percent increase from the January budget) and 270,897 children (a 10 percent increase from the January budget) will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology).

Background. California provides Medi-Cal "specialty" mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21.

County Mental Health Plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the county. Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2013.

The 2012 budget implemented the 2011 Realignment of Medi-Cal Specialty Mental Health for adults and children.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these revised estimates.

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

1. Please provide an overview of this issue

2. Please highlight key changes to this estimate compared to January.

3. Please comment on the revised (and increased) caseload projections.

13. Drug Medi-Cal – May Revision Update

Budget Issue. The May Revision includes $202.1 million ($92 million federal funds and $110 million local funds) for DMC. Since DMC was realigned in 2011, there is no longer General Fund support for this program. See following table for DMC funding summary.

Table: Drug Medi-Cal Program May Revision Summary (dollars in thousands)

	2013-14		
Service Description	**County Funds**	**Federal Funds**	**Total Funds**
Narcotic Treatment Program	$61,590	$61,501	$123,091
Outpatient Drug Free Treatment Services	$41,704	$23,490	$65,193
Day Care Rehabilitative Services	$9,563	$9,563	$19,126
Perinatal Residential Substance Abuse Services	$718	$718	$1,436
Naltrexone Treatment Services	$0	$0	$0
Annual Rate Adjustment	-$1,939	-$1,654	-$3,593
Drug Medi-Cal Program Cost Settlement	-$1,630	-$1,630	-$3,259
DRUG MEDI-CAL TOTAL	**$110,007**	**$91,988**	**$201,994**

Caseload. The May Revision projects an unduplicated DMC caseload of 63,205 individuals.

Background. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries.

At the time this agenda was prepared, DHCS had not provided unduplicated May Revision DMC caseload information

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these revised estimates.

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

1. Please provide an overview of this issue

2. Please highlight key changes to this estimate compared to January.

14. Non-Designated Public Hospital Program Change in Reimbursement Methodology

Budget Issue. AB 1467 (a 2012 budget trailer bill) changed the non-designated public hospital (NDPH) reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. Additionally, under this change in methodology, DHCS would seek a state plan amendment (SPA) to increase Safety Net Care Pool (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding available to California. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve.

DHCS submitted a SPA to the federal CMS for this proposal; however, CMS has not approved the SPA and has raised major issues regarding the DSRIP component. Consequently, in the May Revision, DHCS proposes that NDPHs continue to receive payments under their current methodology until December 31, 2013 and then transition to a diagnosis related grouping on January 1, 2014. This proposed change results is a loss of $94.4 million General Fund in the current year and $94.4 million General Fund in the budget year.

Background. NDPHs are publicly owned and operated facilities, the majority of which are operated by health care districts. There are approximately 46 NDPHs. Approximately 16 of the NDPHs are designated as Critical Access Hospitals (CAHs) under Medicare. To be designated a CAH, a hospital must be located in a rural area; provide 24-hour emergency services; have an average length of stay for its patients of 96 hours or less; be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital; and have no more than 25 beds.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve DHCS's proposal to withdraw this proposed change in NDPH reimbursement methodology as it appears that CMS is not willing to approve the SPA. The budget should reflect that this methodology would not be incorporated in the budget year.

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

1. Please provide an overview of this proposal.