

# SUBCOMMITTEE #3: Health & Human Services

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Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist  
Senator Bill Emmerson



March 22, 2012

9:30 AM or  
Upon Adjournment of Session

Room 4203  
(John L. Burton Hearing Room)

(Michelle Baass)

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**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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## 4260 Department of Health Care Services

### I. BACKGROUND – Medi-Cal Program

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

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

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

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

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

Most Medi-Cal clients are from households with incomes at or below 100 percent of federal poverty level (\$18,890 annually for a family of three).

**Enrollment.** Estimated Medi-Cal enrollment for the current year is 7.7 million people and for 2012-13 it is 8.3 million people. Medi-Cal provides health insurance coverage to over 20 percent of Californians.

**Summary of Governor’s Budget for 2012-13.** As shown in the table below, the Governor proposes total expenditures of almost \$57.7 billion (\$14.8 billion General Fund, \$34.3 billion federal Title XIX Medicaid funds, and \$8.7 billion in other funds) for Medi-Cal in 2012-13.

This reflects a proposed *increase* of about \$7.5 billion (total funds), or 15 percent, as compared to the revised 2011-12 budget.

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

	<b>2011-12</b>	<b>2012-13</b>	<b>Difference</b>	<b>Percent</b>
	<b>Revised</b>	<b>Proposed</b>		
Benefits	\$46,929.5	\$54,416.2	\$7,486.7	16.0%
County Administration (Eligibility)	2,913.7	3,015.5	101.8	3.5%
Fiscal Intermediaries (Claims Processing)	389.5	303.0	-86.5	-22.2%
<b>Total-Local Assistance</b>	<b>\$50,232.7</b>	<b>\$57,734.7</b>	<b>\$7,502.0</b>	<b>14.9%</b>
General Fund	\$15,297.1	\$14,800.1	-\$497.0	-3.2%
Federal Funds	\$31,414.3	\$34,271.7	\$2,857.4	9.1%
Other Funds	\$3,521.3	\$8,662.9	\$5,141.6	146.0%

## II. VOTE ONLY

### 1. Abolish Four Funds That Are No Longer Used

**Budget Issue.** The budget proposes to add sunset dates for the following special funds:

1. Emergency Services and Supplemental Payments Fund (0693)
2. Medi-Cal Medical Education Supplemental Payment Fund (0550)
3. Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund (0549)
4. Small and Rural Hospital Supplemental Payments Fund (0688)

The Emergency Services and Supplemental Payments Fund has a balance of \$10,000, DHCS is working with the State Controller's Office to transfer this balance to the Distressed Hospital Fund (as allowed by state law).

**Background.** The supplemental funds proposed to be discontinued were originally established to supply funds for the nonfederal share of supplemental payments to Disproportionate Share Hospitals.

The funding mechanism for the non-federal portion of these supplemental payments has changed since the establishment of the funds, most notably by SB 1100 (Chapter 560, Statutes of 2005). The intent of SB 1100 was to zero out the balances of the prior supplemental funds by transferring 20 percent of the money in the prior supplemental funds to the Distressed Hospital Fund each year over a five year demonstration period.

Existing statute does not specify a sunset date for these funds, nor does it provide any other mechanism by which the funds can be abolished. Amending current law to provide a sunset date for the statutory references to these prior supplemental funds will avoid inaccurate and outdated fiscal records, inconsistencies with current law, and DHCS staff time to track the funds and provide reports.

**Subcommittee Comment and Recommendation—Approve.** This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

## **2. Medi-Cal Coverage of Juvenile Inmate Inpatient Costs**

**Budget Issue.** The DHCS is requesting one permanent position (an associate governmental program analyst) to assist in the development of a process to allow counties and the California Department of Corrections and Rehabilitation (CDCR) to receive available federal funds for inpatient hospital services and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates off the grounds of a correctional facility. The cost of this position is \$99,000 (\$49,500 reimbursement from counties and \$49,500 federal funds).

**Background.** Current law provides Medi-Cal eligibility to adults incarcerated in a state correctional facility if the individual receives inpatient hospital services off the grounds of a correctional facility. AB 396 (Chapter 364, Statutes of 2011) allows counties and CDCR to receive any available federal financial participation for acute inpatient hospital services and inpatient psychiatric services provided to juvenile inmates who are admitted as patients to a medical institution off the grounds of the correctional facility, and who, but for their institutional status as inmates, are otherwise eligible for Medi-Cal benefits. DHCS is responsible for developing a process that would allow CDCR and counties that elect to voluntarily provide the nonfederal share of expenditures to be able to claim for federal funds.

**Subcommittee Comment and Recommendation—Approve.** This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

### **3. Medi-Cal Ground Emergency Medical Transportation**

**Budget Issue.** The DHCS is requesting one and a half (1.5) positions and reimbursement authority for internal accounting and legal services efforts to initiate the Medi-Cal Ground Emergency Medical Transportation (GEMT) Services Program. The annual cost for this proposal is \$238,000 (\$119,000 reimbursements and \$119,000 federal funds).

**Background.** Local fire departments in their first response capacity participate in transporting Medi-Cal patients at an increasing rate. For example, ambulance transports of Medi-Cal enrollees increased 19 percent from 2006 to 2009.

AB 678 (Chapter 397, Statutes of 2011) allows GEMT service providers owned or operated by public entities to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment that these providers would otherwise receive, up to 100 percent of their actual allowable costs. The non-federal share of the supplemental reimbursement would be paid with funds from specified governmental entities through certified public expenditures (CPE). The intent of this legislation is to relieve the financial burden of these eligible public entities by providing supplemental reimbursement at no cost to the state. AB 678 also authorizes the reimbursement of DHCS administrative and staffing costs, so that the General Fund is not affected.

**Subcommittee Comment and Recommendation—Approve.** This proposal is consistent with state law. No issues have been raised with this proposal. It is recommended for approval.

#### 4. Maternal, Child and Adolescent Health Reductions

**Budget Issue.** The DHCS requests to reduce federal expenditure authority by \$1.2 million (\$755,000 in state operations and \$405,000 in local assistance) and eliminate 4 positions related to its work on maternal, child and adolescent issues.

(Reductions to the Department of Public Health's MCAH funding were discussed at the March 8, 2012 Senate Budget Subcommittee #3 Hearing.)

This proposed reduction is a result of several factors, including:

- The redirection of Title V Block Grant funds to programs that were previously funded with General Fund. Since 2007-08, a cumulative total of \$13.4 million in Title V funds have been redirected.
- A net reduction in the federal Title V Block Grant funding. On July 15, 2011, the Department of Public Health received notice from the federal government that the Title V Block Grant would be \$800,000 less than the previous year.
- The increased rate of spending by local health jurisdictions (LHJs). In efforts to ensure that local health jurisdictions spent down the local assistance portion of the Title V Block Grant, the department has awarded LHJs contracts that, cumulatively, exceeded the actual federal block grant amount.

The proposed DHCS reductions are:

- \$605,000 – Children's Medical Services (CMS) – Of this reduction, \$200,000 would come from the CMS program's operating expenses and equipment support budget. The remaining \$405,000 would be from a reduction to the High-Risk Infant Follow-Up (HRIF) Program under the California Children's Services (CCS) program. The CCS HRIF program identifies infants who might develop CCS-eligible conditions after discharge from a CCS-approved Neonatal Intensive Care Unit (NICU).

CMS will reduce the following: (1) support for one coordinator position at each of the CCS-approved NICUs, (2) the Quality Improvement Collaborative contract with reduction in activities to identify, measure, and improve the outcomes of graduates of CCS-approved NICUs, (3) the level of contractor assistance for the Neonatal Quality Improvement Collaborative, which helps reduce hospital acquired infections at participating CCS-approved NICUs, and (4) the interagency contract with California State University, Sacramento, which provides oversight and training of hospital staff in the usage of the Data Management System.

- \$373,000 – Primary and Rural Health Division (PRHD) – The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This reduction includes the elimination of 4 state positions and will result in delays of

technical assistance, grant execution, and a decrease in support to community health centers and contract oversight.

- \$182,000 – DHCS Audits and Investigations – A 50 percent reduction in the number of audits performed on MCAH local contractors.

**Subcommittee Staff Comment and Recommendation—Approve.** A reduction in the federal block grant and the state’s fiscal situation require an assessment of MCAH programs and a prioritization of funding for those programs that are the most effective. It is recommended to approve this proposal.

## 5. Breast and Cervical Cancer Treatment Program

**Budget Issue.** The DHCS is requesting an increase of \$537,000 (\$269,000 General Fund) to continue six limited-term positions until December 31, 2013 to conduct eligibility processing for the Breast and Cervical Cancer Treatment Program (BCCTP).

Unlike other Medi-Cal programs where county eligibility workers make determinations, DHCS staff performs all the eligibility activities for BCCTP. This processing includes compliance with federal requirements such as citizenship verification, redetermination functions, and new applications.

The DHCS states continuation of these positions are necessary for completing redetermination reviews, obtaining retroactive coverage, and to ensure that people are able to access treatment services in a timely manner. Current workload is expected to continue and may increase due to more Medi-Cal enrollees pervasively.

The positions and a summary of key activities are as follows:

- Associate Governmental Program Analysts. A total of four positions are requested for extension. These positions are to (1) perform initial eligibility determination for new applicants; (2) perform determinations for annual review; (3) perform determinations for retroactive coverage; and (4) provide other assistance related to this work.
- Staff Service Manager I. This position is responsible for (1) supervising; (2) reviewing cases for accuracy in eligibility; (3) interpretation of changes to Medi-Cal as they pertain to this program; and (4) updating policies and procedures.
- Office Technician. This position is responsible for (1) organizing all new applications; (2) assigning cases; (3) sets up forms and redetermination packets; (4) files closed cases; and (5) various support activities related to this work.

**Background.** Established in 2002, this federal program provides cancer treatment services through Medi-Cal as appropriate, contingent upon eligibility. AB 430 (Statutes of 2011) also established a corresponding state-funded program for women and men who do not meet the eligibility criteria for the federal program.

Approximately 4,200 BCCTP applications are received annually. BCCTP staff must complete annual redeterminations each year on 12,136 of the 12,710 active, ongoing BCCTP cases. The remaining cases are state BCCTP cases that do not receive federal funding and are therefore not subject to the federal annual redetermination requirement. As of June 30, 2011, there are 6,864 federal cases overdue for an annual redetermination.

**Subcommittee Staff Comment and Recommendation—Approve.** It is recommended to extend these six positions for the Breast and Cervical Cancer Treatment Program to ensure people have access to treatment.

## 6. Extend Sunset Date for Rogers Amendment

**Budget Issue.** The budget proposes trailer bill language to extend the Rogers Amendment sunset date from January 1, 2013, to July 1, 2013, for capitation rates (known as Rogers Rates) paid to non-contract hospitals for emergency inpatient and post-stabilization services provided to Medi-Cal managed care plan (Plan) enrollees. The proposal would also allow DHCS to implement the Rogers rates methodology after June 30, 2012 via All Plan Letters (APL) or other similar instructions, rather than through the regulatory process.

**Background.** Medi-Cal provides health care services to 7.65 million beneficiaries through two distinct health care delivery systems: the traditional fee-for-service (FFS) system and the managed care system. Approximately 4.3 million Medi-Cal beneficiaries receive health services by enrolling in contracted Medi-Cal managed care Plans in 30 counties. These Plans emphasize primary and preventative care and offer established networks of organized systems of care. Most health care plans contracting with the Medi-Cal program are licensed under the Knox-Keene Health Care Service Plan Act of 1975.

Section 6085 of the Federal Deficit Reduction Act of 2005 established an upper limit to the amount Medicaid health plans may pay to hospitals that are outside the Plans' provider networks (out-of-network hospitals). The federal law, known as the "Rogers Amendment," was in response to demands by out-of-network hospitals for payments that were above the established Medicaid rates normally paid by health plans across the nation for inpatient emergency services.

AB 1183 (Chapter 758, Statutes of 2008) required DHCS to establish inpatient hospital rates as limits to the amounts that may be paid by Medi-Cal Plans to out-of-network hospitals. These rates are for both emergency inpatient bed days and for post-stabilization inpatient bed days.

DHCS is also required to develop and implement a payment methodology based on diagnosis-related groups (DRGs). Statute requires implementation by July 1, 2012, or on a date when the Director of DHCS executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later. When implemented, these DRG rates will replace the existing Rogers Rates payment methodology.

Current statute provides for the Rogers Rates to sunset on January 1, 2013. Currently, the DRG methodology is expected to be implemented January 1, 2013. However, if there are delays past January 1, 2013, DHCS will not have statutory authority to continue payments under the Rogers Rates methodology to out-of-contract hospitals providing emergency and post-stabilization services to Plan enrollees. DHCS requests that statute be amended to extend the sunset date to July 1, 2013. Once the DRG methodology is implemented, the Rogers Rates will no longer be used.

Additionally, DHCS will need to establish a payment mechanism to cover the time period from the date of expiration of the California Medical Assistance Commission (CMAC) to the date the DRG methodology becomes effective. Existing law requires DHCS to carry out the Rogers Rates methodology through the regulatory process. This proposal would allow DHCS the ability to establish and implement the interim payment mechanism in a timely manner by granting DHCS the authority to extend the Rogers Rates methodology after June 30, 2012, when the CMAC methodology ends, via APLs or similar instruction.

**Subcommittee Staff Comment and Recommendation—Approve.** Extending the sunset date for an additional six months would allow payments to continue under the Rogers Rates methodology if the DRG rate methodology is not implemented on January 1, 2013. It would also provide plans with a greater degree of program stability by providing more predictability in reimbursement rates. No issues have been raised regarding this proposal.

## 7. Medi-Cal Targeted Case Management

**Budget Issue.** The DHCS is requesting to change 8 limited-term positions to permanent positions to support the federal oversight and corrective action for the Targeted Case Management Program. These positions are funded at a cost of \$445,000 reimbursement from Counties and \$445,000 in federal funds.

The eight positions include: (1) a Health Program Audit Manager I; (2) three Health Program Auditor IVs; (3) three Health Program Auditor IIIs; and (4) an Accountant Trainee.

**Background.** Targeted Case Management provides comprehensive case management services to Medi-Cal eligibles in six target populations—public health, adult probation, outpatient clinics, public guardian, community, and linkages. Local government agencies (LGAs) (mainly counties) use a “certified public expenditure” (CPE) approach to obtain federal reimbursement. Without this federal reimbursement, many of these services would cease.

In 2005-06, the federal CMS determined that DHCS was out of compliance with federal regulations that prohibit payments to exceed actual expenditures incurred by LGAs. In addition, CMS could not determine whether the CPE expenditures incurred were eligible and properly certified by the LGA. Consequently, CMS placed Targeted Case Management (TCM) local governmental agency claims on deferral in 2003-04 and has continued to defer claims through the 2006-07 budget year for a total of \$39 million.

During this timeframe, the federal CMS sent notifications requesting the DHCS to respond to corrective actions to resolve the claims. These corrective actions included performing desk reviews and audits of cost reports and claims to examine the encounter rates, service costs and CPE. DHCS states that these functions need to continue and be expanded for all of the fiscal years in question and going forward.

CMS notified DHCS that it would disallow \$18.9 million of the \$39 million of deferred claims and the federal funds must be returned. DHCS has the responsibility to recover these funds from LGAs.

**Subcommittee Staff Comment and Recommendation—Approve.** Subcommittee staff concurs with the DHCS regarding their concern with fiscal integrity and the need for the state staff. This proposal is recommended for approval.

## **8. Local Educational Agency (LEA) Medi-Cal Billing Option Program - Staff**

**Budget Issue.** The DHCS is requesting to change 14 limited-term positions to permanent positions to perform financial oversight requirements of the “Local Educational Agency” (LEA) billing option provided under the Medi-Cal Program. The positions are funded \$820,000 from federal funds and \$820,000 from LEAs; it does not require any General Fund.

**Background.** There are approximately 471 LEA providers participating in the LEA billing option program. The LEA billing option provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment.

The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

As California’s lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being appropriately expended.

These limited-term staff are in the process of completing the reconciliation and audits of the 2006-07 (392 reports), 2007-08 (403 reports), and 2008-09 (422 reports) cost reimbursement reports. DHCS estimates that these activities alone would take at least three years. Additionally, it anticipates 450 reports would need to be reviewed for 2009-10.

In the past the federal CMS has deferred payments to LEAs pending DHCS’ completion of cost reimbursement report audits. DHCS notes that if it does not complete these audits, it is likely that CMS will resume deferring LEA claims and disallow \$134 million in deferral claims in response to the department’s failure to comply with oversight requirements.

**Subcommittee Staff Comment and Recommendation—Approve.** Permanent workload for this program has been established. It is recommended to approve this proposal to ensure federal payments to local educational agencies.

### III. ISSUE FOR DISCUSSION

#### 1. Sacramento Geographic Managed Care: Dental Services

**Oversight Issue.** It is clear the existing Sacramento Geographic Managed Care (GMC) Dental Services model is inadequate as articulated in correspondence between Senator Steinberg and the Department of Health Care Services (see hand out #1), and as documented through the extensive efforts of First 5 Sacramento, the Sacramento GMC Subcommittee, and the Board of Supervisors.

The March 15<sup>th</sup> hearing of the Select Committee on Healthcare Workforce and Access to Care, chaired by Assembly Member Pan, also illustrated the need for vast improvement with the model.

Senator Steinberg is submitting *placeholder* trailer bill legislation to change state statute, effective July 1, 2012, to improve dental services for children enrolled in Medi-Cal in Sacramento (see hand out #2). Key components of this language are as follows:

- Provide enrollment on a “voluntary” basis in lieu of existing “mandatory” enrollment.
- Require the department to establish performance measures and benchmarks for dental health plans, and to post each plan’s performance on the department’s website at least twice annually.
- Require the dental health plans to provide performance data to the department.
- Require the department to utilize dental health plan performance data for contracting purposes, including for the establishment of contract incentives and disincentives.
- Require the use of an independent External Quality Review Organization for dental health plans as is similarly done for Medi-Cal Managed Care health plans, and have this information posted on websites for public transparency.
- Require the department to review and approve dental health plan marketing plans.
- Require the department to review and approve member services procedures.
- Require the Department of Managed Health Care to report to the Legislature regarding its surveys of the five dental plans participating in the Sacramento Geographic Managed Care Program.

Discussions with stakeholder interests and the Administration are to continue over the next two months to further craft this proposed language which is intended to be included in the Omnibus Health Trailer Legislation for the enactment of the Budget for 2012-13. Statutory changes are necessary in order to effect changes by July 1, 2012, and fiscal assumptions will need updating.

It should be noted that many of the components in the proposed language were included in the Administration’s trailer bill language submitted to the Legislature in January as part of the

Governor's proposed transition of the Healthy Families Program to improve dental health plan services. However, the proposed trailer bill language submitted today by Senator Steinberg does not address or include any aspects regarding the Healthy Families Program transition, only dental health plan improvements.

**Background—Summary of Key Concerns and Recent Local Actions.** First 5 of Sacramento, chaired by Board of Supervisor Phillip Serna, commissioned the "Sacramento Deserves Better" report which analyzed access, utilization and quality of dental care under the GMC Dental Services model. Key findings from this 2010 report included the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service.
- Only 30 percent of children in GMC Dental Services received a dental service in 2010.
- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state.
- Dental plans have not complied with "first tooth/first birthday" recommendation for the initial dental visit.
- Inadequate prevention services were provided.
- Minimal oversight by the state Department of Health Care Services of GMC Dental Services contracts.

The County formed a GMC Dental Subcommittee, consisting of numerous local stakeholders, to the County Public Health Advisory Board to develop recommendations for the State Department of Health Care Services (DHCS) to improve the GMC Dental Services model.

From this effort, correspondence to the DHCS offering recommendations was provided on several occasions, culminating with a comprehensive package of suggested contract changes provided in December 2011.

Key recommendations from the GMC Dental Subcommittee have included the following:

- Provide for "voluntary" enrollment in lieu of existing "mandatory" enrollment.
- Implement the Healthy Families Program utilization strategies and dental quality measures in Medi-Cal dental contracts.
- Allow families who choose a Federally Qualified Healthcare Center (FQHC) clinic as a dental home to maintain it.
- Develop comprehensive contracts with strong performance measures, including the ability to withhold payments if standards are not met, and the ability to provide incentives for outreach and performance.
- Improve state oversight, including data analysis, on-site visits and audit reviews of Dental Plan performance.

- Address the need for increased patient education and outreach strategies to support access to dental services and rights of Medi-Cal patients to services.
- Make improvements to the Medi-Cal Ombudsman process.

At the request of Supervisor Phillip Serna, the Sacramento Board of Supervisors will be receiving regular updates on GMC Dental Services, including action steps taken on numerous recommendations to the DHCS and to the participating Dental Plans.

**Background—Structure of Existing Program.** Presently, Medi-Cal operates dental health managed care in two geographic areas: Los Angeles and Sacramento. Los Angeles operates on a voluntary enrollment basis and Sacramento operates on a mandatory enrollment basis. Initiated in 1994 as a pilot project, the State Department of Health Care Services (DHCS) contracts with five Geographic Managed Care Dental Plans (Dental Plans) to provide Medi-Cal dental services in Sacramento. Each of these Dental Plans is licensed by the Department of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975.

Presently, the five Dental Plans include Liberty Dental, Access Dental, Health Net, Western Dental Services, and Community Dental. Each Dental Plan receives a DHCS negotiated per member per month reimbursement rate (presently about \$12) for each recipient enrolled in their plan. Due to the elimination of adult dental benefits in Medi-Cal, other than certain federally required services for adults, the program predominately provides services to children and adolescents (less than 21 years of age). There are about 110,000 children enrolled in the program.

Except for a few aid codes, Medi-Cal recipients in Sacramento are *mandatorily* enrolled in one of the Dental Plans. It is the *only county in the state* that has mandatory enrollment for dental services. Los Angeles County also utilizes managed care plans for the provision of dental services but enrollment is done on a voluntary basis. Only about 15 percent of Medi-Cal recipients in Los Angeles enroll in a dental managed care plan.

Recipients are entitled to receive dental benefits from Dentists within the Dental Plan's provider network. Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services are to include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days) and preventive dental care appointments (offered within 40-days).

Dentists who wish to provide services under Geographic Managed Care must be a member of one of the Dental Plan's provider networks and must be enrolled in the Denti-Cal Fee-For-Service Program.

In addition, the GMC Dental Subcommittee is actively engaged with the DHCS to significantly revise the state's Request for Proposals (RFP) process used to contract with Dental Plans participating in the GMC Dental Services model.

**Background—Summary of Recent Actions by DHCS.** The DHCS recognizes improvements to the GMC Dental Services model are needed and Director Douglas has made a personal commitment to this effort. Recent actions have included the following:

- Met with the five dental health plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children.
- Provided a March 7<sup>th</sup> letter (see hand out #1) to dental health plans articulating expectations and necessary improvements.
- Convened stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA) which in its final form will be used as the basis for contracting with dental health plans.

**Prior Subcommittee #3 Hearing of March 8<sup>th</sup>.** In its March 8<sup>th</sup> hearing, the Subcommittee questioned the Department of Managed Health Care (DMHC) regarding their oversight role of specialty care plans, including dental plans

**Subcommittee Staff Comment and Recommendation.** The Sacramento GMC Dental Services model has experienced continued problems concerning access to care, referral to specialty dental care, utilization rates, and Dental Plans meeting performance indicators. A report from 2003, “Sacramento Geographic Managed Care: Eight Years Later” also noted considerable concerns regarding the delivery of dental services under the mandatory enrollment structure. The First 5 report and subsequent recommendations from the GMC Dental Subcommittee have documented that considerable change is necessary.

It is recommended to adopt Senator Steinberg’s proposed placeholder trailer bill language in lieu of the Administration’s proposed trailer bill language regarding improvements to dental health plan services and to continue discussions over the next two months with stakeholders and the Administration.

The Administration’s proposal to expand dental managed care is discussed under the Transition of Healthy Families Children to Medi-Cal issue later in the agenda.

## 2. 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 Medi-Cal managed care beneficiaries 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.

Beneficiaries would receive written notice 60 days prior to the end of an enrollment year, allowing them to change plans during this 60-day period. If the beneficiary does not elect to change plans, he or she would be required to remain in their plan for one year until the next open enrollment period. Additionally, under this proposal, a beneficiary would have the option to change to an alternate plan within the first 90 days following initial enrollment into a managed care plan.

This proposal would achieve \$3.6 million General Fund savings in 2012-13 as the number of initial health assessments and mailings performed annually by plans is reduced. This proposal would be implemented October 1, 2012, and cover the nine remaining months of the first fiscal year and each year thereafter.

**Table: Estimated Savings with Enrollment Lock-in Proposal**

	2012-13	
	Total Funds	General Fund
Total Cost Under Current System (for nine months)	\$10,722,852	\$5,361,426
Cost to Change Enrollment System	-600,000	-300,000
Cost to Mail Enrollment Packets	-419,194	-209,597
Cost for New Health Assessment	-1,676,777	-838,389
Defer Managed Care Payment	-891,876	-445,938
<b>Savings Under This Proposal</b>	<b>\$7,135,005</b>	<b>\$3,567,503</b>

The total savings for 2013-14 would be \$12.1 million. In addition, the state would hold the June 2014 payment to the health plans, which would reduce the savings in 2013-14 for this proposal by \$110,704, for a net savings of \$11.9 million (about \$6 million General Fund) in 2013-14.

It should be noted that this proposal requires an amendment to California’s 1115 Medicaid Waiver.

**Background.** Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month. Approximately 16,687 enrollees (combined for Two Plan Model and Geographic Managed Care) currently switch plans each month, which totals 200,240 changes per year. This represents 5.6 percent of projected mandatory enrollment.

Commercial health plans, Medicare Advantage and Part D Plans, and the Healthy Families Program all have annual open enrollment periods.

DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies since enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Improvement in the monitoring of clinical measures used to assess quality of care, such as, HEDIS® (Healthcare Effectiveness Data and Information System);
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using their Health Plan; and
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution).

***Mandatory Enrollment of SPDs into Managed Care.*** In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from CMS authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011 and will last twelve months. Concerns have been raised regarding the low percentage of enrollees actively selecting their managed care plan versus being defaulted into a plan. About 60 percent of this population has been defaulted into a managed care plan and often do not realize that a change to their health coverage was made. Additionally, there have been challenges regarding an enrollee's ability to continue care with a provider. Guidance provided during the SPD transition to managed care states that enrollees would be able to change plans at any time of the year, as needed.

**Subcommittee Staff Comment and Recommendation—Deny Proposal.** It is recommended to deny the trailer bill language and to adjust the Medi-Cal budget accordingly. Given the recent challenges of mandatorily enrolling SPDs into managed care, it is important to keep the policy that Medi-Cal managed care enrollees can change health plans at any time. This allows an enrollee the ability to change plans to ensure that his or her health needs are being met.

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

1. Please provide a summary of this request.

### 3. Federally Qualified Health Center/Rural Health Clinic Payment Reform

**Budget Issue.** The DHCS proposes to integrate all Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) costs into managed care capitated rates by reforming the payment methodology under Medi-Cal. Under this proposal, payments made to FQHCs and RHCs (participating in Medi-Cal managed care contracts) would change from the prospective payment system (PPS) system--a cost and volume-based payment--to a fixed payment to provide a broad range of services to its enrollees. The “wrap-around” payment funds (discussed later) would also be included in the capitated rate; thereby requiring health plans to be fully responsible for reimbursement to FQHCs and RHCs.

Payments to FQHCs and RHCs for beneficiaries who are both Medicare and Medi-Cal eligible would be exempt from this proposal.

**Eliminate Operating Restrictions.** In addition, the administration proposes to eliminate current operating restrictions that prevent best practices, such as group visits, telehealth, performing multiple services on the same day, and telephonic disease management. It argues that eliminating these operating constraints would create efficiencies and allow FQHCs and RHCs to institute best practices.

**Efficiency Adjustment and Savings.** By removing the operating restrictions, DHCS finds that these centers would realize efficiencies in their practices and; consequently, DHCS would reduce their payment by ten percent. This reduction would generate \$26 million General Fund savings in 2012-13 and about \$58 million General Fund savings in 2013-14.

In order to realize the budget year savings, the administration is proposing to delay \$43.6 million (General Fund) in managed care payments to FQHCs and RHCs into 2013-14.

The DHCS notes that the ten percent reduction is a net reduction to these centers and that health plans would not be able to take an additional administrative cut from this rate.

**Federal Waiver.** The Administration is seeking a waiver from the federal government to reform the payment methodology and to eliminate the operating restrictions. If the federal government does not approve a waiver of the PPS payment requirements, under this proposal DHCS would continue forward with the proposal to eliminate the PPS “wrap” payments and provide all FQHC/RHC funding for managed care beneficiaries through managed care plan capitation rates. In the absence of a waiver, FQHC operating restrictions would remain in place and plans would be required to pay FQHCs at PPS rates, to the extent that plans use these clinics for services.

**Proposed Rate Calculation.** The clinic-specific, capitated rate would be calculated using the historical per-beneficiary revenue that the clinic would have received under the PPS system as follows:

- Rate based on a facility's current average plan revenue Per Member Per Month (PMPM) (PPS rate X number of plan beneficiaries X average number of visits)
- Method to adjust plan funding quickly regarding shifts in FQHC utilization
- An efficiency savings of ten percent would be removed from the funding provided to plans and the rate paid to FQHC/RHCs.

After the first year, subsequent capitated rate calculations would be developed based on experience and costs, risk mix, and performance and quality outcomes.

**Background.** FQHCs and RHCs are community-based centers that provide primary and preventative health care services to medically underserved populations or areas without regard to a patient's ability to pay. In addition to receiving grants from the federal government, these health centers are reimbursed for providing Medicare and Medi-Cal services. There are 681 FQHCs and 293 federally designated RHCs in California. In 2009-10, FQHCs and RHCs represented over 90 percent of Medi-Cal expenditures for clinic-based care. In 2009-10, about 1.6 million Medi-Cal beneficiaries made 6.8 million health center visits and nearly 400,000 beneficiaries made 2.1 million rural clinic visits. Also in 2010, 64 percent of primary care visits in the doctor's office or clinic setting were at FQHCs and RHCs.

Additionally, according to the mental health and substance use needs assessment conducted on DHCS' behalf as part of California's Section 1115 Bridge to Reform waiver approval, FQHCs and RHCs play an important role in the provision of mental health and substance use services in California, particularly for people living in rural areas and for underserved populations such as people experiencing homelessness. In the past, FQHCs were required to either provide mental health and substance use services, or have referral relationships with other agencies that could serve people with mental health and substance use treatment needs. However, all new FQHCs are now required to directly provide these services, making FQHC providers an even more valuable resource for ensuring access to mental health and substance use services. In 2010, 108,597 Californians received mental health services and 21,893 people received substance use services from FQHCs.

FQHCs and RHCs were exempt from the 10 percent provider rate reduction authorized in the 2011-12 budget.

**PPS.** Federal law requires Medi-Cal to reimburse FQHCs and RHCs based on reasonable costs. The current reimbursement system is based on a prospective payment system (PPS). Under PPS, Medi-Cal generally reimburses centers a per-visit rate, which is adjusted by the Medicare Economic Index annually.

Medi-Cal managed care plans commonly contract with FQHCs and RHCs as part of their provider networks and are required to reimburse FQHCs and RHCs in their networks for providing services to plan beneficiaries at rates that are, at a minimum, comparable to other providers of similar services in the same network. Federal law requires Medicaid programs to make up the difference between negotiated rates paid by managed care plans and a center's guaranteed PPS fee-for-service rate. An annual reconciliation determines the total difference between plan payments and PPS payments for the number of patient visits. These "wrap-around" payments (or supplemental payments) paid by Medi-Cal to FQHCs and RHCs with managed care contracts totaled \$229 million General Fund in 2009-10.

In addition, FQHCs operate under restrictions that inhibit the clinic's ability to provide efficient care. Restrictions include:

- Payments limited to visits to certain provider types
- Services limited to those provided within the "four walls" of the clinic
- Restriction against multiple payments for multiple services in the same day

These restrictions are in the California's legal definition of a payable visit under the PPS rate payment system.

**Subcommittee Staff Comment and Recommendation—Deny Proposal.** This is a major policy proposal with a very aggressive timeline. It would have a substantial impact on the community-based center delivery system.

FQHCs and RHCs are critical to the existing Medi-Cal provider network and the future Medi-Cal expansions with federal health care reform. As exemplified by:

- In 2010, 64 percent of primary care visits for Medi-Cal beneficiaries was provided in FQHCs and RHCs.
- In its "Management Brief: DHCS' Monitoring Plan and Initial Assessment of Healthcare Access for Medi-Cal Beneficiaries" completed in October 2011, DHCS indicates that it found that FQHCs and RHCs treated a much higher average number of Medi-Cal beneficiaries during the year compared to physicians in solo practices and other organized outpatient clinics.
- In 2014 under federal health care reform, it is projected that two to three million individuals will be eligible for Medi-Cal; thereby, further increasing the demand for health care services at these centers.

Consequently, it is critical to protect the sustainability of these centers. The proposed rate cut would likely force some FQHCs and RHCs to close and others to restrict hours and limit patient access at a time when the state should be developing methods to increase capacity and maximize the ability to provide more services.

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

1. Please provide a summary of the proposal.
2. Has DHCS begun discussions regarding this specific proposal with the federal CMS? What has been CMS's feedback?

#### 4. Value-Based Purchasing

**Budget Issue.** The DHCS is proposing trailer bill to establish a process for Value-Based Purchasing in the Medi-Cal fee-for-service (FFS) system. This proposal would save \$75 million General Fund in 2012-13 and annually thereafter. Of the \$75 million, \$26.6 million is attributable to the savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions (for Medi-Cal managed care), as required by the Affordable Care Act (ACA) (effective July 1, 2012).

Under this proposal, DHCS would implement value-based service design to ensure beneficiary access to necessary health care services by adding services or by identifying and reducing services that do not improve health outcomes, may cause harm to patients, or that are overused and should only be provided under limited conditions. Although this process would allow DHCS to change the way in which providers may deliver services, it would not change the benefits covered under the State Plan.

The proposed value-based service design process encompasses the following:

- Evidence review which shall include systematic reviews and individual studies published in peer-reviewed literature or evidence-based treatment guidelines issued by organizations whose primary mission is to conduct objective analyses of the effectiveness of medical or evidence-based clinical practice guidelines.
- Determination of fiscal effect by analyzing proposals for the costs and savings associated with adding, modifying, limiting, or eliminating services.
- Feasibility analyses to consider administrative and process issues related to the addition, modification, limitation, or elimination of services, such as the cost and timeframe for computer system changes, the staffing and expertise needed to craft utilization policies that limit inappropriate use of a service without interfering with appropriate use of that same service, and the ability to use utilization management.

**Stakeholder Input.** Under this proposal, DHCS would inform and consult with stakeholders, including health professionals, Medi-Cal providers, and consumer advocacy organizations for input prior to implementing changes pursuant to the Value-Based Purchasing process. DHCS would notify stakeholders of proposed changes to targeted services, rate methodologies and payment policies by regularly updating the Medi-Cal website. Stakeholders would have 30 days to provide written input regarding changes proposed through the Value-Based Purchasing process and, upon request, DHCS would provide a public meeting to hear their comments. DHCS would respond to stakeholder comments. Implementation of proposed changes would occur no sooner than 30 days from the date the department notifies stakeholders of the proposed changes or 30 days from the date a public meeting is held.

**Outcome Review.** DHCS would monitor policy and program changes to ensure that the department obtains the intended results for achieving value regarding clinical quality

outcomes, access, and cost effectiveness. Where ongoing monitoring indicates results are not as expected or negative, DHCS would modify the intervention accordingly.

**Federal Approval.** DHCS states it would not implement changes pursuant to the Value-Based Purchasing process until it obtains any necessary federal approvals. DHCS would implement changes in the development of rate methodologies and payment policies only if they comply with applicable federal Medicaid requirements and if federal financial participation is available.

**Background.** Currently, DHCS must use regulations or statute to add, modify, limit, or eliminate reimbursement and services in the Medi-Cal program. For example, DHCS uses the Medi-Cal Manual of Criteria to define services associated with covered benefits, which is embedded in the California Code of Regulations (CCR). According to DHCS, the regulatory process is time-consuming and ineffective, often taking a year or more for completion. During this processing time, the Medi-Cal program continues to pay for services and utilize payment methodologies that may be ineffective and inefficient. According to DHCS, due to the intensive staff effort required to promulgate regulations, the last formal regulatory update to the Manual of Criteria was on December 6, 2007.

Value-Based Purchasing is an approach that is commonly used in the private sector by large, self-insured companies, major public entities responsible for health care purchasing such as CalPERS, and by purchasing coalitions such as the Pacific Business Group on Health. As such, this proposal seeks to align DHCS with other major health care purchasers.

Health care spending continues to increase at a significant rate, but the increased cost is not always accompanied by an increase in the quality of care or value to the consumer. For example, experts estimate that Medicare wastes 20 to 30 percent of its \$500 billion in annual expenditures on treatments and procedures that have minimal or no benefit to the patients.

**Subcommittee Staff Comment and Recommendation—Hold Open.** While the DHCS argues that the Medi-Cal health care delivery system needs to be able to more rapidly respond to the changing field of health care than the current regulatory process allows, the proposed process is outside the current regulatory framework which has established safeguards to ensure stakeholder participation and disclosure of departmental actions. How this process would ensure an appropriate level of input from stakeholders and accountability to the public and Legislature is unclear. Discussions on striking a balance between the ability to be able to rapidly respond to the changing field of health care and the engagement of stakeholders need to continue.

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

1. Please provide a summary of this proposal.
2. What are the barriers with the current regulatory process?

## 5. Eliminate Sunset for AB 1629 – Nursing Home Quality Assurance Fee

**Budget Issue.** The DHCS proposes to eliminate the sunset date for the nursing home quality assurance fee (QAF) program and the rate-setting methodology established under AB 1629 (Statutes of 2004) and; thereby, make this program permanent. The QAF program sunsets on July 31, 2013.

If the QAF program and rate-setting methodology sunset dates are not extended, the department will no longer be authorized to assess and collect the QAF and continue paying facility-specific rates to nursing homes. Maintaining the QAF collection offsets General Fund expenditures and can fund rate increases to the skilled nursing facilities. According to DHCS, if the QAF sunsets, over \$400 million in General Fund support could be at risk.

In lieu of the AB 1629 methodology, the department indicates it may have to revert to a flat, non-facility-specific rate system and would be unable to fund enhanced payments through the Quality and Accountability Supplemental Payment System (QASP) due to the General Fund impact. Reverting to a flat rate reimbursement system offers little or no incentive to facilities to maintain or improve quality.

If the department is unable to permanently continue the current rate reimbursement methodology and the QAF program, the state is at risk for potential increases in the General Fund portion of the rate expenditures.

**Background.** Certain nursing home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QAF). Use of QAF has enabled California to provide reimbursement increases to certain nursing homes with *no* added General Fund support.

AB 1629 imposes a QAF on skilled nursing facilities and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to certain nursing facilities that support improvement efforts. The Legislature's goal with AB 1629 and the new reimbursement system was that it would result in improvements in individual access to appropriate long term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, and provider compliance with all applicable state and federal requirements.

**California's Nursing Home Quality.** A systematic review of how, or if, AB 1629's goals have been met or if quality of care in nursing homes has improved since AB 1629 has not been undertaken. DHCS refers to two studies conducted by the Department of Public Health regarding AB 1629. The first study was conducted in 2007 to cover the three years immediately prior to the passage of AB 1629 to serve as a baseline. The second study was conducted in 2009 and assesses two years after the implementation of AB 1629. Neither study comprehensively reviews how AB 1629's reimbursement methodology impacted the quality of care in nursing homes.

However, research indicates that the quality of care provided in California’s nursing homes can still be improved. In its 2010 Snapshot, the federal Agency for Healthcare Research and Quality gave California a "weak" rating in regards to its nursing home care quality. (It has been considered “weak” since the 2007 snapshot.) California scored 26.32 (out of 100) for nursing home care and was below the 25<sup>th</sup> Percentile (75<sup>th</sup> Percentile – 60.53; 50<sup>th</sup> Percentile – 47.37; and 25<sup>th</sup> Percentile – 31.58) for performance across states. California scored worse than average in 14 out of 19 quality measures and better than average in five of the 19 measures based on 2008 data.

California scored **worse than average** in the following measures:

Measure Name	State Rate	All-State Average	Regional Average
Nursing home long-stay residents - bed/chair bound	5.3	3.5	5.5
Nursing home long-stay residents - with moderate to severe pain	7.5	6.5	7.6
Nursing home long-stay residents - received flu vaccine	82.3	89.9	83.5
Nursing home short-stay residents - received flu vaccine	79.3	82.7	78.7
Nursing home long-stay residents - received pneumococcal vaccine	76.1	86.3	77.6
Nursing home short-stay residents - received pneumococcal vaccine	74.2	79.7	75.2
Nursing home short-stay residents - with moderate to severe pain	26.6	20.3	27.1
Nursing home long-stay residents - physically restrained	8.4	3.4	5.1
Nursing home long-stay residents - high-risk with pressure sores	13.2	11.4	12.0
Nursing home long-stay residents - low-risk with pressure sores	2.2	2.0	2.4
Nursing home short-stay residents - with pressure sores	27.5	18.1	22.9
Nursing home long-stay residents - low-risk with less control of bowels or bladder	56	50.2	56.5
Nursing home long-stay residents - low-risk with urinary catheter left in	6.57	6.2	6.8
Nursing home long-stay residents - with too much weight loss	10.7	8.3	9.6

California scored **better than average** in the following measures:

Measure Name	State Rate	All-State Average	Regional Average
Nursing home long-stay residents - with declining mobility	14.5	15.5	14.8
Nursing home long-stay residents - with increased need for help	13.8	15.4	13.9
Nursing home long-stay residents - with urinary tract infections	7.9	8.8	8.3
Nursing home short-stay residents - with delirium	1.4	2.7	4.0
Nursing home long-stay residents - more depressed or anxious	10.9	13.7	12.0

**Subcommittee Comment and Recommendation—Hold Open.** The periodic review of this program is important to allow the Legislature, stakeholders, and the Administration the opportunity to review whether and how the reimbursement methodology and QAF are contributing to the goals set forth in AB 1629 including the provision of quality care in nursing homes. It is recommended to leave this item open as discussions continue.

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

1. Please provide a brief summary of the proposal.
2. What is DHCS' assessment of AB 1629's impact on the quality of care in nursing homes?

## 6. Eliminate Sunset for LEA Medi-Cal Billing Option Program

**Budget Issue.** The DHCS proposes to (1) delete the current program sunset date of January 1, 2013, for Local Educational Agency (LEA) Medi-Cal Billing Option (LBO) program, (2) eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs, and (3) remove the maximum annual funding amount of \$1.5 million for contractor costs and makes the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee.

DHCS finds that:

- Eliminating the sunset date clause would reduce the administrative requirements and costs to develop, track, and submit proposed legislation to extend the sunset date.
- Eliminating the baseline requirement prior to funding LBO contract costs would allow DHCS to reduce federal Medicaid payments to fund contractor costs without delay. Not acting could potentially restrict DHCS from generating sufficient funds to cover all necessary contractor costs. DHCS must monitor reimbursements to the LEAs to ensure the baseline requirement is met prior to funding contractor costs required for the LBO program.
- Eliminating the maximum annual funding amount of \$1.5 million for contractor costs and making the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee would allow sufficient flexibility to accommodate reasonable cost increases associated with contract services. The current amount, \$1.5 million, has remained static since 2001.

**Background.** California established the LBO program in 1993 to allow school districts to claim federal reimbursement by matching local education dollars already being spent on health services for Medi-Cal children. DHCS and the California Department of Education (CDE), along with a consortium of private foundations, collaborated to develop the LBO program which allows LEAs to generate more funds for services provided to California's children.

DHCS works directly with the LEA Ad Hoc Workgroup Advisory Committee that was organized in 2001 to identify barriers for existing and potential LEA providers and to recommend new LBO program services. Committee members represent urban, rural, large and small school districts, county offices of education, the local education consortium, local educational agencies, and CDE.

In April 2000, the United States Government Accountability Office ranked California in the bottom quartile among states that have school-based Medicaid programs with respect to the amount of its LEA claims per Medicaid-eligible child. In October 2001, SB 231 (Ortiz, Chapter 655, Statutes of 2001) created methods to increase the per-student amount of Medicaid reimbursements received by the State of California.

**Subcommittee Staff Comment and Recommendation–Modify.**

1. It is recommended to eliminate the sunset date for this program. It is important to ensure that the LBO program is ongoing and uninterrupted since it allows LEA providers to leverage existing local resources with federal reimbursements to support services for students with special needs.
2. It is also recommended to eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs. These requirements have not been updated since 2000-01 which restricts DHCS' ability to fund contractor costs.
3. It is recommended to reject the provision to remove the maximum annual funding amount of \$1.5 million for contractor costs. Money that is diverted to contractor costs associated with managing the LBO program is money that would otherwise go to schools. It is recognized that this amount has not been updated since 2000-01; however, it was agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee. AB 2608 (Bonilla) is moving through the policy process and provides the opportunity for DHCS and stakeholders to agree upon updates to this statute.

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

1. Please provide a summary of this proposal.
2. Has DHCS engaged with the LEA Ad Hoc Workgroup Advisory Committee regarding this proposal? Please comment.

## 7. Redirecting Unpaid Stabilization Funding

**Budget Issue.** The DHCS proposes to redirect all unpaid private and nondesignated public hospitals’ stabilization funding for fiscal years 2005-06 through 2009-10 (including the extension period of the Medi-Cal Hospital/Uninsured Demonstration through October 31, 2010) for purposes of General Fund savings.

**Table: Remaining Stabilization Funds** (in millions)

Year	Hospital Type	Total Funds	General Fund
2005-06	Private	\$10.578	\$5.289
2006-07	Private	\$19.146	\$9.573
2007-08	Non-Designated Public Hospitals	\$2.152	\$1.076
2008-09	Private	\$3.894	\$1,947,000
2010-11	Private	\$73.764	\$36.882
<b>Total</b>		<b>\$109.534</b>	<b>\$54.767</b>

Of the \$54.7 million General Fund remaining, \$11.89 million will be paid to a hospital that incorrectly received underpayments in 2005-06 and 2006-07. The difference, \$42.8 million, would be used to offset General Fund expenditures.

Additionally, DHCS proposes to provide the Director of DHCS the authority to utilize a portion of the redirected funding to make payments to hospitals that received Disproportionate Share Hospital (DSH) Replacement underpayments in 2005-06 and 2006-07, if a determination is made that such underpayments occurred.

Finally, DHCS proposes to continue to exercise its powers received from California Medical Assistance Commission’s (CMAC) dissolution for the years that have not yet been finalized even though the All Patient Refined-Diagnosis Related Group (APR-DRG) have been implemented.

**Background.** SB 1100 (Statutes of 2005) established the Medi-Cal Hospital/Uninsured Care Demonstration Project Act which set forth a methodology for distributing the funding made available under the Demonstration. Under SB 1100, additional funding termed “stabilization funding” may be available to private DSH and non-designated public hospitals for the period of the Demonstration Project.

Stabilization payments (STB) cannot be paid out until DHCS completes the final reconciliation of the hospital workbooks. The reconciliation for 2005-06 is scheduled to be finished in 2011-12 and the reconciliations for 2006-07 and 2007-08 are scheduled to be completed in 2012-13.

Under the 2005 Demonstration Project, private DSH and nondesignated public hospitals are permitted to receive stabilization funding as determined under specific formulas. Most of this funding has not been paid out for the entire Demonstration Period. In December 2009, upon

request by private hospitals, an interim STB payment for 2005-06 (\$25.5 million) was made to relieve private hospitals' cash crisis.

**Hospital Quality Assurance Fee.** In 2009, AB 1383 (Statutes of 2009) established the Hospital Quality Assurance Fee (QAF) program and included supplemental payments to all private and nondesignated hospitals up to the available Upper Price Limit (UPL) and provided significant supplemental payments under Medi-Cal managed care. Subsequently, SB 90 (Statutes of 2011) continued the Hospital Quality Assurance Fee program and associated supplemental payments for private hospitals, and AB 113 (Statutes of 2011) instituted an intergovernmental transfer (IGT) program, which funded supplemental payments for non-designated public hospitals.

These programs have resulted in billions of additional revenue being provided to these hospitals. Given the significant additional funding provided under these QAF and IGT programs, DHCS believes that redirecting the unpaid stabilization funding is appropriate to achieve State General Fund savings without impacting beneficiary access or a significant impact on the financial status of the hospitals.

**Subcommittee Staff Comment and Recommendation—Approve.** This proposal would provide one-time General Fund savings without impacting access or a significant financial impact to the hospitals. The programs discussed above resulted in billions of additional revenue being provided to these hospitals.

In addition, it provides DHCS the authority to correct underpayments to hospitals, if necessary, without impacting the General Fund. This proposal is also necessary to allow DHCS to retain the power to finalize payments made with the authority granted to fulfill the responsibilities transferred from CMAC after the implementation of the APR-DRGs without this change DHCS would be unable to finalize payments previously handled by CMAC.

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

1. Please provide a summary of this proposal.

## 8. Interest Rates on Medi-Cal Overpayments

**Budget Issue.** The DHCS is proposing legislation that would require DHCS to assess interest against Medi-Cal provider overpayments at the Surplus Money Investment Fund (SMIF) rate or seven percent per year (annum), whichever is higher. The legislation would also require DHCS to pay interest at the same rate to a provider who prevails in an appeal of a payment disallowed by DHCS.

This would result in \$1.5 million (\$750,000 General Fund) savings in 2012-13 and \$3 million (\$1.5 million General Fund) savings in 2013-14.

**Background.** The Third Party Liability and Recovery Division (TPLRD) is responsible for ensuring that the Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties to pay for health care services to beneficiaries, and for taking all reasonable measures to ensure that the Medi-Cal program is the payer of last resort. TPLRD's Overpayments (OP) Section is responsible for enforcing fiscal compliance with Medi-Cal laws and regulations by Medi-Cal providers and beneficiaries and to recover funds due the Medi-Cal program for overpayments made to those providers and beneficiaries. In fiscal year 2010-11, the OP Section recovered over \$204 million (Total Fund).

Overpayment cases are referred to TPLRD by the Audits and Investigations (A&I) Division and by the Medi-Cal Fiscal Intermediary. Once an audit identifies that an overpayment has been made to a Medi-Cal provider, DHCS issues a demand for payment. If the provider does not pay the overpayment in full within 60 days, DHCS assesses interest on outstanding overpayments in accordance with the State Controllers Office's SMIF rate.

The 47-year average for the SMIF rate is 5.5 percent; however, the average SMIF rate over the last 20 years is 2.75 percent. The current SMIF rate is 0.480 percent and is far below the current lending rates of financial institutions and the state's borrowing rate. Since the current borrowing rate is higher than the SMIF rate, providers have little or no incentive to repay overpayments within the first 60 days or to secure financing from an alternate source. Providers opt to either allow DHCS to offset their claims flow until the overpayment is fully reimbursed, make partial payments, or enter into a repayment agreement with DHCS rather than paying the overpayment obligation immediately and/or obtaining financing from a financial institution.

Until recently, federal law required DHCS to return the federal portion of an overpayment to CMS within 60 days of discovery of the overpayment regardless whether DHCS has recovered the overpayment from the provider. In 2010, the Affordable Care Act extended the timeframe states have to reimburse the federal portion of an overpayment to one year from the date of discovery. If the state recovers the overpayment from the provider prior to the one-year deadline, the federal portion must be returned at the time the state receives payment. However DHCS continues to refund federal portion at 60 days due to extensive system changes required to refund at one year. When providers fail to repay overpayment debt before the federal portion is refunded, the state must borrow funds or redirect funds to repay CMS.

Since the state currently borrows at a rate that is higher than the rate charged to providers, the difference must come from funds that DHCS could otherwise allocate to the provision of more services to the Medi-Cal population. The higher the state expenditures are, the more money the state must borrow. In instances where the state does borrow externally, interest rates have been up to 3 percent in recent years. This is much higher than the current SMIF rate.

Other TPLRD recovery programs, such as estate recovery and the collection of quality assurance fees, assess interest on unpaid recovery debt at a rate of seven percent per annum.

It should be noted that the interest rate charged by Medicare for overpayments is 11.5 percent and has been above 10 percent since at least the year 2000.

**Subcommittee Staff Comment and Recommendation—Approve.** Because interest rates assessed on Medi-Cal provider overpayments are so low, they neither deter provider overbilling, nor do they encourage timely repayment of overpayments. Rather, the low interest rates actually cause a loss of General Fund revenue. These low interest rates afford providers little to no incentive to repay Medi-Cal overpayments promptly or to secure financing from an alternate source to repay the debt. It is recommended to approve this proposal.

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

1. Please provide a summary of this proposal.

**9. Hospital Quality Assurance Fee**

**Budget Issue.** In order to extend the Hospital Quality Assurance Fee (QAF) program through 2013, as required by SB 335 (Statutes of 2011), DHCS requests the following:

- To extend 9.5 positions that are set to expire on June 20, 2012 until December 31, 2015 for a cost of \$1 million (\$471,000 from the Hospital Quality Assurance Revenue Fund and \$562,000 in federal funds)
- Contract funds to calculate and validate capitation rates for a cost of \$600,000 for 2011-12 and \$100,000 for 2012-13 (costs for these contracts would be split equally between the Hospital Quality Assurance Revenue Fund and federal funds)

**Table: Estimated Revenue from Hospital Quality Assurance Fee** (dollars in millions)

	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14 (6 months)</b>
QAF Revenue	\$2,637	\$2,942.3	\$1,533

Note: The estimated QAF revenue information is presented on an accrual basis.

**Table: Proposed Payments** (dollars in millions)

	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14 (6 months)</b>
Direct Grants to Public Hospitals	\$47	\$68	\$27
Hospital Payments (includes Private and Non-Designated Hospitals, Managed Care Plans, and Mental Health Plans)	\$2,591	\$7,018	\$2,626
Children’s Health	\$255	\$472	\$193
DHCS Staff and Administration	\$1	\$1	\$1
<b>Total Payments</b>	<b>\$2,894</b>	<b>\$7,559</b>	<b>\$2,846</b>

Note: The estimated payments are presented on a cash basis. The DHCS Staff and Administration information for 2013-14 reflects the approximate budget authority for 12 months; the rest of the items in 2013-14 represent six month estimates.

Each of the proposed expenditures from Table 2 is described below:

- **Direct State Grants to Public Hospitals.** As contained in statute, Public Hospitals are to receive direct grants in support of health care expenditures. Public hospitals include both those operated by counties and by the University of California system. These grants are not considered Medi-Cal payments and cannot be matched with federal funds. This is because these hospitals are now paid at the maximum amount that qualifies for federal matching funds under the existing Hospital Financing Waiver.
- **Hospital Payments.** This reference in the table above broadly covers several areas. First, private hospitals (those paying the fee) will receive *supplemental* Medi-Cal payments for inpatient and outpatient hospital and subacute care services. These supplemental payments are in addition to existing Medi-Cal per diem payments.

Second, the DHCS will increase Medi-Cal payment rates to Managed Care Plans (Plans) and require them to “pass-through” all of these funds to hospitals. The Plans will receive funds for those hospitals located in their service region as well as funds for hospitals in neighboring counties where there is no Medi-Cal Managed Care. The Plans will then pay *supplemental* payments to these hospitals as directed by the DHCS. The amount a hospital will receive will be based on the number of total Medi-Cal Managed Care days it provides.

Third, the DHCS will provide payments to County Mental Health Plans to “pass-through” to hospitals providing Acute Psychiatric Services. This is a *supplemental* payment made in a similar manner as done with the Managed Care Plans.

Fourth, non-designated hospitals (District Hospitals) will also receive *supplemental* Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals since non-designated hospitals are not paying the QAF.

- **Children’s Health.** As contained in statute, funds are provided for health care coverage of children. The funds are an offset to General Fund support in the Medi-Cal Program for providing services to children. These funds will be matched with federal funds.
- **Department of Health Care Services—9.5 State Staff.** For 2012-13, DHCS requests to extend 9.5 positions to administer this program.

The DHCS states the workload for these staff includes the following key items:

- Develop and secure federal approval for State Plan amendments, fee models.
- Monitor plans’ contracts with hospitals to ensure compliance resulting in pass-through of appropriate funds.
- Reconcile QAF funds included in the capitation rates paid to managed care plans to actual amounts paid to hospitals.

- Respond to legal issues regarding the QAF program.

**Background.** The enabling legislation specifies a three-tier QAF structure which is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Certain categories of hospitals, such as designated public, small and rural, most specialty care and long-term care, are exempt from paying the fee.

Statute establishes a per diem fee assessed on every private acute care hospital for every acute, psychiatric, and rehabilitation inpatient day at the following:

- \$86.40 per managed care day (other than Medi-Cal)
- \$383.20 per Medi-Cal day
- \$48.38 per prepaid health plan hospital managed care day
- \$214.59 per prepaid health plan hospital Medi-Cal managed care (MCMC) day
- \$309.86 per Fee for Service (FFS) day (other than Medi-Cal).

It should be noted that DHCS may alter the specified QAF amount in order to obtain federal CMS approval. As such, the above fee schedule may be altered.

DHCS anticipates receiving CMS approval for this QAF by the end of March or early April.

**Subcommittee Staff Comment and Recommendation—Hold Open.** The DHCS must obtain federal CMS approval for this program. It is important to obtain an update from DHCS to enable the Legislature to work collaboratively with the Administration to secure federal CMS assistance and approval.

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

1. Please provide a brief overview of the structure for this Quality Assurance Fee (QAF).
2. Please provide an update regarding progress being made with the federal CMS regarding the approval of this QAF.

## 10. Money Follows the Person

**Budget Issue.** The DHCS requests to (1) extend three existing limited-term positions (set to expire June 30, 2012) and (2) establish five new limited-term positions to maintain the current Money Follows the Person (MFP) program, meet program benchmarks, expand MFP into additional counties, and implement Minimum Data Set (MDS) 3.0 Section Q (a new federal code requirement that addresses discharge planning for nursing home residents).

The term of the new positions would be from July 1, 2012 to March 31, 2016, to coincide with the federal grant. The cost to extend the existing positions and establish the new positions is \$892,000 in federal funds.

The five new positions would:

- Train nursing facilities and Local Contact Agencies (LCAs) on MDS 3.0 Section Q requirements.
- Automate several accounting and data collection activities (staff currently processes every piece of data manually).
- Ensure that CMS mandated Quality of Life surveys are completed correctly and timely.
- Adjudicate treatment authorization requests from home and community-based providers for California Community Transitions participants.

**Background.** California received a Money Follows the Person grant in January 2007 and developed the California Community Transitions (CCT) project. This grant is to be used to target Medicaid enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal is to offer a menu of social and medically necessary services to assist them to remain in their home or community environments. In 2010, MFP transitioned 205 individuals from a health facility into the community.

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

By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

**Subcommittee Staff Comment and Recommendation—Approve.** The proposal is consistent with Olmstead implementation in California and the positions are warranted. It is recommended for approval.

**Questions.** The Subcommittee request DHCS to respond to the following questions:

1. Please provide a summary of this proposal.
2. Please discuss your goals for this project.

## 11. Access Monitoring Program

**Budget Issue.** The DHCS is requesting two permanent positions to comply with new federal requirements to establish a system for continuously monitoring Medi-Cal beneficiaries' access to health care services. These positions are in addition to the one permanent position to be redirected within DHCS to this program. Additionally, DHCS is also requesting \$334,000 in contract dollars to hire consultants to assist with stakeholder meetings and monitoring methodology. The cost of the positions and contract would be \$564,000 (\$282,000 General Fund and \$282,000 Federal Funds).

**Background.** AB 97 (Statutes of 2011) requires DHCS to implement a 10 percent provider payment reduction. Prior to implementation, DHCS had to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) to modify its Medicaid State Plan via a State Plan Amendment (SPA). New requirements set forth by CMS for approval of SPAs necessitate California to develop and implement a system for monitoring healthcare access for its Medi-Cal beneficiaries.

In the past few months, DHCS has been working with CMS to establish a health care monitoring plan for Medi-Cal's beneficiaries enrolled in fee-for-service. The proposed plan includes 22 measures and focuses on provider availability, service utilization, and outcomes.

Monitoring of these measures would occur on a quarterly basis. DHCS would publish results from a full year of health care access monitoring in the form of an annual report which would be made available to the public. CMS is also requiring that states implement an ongoing mechanism allowing beneficiary feedback, such as information collected through surveys, hotlines or beneficiary Ombudsman offices. Currently, California does not have a mechanism in place to receive information from enrollees pertaining to health care access issues in the Medi-Cal program. Therefore, the addition of a Medi-Cal beneficiary help line similar to that implemented for Medi-Cal Managed Care will be established to meet this new requirement.

Additionally, the Bridge to Reform Waiver requires the department to evaluate health care access for the populations enrolled under the waiver.

**Subcommittee Staff Comment and Recommendation – Approve.** Based on the recent federal requirements, the state must assure access for program beneficiaries not only when rate adjustments are being proposed, but continuously as a routine part of their operations. Consequently, this proposal is recommend for approval so that DHCS can establish an access monitoring program.

**Questions.** The Subcommittee request DHCS to respond to the following questions:

1. Please provide an update on the AB 97 lawsuits.

## 4280 Managed Risk Medical Insurance Board

### I. BACKGROUND

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

- Healthy Families Program
- Pre-Existing Conditions Insurance Program
- Major Risk Medical Insurance Program
- Access for Infants and Mothers Program
- County Children’s Health Initiative Matching Program

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

**Pre-Existing Conditions Insurance Program (PCIP).** As a result of the federal Affordable Care Act of 2010, California has a contract with the federal Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013 when the national health reform is set to begin. The program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last 6 months.

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

**Access for Infants and Mothers (AIM).** AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant’s contribution to cover the cost.

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

**Budget Overview.** The budget proposes expenditures of \$965.6 million (\$136.2 million General Fund) and 99.7 positions for MRMIB. See table below for more information.

**Table: MRMIB Program Funding** (dollars in thousands)

<b>Program</b>	<b>2011-12</b>	<b>2012-13</b>	<b>Change</b>
Major Risk Medical Insurance Program	\$38,592	\$43,015	\$4,423
Access for Infants & Mother	\$132,156	\$127,096	-\$5,060
Healthy Families Program	\$1,189,770	\$444,627	-\$745,143
County Health Initiative Program	\$1,951	\$2,213	\$262
Pre-Existing Conditions Plan (PCIP) Program	\$320,681	\$348,618	\$27,937
<b>Totals Expenditures</b>	<b>\$1,683,150</b>	<b>\$965,569</b>	<b>-\$717,581</b>
General Fund	\$288,610	\$136,213	-\$152,397
Federal Funds	\$843,812	\$358,049	-\$485,763
Federal Funds—High Risk Health Insurance	\$320,681	\$348,618	\$27,937
Children’s Health & Human Services Special Fund	\$123,160	\$11,342	-\$111,818
Managed Risk Medical Insurance Fund	\$38,538	\$43,015	\$4,477
Other Funds	\$68,349	\$68,332	-\$17

**Workforce Cap Plan.** Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, MRMIB was required to reduce its budget by 5 positions and \$352,000 (\$123,000 General Fund). This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

**II. ISSUE FOR DISCUSSION**

**1. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS**

**Budget Issue.** The Governor proposes to shift *all* Healthy Families Program (HFP) children into Medi-Cal over a nine-month period beginning in October 2012. Approximately 870,000 eligible enrollees would move to Medi-Cal in phases between October 2011 and June 2013.

This shift (without any change to the HFP rate, as discussed in the next issue) would be a net cost to the state of about \$10 million General Fund in 2012-13 and \$43.5 million General Fund in 2013-14. See table below for details on the net fiscal impact to the state with this transition.

**Table: Nine-Month Net Impact to State with Healthy Families Program Shift to Medi-Cal**  
(in thousands)

	<b>Total Funds</b>	<b>General Fund</b>
<b>MRMIB</b>		
Benefits Savings	-\$427,083	-\$149,479
Administrative Savings	-\$22,782	-\$7,974
Premiums	\$60,345	\$21,121
FQHC Wraparound Payments	-\$24,613	-\$8,614
<b>MRMIB Total</b>	<b>-\$414,133</b>	<b>-\$144,946</b>
<b>DHCS</b>		
Benefit Cost	<b>\$498,258</b>	<b>\$168,112</b>
Premiums	-\$43,211	-\$15,124
<b>Subtotal</b>	<b>\$455,047</b>	<b>\$152,988</b>
County Administrative Cost 100-150% FPL	\$8,482	\$4,241
Other Administrative Cost 150+ FPL	\$15,497	\$7,749
<b>Subtotal</b>	<b>\$23,979</b>	<b>\$11,990</b>
Family Health Impact	-\$46,562	-\$10,019
<b>DHCS Total</b>	<b>\$432,464</b>	<b>\$154,959</b>
<b>Net Impact to State</b>	<b>\$18,331</b>	<b>\$10,012</b>

**Transition Phase-In.** The table below displays the proposed phased-in approach.

**Table: Proposed Transition of HFP Enrollees to Medi-Cal**

Phase	Impacted Enrollees	Eligibles	Percent of Eligibles	Phase-In Period
1	HFP children with a “matching” Medi-Cal managed care plan	411,506	47 %	October – December 2012
2A	HFP children in a plan that subcontracts for Medi-Cal managed care	271,536	31%	January – March 2013
2B	HFP children in a managed care plan that does not contract or subcontract with Medi-Cal	145,069	16%	January – March 2013
3	HFP children in fee-for-service	49,671	6%	January – June 2013
	<b>TOTAL Children</b>	<b>870,782</b>		

Note: This table does not reflect a growth in the HFP caseload and was a point-in-time estimate.

**Table: Proposed Phase-In Schedule**

	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-12	May-13	Jun-13
<b>Phase 1</b>	136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889
		136,889	136,889	136,889	136,889	136,889	136,889	136,889	136,889
			136,889	136,889	136,889	136,889	136,889	136,889	136,889
<b>Phase 2A and 2B</b>				141,368	141,368	141,368	141,368	141,368	141,368
					141,368	141,368	141,368	141,368	141,368
						141,368	141,368	141,368	141,368
<b>Phase 3</b>				7,182	7,182	7,182	7,182	7,182	7,182
					7,182	7,182	7,182	7,182	7,182
						7,182	7,182	7,182	7,182
							7,182	7,182	7,182
								7,182	7,182
									7,182
<b>Total</b>	136,889	273,778	410,667	559,217	707,767	856,317	863,499	870,681	877,863
<b>2012-13 Enrollment Months</b>									5,556,678

Note: This table reflects a 0.6 percent growth in the HFP caseload.

According to DHCS, all HFP beneficiaries moved into Medi-Cal managed care during Phase 1 will be allowed to keep their provider if their provider is in the plan’s Medi-Cal network. HFP beneficiaries transitioning in Phase 2A will be enrolled into a Medi-Cal managed care plan based on their provider’s linkage to a plan so those beneficiaries *may* not have to change providers.

However, in Phase 2B, beneficiaries whose providers are not, or will not be, in a Medi-Cal managed care plan network will be covered by the same continuity of care requirements currently in place for the Seniors and Persons with Disabilities population (these requirements are supposed to guarantee a beneficiary can continue to see a provider to receive ongoing treatment for a condition for up to one year after enrollment) will also be applied to the incoming HFP population. These providers must be willing to see the patient and accept payment from the health plan at the Medi-Cal rate.

**Dental Managed Care.** Furthermore, under this proposal, once the enrollees transition into Medi-Cal for medical care, they will concurrently transition into Medi-Cal for dental coverage. Individuals enrolled in an HFP dental plan would transition to the same dental plan to the extent that the plan is a Medi-Cal dental managed care plan. If the enrollee's HFP dental plan is not a Medi-Cal dental managed care plan, DHCS would be authorized to contract with the dental plan to allow the individuals to enroll in the same plan. These new dental health plans will also be available for voluntary enrollment by existing Medi-Cal enrollees. Individuals who are enrolled in the HFP Exclusive Provider Organization would enroll in the Medi-Cal dental fee-for-service system.

**Eligibility Processing.** Additionally, the proposal would:

- **County Performance Standards.** Establish new county eligibility reporting and performance standards. Counties would be required to report to DHCS the number of applications and annual redetermination forms processed on a monthly basis, a breakout of applications and annual redetermination forms based on poverty level, final disposition of applications and annual redetermination forms, and average number of days to process applications and annual redetermination forms received directly from the county and from the Single Point of Entry (SPE). DHCS would determine the manner and time period for county submission of reports and would provide enrollment information regarding the transition enrollees to the Legislature within one year of enactment.
- **Single Point of Entry Processing Standard.** Establish a new 10 working day standard for counties for processing applications and redetermination forms received from the SPE and for acting on information received from the SPE that may impact eligibility for individuals with incomes between 150 percent and 250 percent of the federal poverty level (FPL).
- **New Budgeting Methodology for Eligibility Processing.** Develop a new budgeting methodology for eligibility processing in consultation with the counties.
- **Managed Care Performance Standards.** Require Medi-Cal managed care plans into which the HFP enrollees would transition, to meet specified performance standards and comply with all existing performance standards and measurements set forth in the law *prior* to the transition of any children.

- **Continuity of Care.** Require plans to allow the enrollees to remain with their current primary care provider, or report to DHCS how they will provide continuity of care.

New applicants seeking services as of October 1, 2012 will go straight into Medi-Cal and continue to be able to apply for health care services through County Human Services Offices or through the existing Single Point of Entry (SPE). Counties would make eligibility determinations as they do today for children applying at the local county office.

Children with incomes up to 150 percent of FPL would enroll into no-cost Medi-Cal, receive services through the Medi-Cal delivery system and receive ongoing case management through the County.

Children with incomes above 150 percent of FPL and up to 250<sup>1</sup> percent of FPL would enroll in Medi-Cal and be subject to premiums. DHCS will use the same premium amounts as Healthy Families. The existing contractor that handles Healthy Families eligibility determinations or the counties would handle the ongoing management of the cases for individuals with incomes above 150 percent of FPL and up to 250 percent of FPL. To the extent the current eligibility processing vendor handles the ongoing case management for these children, DHCS *may* contract with select counties (i.e., a “regional” approach rather than all counties) to make the annual redetermination. (The details on these processes have not yet been worked out.)

The SPE vendor would continue to do the initial screening of applications it receives and would grant presumptive eligibility<sup>2</sup> for those who appear to meet established income guidelines. The SPE would forward the case to the county for a *final* eligibility determination. Once the county establishes eligibility, the income level of the child would determine how the case would be managed as described above.

Healthy Families children that are eligible for California Children’s Services (CCS) will continue to receive CCS under the Medi-Cal program as they do today. Counties will continue to administer CCS for these children and be required to fund the same share of the non-federal share of the CCS costs as they do today for these children with a CCS-eligible condition.

***Proposed Benefits of Transition.*** The Administration recognizes that many details need to be worked out once this proposal is enacted. They state that key benefits of this consolidation would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of FPL;
- Families would be able to apply for coverage at a county, by mail, or on-line and will not have to have their application bounced between programs;

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<sup>1</sup> Income eligibility for targeted low-income children is technically 200 percent of the FPL pursuant to federal Medicaid law. Thus for individuals with incomes above 200 percent and up to 250 percent of the FPL, an income deduction is provided in an amount that will result in an effective income of 200 percent of the FPL.

<sup>2</sup> DHCS is working out the details for how presumptive eligibility will be handled since elimination of this would be considered ACA maintenance of effort violation.

- Children at or below 150 percent of FPL would no longer pay premiums, as is presently done in the Healthy Families Program;
- Children would receive retroactive coverage for three-months *prior* to their application;
- Children would be eligible for the free federal Vaccines for Children (0 to 18 years);
- Makes available to low-income children comprehensive Medi-Cal services including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;
- Many children would be able to remain with their existing provider during the transition as Health Plans contract with providers for both Medi-Cal and Healthy Families. It is estimated that 78 percent of children in Healthy Families match to a health plan that currently participates in both Medi-Cal and Healthy Families (either via a contract or subcontract, Phase 1 and Phase 2A);
- There has been a considerable decline in the commercial health plans participating in Healthy Families in many counties. By consolidating Healthy Families and Medi-Cal, children will have more stable plan choices;
- Consolidates health care entitlement programs under one department so that duplicative systems and processes can be eliminated to gain administrative efficiencies;
- Simplifies contracting requirements, rates and other core components of delivering services in the public sector for health plans and providers;
- Increases the ability of the state to monitor encounter data and payment data to better ensure the state is receiving its best value for the dollars it invests in children's coverage;
- Serves as an early building block for successful implementation of federal health care reform. California must implement many changes before 2014, including new online enrollment processes, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Under health care reform, HFP children with incomes under 133 percent of FPL would become Medi-Cal enrollees on January 1, 2014.

**LAO Recommendation.** The LAO finds that the proposal has merit in that consolidating state health programs would improve continuity of care for families who have one child currently enrolled in HFP and one child enrolled in Medi-Cal because all the children could be enrolled in the same plan together. However, the LAO finds that the proposal also raises concerns regarding the potential for interrupted services for HFP enrollees as they transition to Medi-Cal. As an alternative, the LAO recommends that children in families with incomes between 100 percent and 133 percent of the FPL, who are required to shift to Medi-Cal under ACA in 2014, be shifted to Medi-Cal in 2012-13. This shift would serve as a pilot to test guide future decision making in this programmatic area.

**Subcommittee Staff Comment and Recommendation—Hold Open.** There are many outstanding issues that still need to be addressed including ensuring access and continuity of care for these children and county eligibility workflow and timeframes. For example, although DHCS estimates that 78 percent of HFP children are enrolled in a plan that currently participates in both Medi-Cal and Healthy Families this estimate assumes these plans will have the capacity to accept these children as Medi-Cal enrollees.

It should be noted that last year's budget act included language requiring the administration to develop a transition plan for the transfer of administrative functions for the operation of HFP (and the Access for Infants and Mothers Program) to the Department of Health Care Services and submit the plan to the Legislature no later than December 1, 2011. This plan has not yet been submitted.

Additionally, as discussed above, under federal health care reform, HFP children with incomes under 133 percent of FPL (approximately 186,000 children as of November 2011) would become Medi-Cal beneficiaries on January 1, 2014. With this proposal, the administration has decided that children in families with incomes over 133 percent of FPL should also move to Medi-Cal even though this is not required by health care reform. As implementation of health care reform moves forward, including the development of the Health Benefit Exchange, the Legislature may want to consider if it would be more appropriate for these children in higher income families to obtain coverage from the same provider as their parents.

Generally speaking, based on 2009 HEDIS (Healthcare Effectiveness Data and Information Set) quality measures, HFP and Medi-Cal show relatively little difference in quality of care indicators. Furthermore, each program has historically had its own strengths, for example, most would agree that HFP has provided better access to care than Medi-Cal (HFP's higher reimbursement rate is likely a contributing factor to this) and that the Managed Risk Medical Insurance Board has a stronger focus on children's issues, while Medi-Cal's mental health coverage is more broad than HFP and Medi-Cal has more rigorous due process regarding grievances. If these children are shifted to Medi-Cal, the administration should work to ensure that the strengths of the HFP program are incorporated into the Medi-Cal program.

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

1. Please provide an overview of the key concepts of the proposal.
2. Please discuss how DHCS and MRMIB have coordinated and planned for this proposal.
3. How have DHCS and MRMIB reached out to the various constituency interests to engage in working out the details of this proposal?
4. What are the key short-term aspects that need to occur for this to be an effective transition?
5. What are the longer-term components that need to be addressed?
6. How may the state track progress during a phase-in to ensure that children are being transitioned appropriately? How can access be assured?
7. What key issues have been expressed by health plan providers (provider networks, rates)?

## 2. Healthy Families Program Rate Reduction

**Budget Issue.** The administration proposes trailer bill language to require the Managed Risk Medical Insurance Board (MRMIB) to negotiate managed care health plan capitation rates for children receiving health care services in the Healthy Families Program (HFP) at a statewide weighted average capitation rate that is less than or equal to the statewide average capitation rate established by the Department of Health Care Services for health benefits for children up to age 19 in the Medi-Cal program.

The HFP rates are over 25 percent higher (on average) than Medi-Cal rates for children up to age 19. The new rates would be effective October 1, 2012.

With this proposal, the administration estimates \$202.1 million (\$71 million General Fund) savings in 2012-13 and \$279.5 million (\$98.2 million General Fund) savings in 2013-14 and annually thereafter.

**Background.** MRMIB is responsible for negotiating rates with health plans that participate in HFP. The current statewide average benefit cost per month per eligible member (PMPM) for HFP is \$103.44. MRMIB negotiates HFP rates with contracting plans during the months of January through April for Board approval in May. These negotiated rates are effectuated annually with an October 1 start date.

In comparison, with this proposal DHCS, estimates that the rate for these children would be \$76.86 in Medi-Cal. The table below details the components of the Medi-Cal rate.

**Table: Components of Medi-Cal Rate for Children Age 0-19**

Managed Care Cap Rate	\$62.02
Managed Care Carve Out	\$2.58
Fee-For-Service Costs	\$0.43
Dental	\$11.83
<b>Total</b>	<b>\$76.86</b>

According to the administration, there are several differences in benefits, contracting, and financing that help explain the lower Medi-Cal rates compared to HFP. The administration finds that these differences explain why the rate change would not lead to disruption in provider and plan participation. Among these differences are:

1. Mental health benefits are fully carved out in Medi-Cal and Medi-Cal plans have no responsibility for these costs. HFP plans are responsible for mental health services until the member was accepted into the county mental health system.
2. Vaccines for Children program funds are available to Medi-Cal members and not to HFP members saving both the Medi-Cal plan, and provider, the cost of vaccines.

**LAO Comment.** The LAO finds that it is unclear whether or not MRMIB would be able to negotiate a lower rate. It notes that while the benefits offered under HFP and Medi-Cal are largely equivalent, the access to providers may differ between the two programs.

One survey found that when pediatricians who currently see patients enrolled in HFP and Medi-Cal were asked if they would continue to see HFP enrollees after they were transitioned to Medi-Cal, 51 percent replied that they would, while 19 percent replied they would not and 30 percent were unsure. Of pediatricians who currently see patients enrolled in HFP, but not Medi-Cal, 26 percent responded that they would be willing to enroll in Medi-Cal to continue to see those patients, 29 percent said they would not be willing to enroll in Medi-Cal, and 46 percent were unsure. Some pediatricians surveyed expressed concerns regarding differences between HFP and Medi-Cal in terms of rates, administrative procedures, and access to federal vaccine programs and drug formularies.

Overall, the impact of the Governor's proposal on the provider network and beneficiary access to services is unknown, but there would likely be some pediatricians who currently serve HFP enrollees who would not serve these children once they transitioned to Medi-Cal.

**Subcommittee Staff Comments and Recommendation—Hold Open.** It is unknown how many health plans may be willing to contract with MRMIB for HFP at this reduced rate. It is recommended to get an update from MRMIB on these negotiations.

**Questions.** The Subcommittee requests MRMIB and DHCS to respond to the following questions:

1. What is the status of MRMIB's rate negotiations with health plans?
2. What key issues have been expressed from health plan providers regarding this proposal?
3. How does the Administration think it can maintain access while reducing rates?

### **3. Transfer of MRMIB Programs to the Department of Health Care Services**

**Budget Issue.** The administration proposes to eliminate MRMIB and transfer its programs to DHCS. Specifically, as described earlier, the Healthy Families Program would transfer to DHCS beginning October 2012. The remaining programs, the County Children’s Health Initiative Program, Access for Infants and Mothers (AIM), Major Risk Medical Insurance Program (MRMIP), and Pre-Existing Conditions Insurance Plan (PCIP) would transfer to DHCS effective July 1, 2013.

**Subcommittee Staff Comment and Recommendation–Hold Open.** The trailer bill language describing this proposal is not yet available. Two of the programs proposed to be transferred to DHCS, MRMIP and PCIP, would be eliminated on January 1, 2014 with the implementation of health care reform and the Health Benefit Exchange. Consequently, it is unclear why these programs should be shifted to DHCS for six months before elimination.

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

1. Please provide an overview of this proposal.
2. When will the trailer bill language be made available?