SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 2, 2013

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

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

(Michelle Baass)

PLEASE NOTE:

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

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

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0530 California Health and Human Services Agency

1. Office of the Patient Advocate

Budget Issue. The Office of the Patient Advocate (OPA) requests $184,000 (Office of Patient Advocate Trust Fund) and 1.0 two-year limited-term position to develop a Complaint Data Reporting System, as required by AB 922 (Monning, Statutes of 2011). This includes $67,000 for ongoing technical/statistical support from the National Committee for Quality Assurance and $12,000 to cover expenses associated with the design, translation, printing, promotion, and dissemination of the annual complaint reports and annual stakeholder preview sessions.

With approval of this request, OPA indicates that the following milestones will be completed:

- January - Summer 2013 – Conduct a complaint data assessment, convene an interagency workgroup, and initiate the development of the uniform reporting format.
- Fall 2013 – Initiate submission of the complaint data (retroactive to January 2013).
- January 2014 – Begin to conduct preliminary data analysis and quality assurance review.
- June 2014 – Analyze the first reporting year of complaint data, prepare online complaint report design/display, and design report.
- Summer 2014 – Schedule stakeholder preview of data.
- Fall 2014 – Issue the first report online and hold kickoff summit meeting, disseminate printed copies throughout remainder of the year.
- Repeat the cycle annually ongoing

The current year activities (January – June 2013) are being performed by a position on loan from the Department of Managed Health Care (DMHC). This DMHC position is funded with federal grant funds from the Center for Consumer Information and Insurance Oversight (as part of the Consumer Assistance Program grant). In July 2013, this position would be an OPA employee under this proposal.

Background. AB 922 designates OPA as a central resource to ensure that consumers get information on how to obtain health care coverage for which they are eligible or entitled and how to receive timely assistance in resolving problems when they have difficulty accessing care or have other programs with their health plans or providers.

AB 922 requires that OPA, by January 2013, expand its current audience of commercially covered consumers to serve all publicly and privately covered Californians as well as the uninsured. OPA is specifically mandated to provide the following services:

1. Publicly report and analyze aggregate data on consumer complaints regarding health coverage.
2. Render assistance to consumers regarding problems with their health care coverage or services, including assistance with procedures, rights, and responsibilities related to the filing of complaints, grievances and appeals.
3. Develop protocols and procedures for assisting in the resolution of consumer complaints, including the referral of complaints to the appropriate regulator or health coverage program.
4. Develop, in consultation with specified health coverage programs, education and informational guides to be made available to the public online and through public outreach and education programs.
5. Provide outreach and education about health care coverage options and coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform.
6. Operate a toll-free telephone number that can route callers to the proper regulating body or public program, their health plan, or local consumer assistance program.
7. Operate an Internet website, social media and up-to-date communication systems to provide information regarding consumer assistance programs.

Complaint Data Reporting. AB 922 requires OPA to launch a new project focused on collecting, analyzing and reporting aggregated complaint data from California's two health insurance regulators and three other state agencies. These state entities include Department of Managed Health Care (DMHC), Department of Insurance (CDI), Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), and the California Health Benefit Exchange (Exchange).

With the new mandate to collect, analyze and report complaint data from multiple sources, OPA will need to establish and maintain an ongoing Complaint Data Reporting Project to standardize health care complaint data (more than 30 data elements per complaint) for annual submission by five state entities; and provide for the analysis of the aggregated data set for public reporting. The availability of new aggregated complaint data will increase the state's capability to identify systematic problems through better monitoring of trends and to address emerging problems with timely and appropriate enforcement or other needed policy or program changes.

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

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

1. Please provide an overview of this proposal.

2. Please provide an update on implementation of activities specified in AB 922.

3. How is OPA preparing for implementation of the federal health care reform?

2. Aging and Disability Resource Connection Program Continuation

Budget Issue. The California Health and Human Services Agency (CHHS) requests an increase of $250,000 in federal fund budget authority and extension of two limited-term positions until June 30, 2014, to support the Aging and Disability Resource Connection (ADRC) model of streamlining consumer access to community-based long-term services and supports (LTSS) in California. These positions will improve collaboration between community-based Aging and Disability Resource Connection (ADRC) partnerships and Money Follows the Person (MFP) Lead Organizations.

The positions will be fully funded with federal grant funds via an Interagency Agreement with the Department of Health Care Services.

Background. The California ADRC model offers consumers, regardless of age, disability or income level, access to comprehensive information and a "no wrong door" access to services. The ADRC model brings together multiple local agencies to provide a coordinated system of long-term services and supports (LTSS) through partnership between Area Agencies on Aging and Independent Living Centers, as well as other community partners who serve people with long-term chronic conditions and/or disability.

Growth in the ADRC partnership model has been incremental since 2004, when California launched the first two ADRCs. Today, seven regional ADRCs serve 11 of California's 58 counties: San Diego, San Francisco, Del Norte, Orange, Riverside, Nevada, Butte, Colusa, Glenn, Tehama and Plumas. In January 2013, CHHS awarded the Alameda County ADRC partnership $100,000 in federal funds to support development and implementation of a new ADRC Program in a Duals Demonstration county, bringing the total number of ADRC partnerships to eight.

The mission of ADRCs is to empower consumers to consider all options, make informed decisions, and access community LTSS that help them meet their personal goals for independence – regardless of the source of financing (Med-Cal, Medicare, private insurance, federal or state-funded programs, or private pay).

According to CHHS, approval of this request enables CHHS to maintain the state oversight infrastructure that currently supports ADRC replication and ADRC designation, technical assistance to existing and newly forming ADRC partnerships, collaboration with DHCS and Medi-Cal Money Follows the Person Lead Organizations and Minimum Data Set (MDS) 3.0 Local Contact Agencies (LCAs).

Current federal grants that have supported the California ADRC initiatives expire September 30, 2013.

Background—Money Follows the Person. California received a Money Follows the Person (MFP) 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.

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

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

1. Please provide an overview of this proposal.

2. Please describe in more detail how this proposal will further goals of the Money Follows the Person program.

3. CMS State Innovation Models Grant

Budget Issue. CHHS requests an increase of $1.8 million federal funds in 2013-14 as a result of being awarded a Center for Medicare and Medicaid Services Innovation (CMMI) State Innovation Models (SIM) Grant. It is proposed that these funds would be used to develop innovative models that improve the delivery of health care, lower health care costs, and promote better overall health for Californians.

A current year request for increased federal fund expenditures of $850,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

CHHS proposes to contract with the UC Davis Institute for Population Health Improvement for this project.

Background. CMS is providing nearly $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance and lowering costs for residents of participating states. The projects will be broad-based and focus on people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

California intends to utilize existing state and national initiatives, including capitated payment models, accountable care organizations, bundled episode payments, the Coordinated Care Initiative for dual-eligible Medi-Cal and Medicare beneficiaries, and the state's Section 1115 Medi-Cal Bridge to Health Care Reform Waiver, to inform their model design.

California's design process will involve a broad range of advocacy groups that will address its diverse population in order to develop a model that reflects California's complex health care and financing environment. This design process will enable California to apply for a CMMI SIM Testing Grant, anticipated to be announced later in 2013.

The SIM Design Grant complements the goals of the Governor's Let's Get Healthy California Task Force Report, which outlines a ten-year blueprint to make California the healthiest state in the nation and reduce health care costs. The Task Force's goals and priorities will be used as a basis for the State Health Care Innovation Plan. In anticipation of this grant, the California Health and Human Services Agency formed six private sector work groups in line with the Let's Get Healthy California six strategic goals; the work groups will develop private sector implementation strategies and policy recommendations for the State Health Care Innovation Plan. Health care payment reforms under California's SIM initiative will maximize the value of existing expenditures rather than invest new funds to reform care delivery.

The six strategic goals and workgroups that will inform this process are:
1. Healthy Beginnings – Laying the foundation for a healthy life.
2. Living Well – Preventing and managing chronic disease.
3. End of Life – Maintaining dignity and independence.

4. Redesigning the health system – Efficient, safe, and patient centered care.
5. Creating Healthy Communities – Enabling healthy living.
6. Lowering the Cost of Care – Making coverage affordable and aligning financing to health outcomes.

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

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

1. Please provide an overview of this proposal.

4260 Department of Health Care Services

1. Adult Dental Services

Budget Issue. Senator Steinberg, Subcommittee #3 and several other Senators, are seeking to restore Adult Dental Services as a benefit in the Medi-Cal Program. Presently, only certain "federally required adult dental services" (FRADS) are offered to most adult enrollees. Generally, FRADS primarily involves the removal of teeth.

Through technical assistance discussions with DHCS, the California Dental Association and others, three options have emerged for consideration. It should be noted these fiscal estimates are preliminary may need to be updated at the time of the Governor's May Revision. Specific Medi-Cal dental procedure codes for these options are available.

The three options are as follows:

Option 1: Restore but not Replace Teeth (increase of $70 million GF).

Through option one, adults would receive a basic level of dental health that is within the standards of care. This involves restoring but not replacing existing teeth and providing basic preventive services to maintain these teeth. The DHCS dental consultants believe this is the bare minimum that must be done if dental benefits are brought back.

Preventive and diagnostic services (exams, oral prophylaxis, fluorides, and radiographs) would be provided. Teeth needing repair would be addressed through restorations (amalgams, composite and stainless steel crowns). Root canal treatments could be considered on a case-by-case basis.

Additional procedures regarding periodontics, implants and dentures would *not* be included in this option.

Option 2: Full Mouth Dentures *plus* Option 1 (increase of $90 million GF).

Under option two, full mouth dentures would be provided in addition to the services described under option one. This option would *not* allow for partial dentures.

Option 3: Full Restoration of All Adult Dental Benefits (increase of $166 million GF).

Option three restores all optional procedures for adults that were eliminated through ABX3 5, Statutes of 2009. This would include preventive, diagnostic, and restorative procedures, as well as root canals, laboratory processed crowns, periodontics, implants and partial dentures.

Background. Adult Dental Services, with the limited exception of "federally required adult dental services" (FRADS) and dental services to pregnant women and nursing home patients,

were eliminated as an “optional” Medi-Cal benefit in 2009 due to the state’s fiscal crisis. Generally, FRADS primarily involves the removal of teeth and treating the affected area.

Subcommittee Staff Comment and Recommendation—Hold Open. The elimination of Adult Dental Services created a dramatic impact on the oral health and overall health of millions of Medi-Cal enrollees. Failure to provide Adult Dental Services prevents many individuals from receiving services needed to preserve teeth for eating, overall health and even employment. Without care, dental disease progresses and the pain and infection that results often leads to increased emergency room use.

With the expansion of Medi-Cal to certain childless adults, under federal health care reform, the state could take advantage of the 100 percent federal funding (for the first three years) for these new enrollees. The federal government would be paying for 100 percent of the costs associated with the restoration of Adult Dental Services for the newly eligible under one of these options.

It is recommended to hold this item open until after the May Revision when the Legislature has a better understanding of the state’s fiscal situation.

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

1. Please provide a brief description of the three options, and from a technical assistance perspective, the pros and cons of each.

2. What additional cost may there be if partial dentures were included in option two?

2. Affordable Care Act (ACA) – MAGI Medi-Cal Verification Plan

Oversight Issue. On March 26, 2013, DHCS submitted California's Modified Adjusted Gross Income (MAGI)-based Medi-Cal Eligibility Verification Plan to the federal government. This plan describes the state's planned policies and procedures to verify enrollee information (e.g., income and residency) that would be used to determine MAGI-Medi-Cal eligibility.

Several stakeholders have raised questions and concerns about California's plan that suggest the state is not maximizing available electronic resources to verify key eligibility data factors for MAGI Medi-Cal, thereby, (1) making it more difficult and cumbersome for people to enroll in Medi-Cal and (2) not complying with federal requirements to only require paper documentation when electronic data matches are unavailable.

Background– ACA Envisions Simplified Medi-Cal Enrollment. The federal ACA envisions simplified Medi-Cal eligibility and enrollment policies and procedures. For example, federal law emphasizes the use of electronic verification and permits the request of paper documentation only in instances when electronic data is not available or establishing the electronic data match would not be cost effective or would have an impact on program integrity.

MAGI Medi-Cal eligibility factors that must be verified include: income, residency, age, social security numbers, citizenship, immigration status, household composition, pregnancy, caretaker relative, Medicare, application for other benefits, deceased status, and deprivation.

Federal law also provides some flexibility to states regarding verification policies within certain parameters, including:

- ***Self-Attestation of Information.*** Most significantly, federal law allows states to accept self-attestation without documentation for many eligibility criteria, except as prohibited by law (e.g., verification is required for citizenship and immigration status information). States may verify non-financial information, including state residency, age, date of birth, and household size, using means other than self-attestation, as long as the agency still complies with other sections of the law that specify the reliance on electronic data.

  DHCS does not plan to use self-attestation for MAGI Medi-Cal except where it is required by federal law (pregnancy) and for the caretaker relative factor.

- ***Post-Enrollment Eligibility Verification.*** Federal law also offers states the option to conduct post-enrollment verification on self-attested data, whereby applicants can enroll in MAGI Medi-Cal or exchange programs based on self-attestation information, with the state or exchange, following up by verifying the information afterwards.

  DHCS does not propose to conduct post-enrollment eligibility verification. All information must be verified prior to a person being enrolled into MAGI Medi-Cal.

- ***Reasonable Compatibility.*** For instances when information obtained from a data source is not consistent with what was provided by an applicant, states can generally define their own standard of "reasonable compatibility" between the two pieces of information as specified. For income information, if *both* the self-attested and verified information are either below, above, or at the income threshold or standard in question, this information must be considered reasonably compatible for MAGI Medi-Cal. For exchange programs the reasonable compatibility standard for income is slightly different and can include using a threshold test.

  In situations where information provided by applicants is not reasonably compatible with an electronic data source (and when an electronic data source is not planned to be used), DHCS plans to request paper documentation. DHCS is not proposing to first ask for a reasonable explanation from the individual, stating that it views this as akin to self-attestation.

CalHEERS. The state is currently designing and building CalHEERS, the state's enrollment system for MAGI Medi-Cal and Covered California health insurance programs. This new IT system, among other things, will interface with other federal and state electronic databases to verify individual application information for MAGI Medi-Cal and Covered California programs. These other electronic resources include:

- ***Federal Services Data Hub (FDSH).*** The federal government will establish a Federal Data Services Hub (FDSH) that states may use to verify certain information, or obtain information, from federal sources including the Social Security Administration, Department of Homeland Security, and Internal Revenue Service. Data elements expected to be verifiable through FSDH include income, age/date of birth, Social Security number, citizenship, immigration status, incarceration status, and other health coverage. According to federal regulation, a state must use FDSH to the extent that information related to Medicaid eligibility is available. While states may obtain information through another mechanism subject to federal approval, California is not proposing to do this. According to DHCS, several states are currently in testing with FSDH, including California.

- ***Statewide Automated Welfare System (SAWS).*** SAWS is made up of three county-based computer systems, or "consortia"—LEADER, C-IV, and CalWIN—and is considered an eligibility determination and case management system for county administration of health and human services programs, including CalWORKs, CalFresh, and Medi-Cal. Each county in the state utilizes one of the consortia. SAWS contains a variety of data elements, including income, demographic, eligibility, program participation, and case management information.

- ***Medi-Cal Eligibility Data System (MEDS).*** MEDS is a statewide database that stores client information, such as Medi-Cal eligibility, demographics, and enrollment in other programs like CalWORKs and CalFresh. MEDS generates a Client Index Number (CIN), which is a unique number assigned to an individual for purposes of tracking benefits receipt across programs and counties, among other things.

- ***Income and Eligibility Verification System (IEVS).*** IEVS is mandated by the federal government, among other functions, it obtains, uses, and verifies information pertinent to the determination of eligibility and share of cost for Medicaid benefits by cross-checking data supplied by applicants against other databases, such as those at EDD and FTB, as well as federal databases, including data from the Social Security Administration.

DHCS Not Maximizing Federal Flexibilities and Electronic Verification. As proposed in the MAGI Medi-Cal verification plan, data verification will be required on most eligibility factors as self-attestation will only be allowed when it is required by the federal government. This does not take advantage of opportunities to streamline the Medi-Cal enrollment process.

Additionally, it appears that DHCS has not explored all options to electronically verify a person's residency information. Legislative staff have repeatedly asked DHCS for its analysis of the feasibility of electronically verifying residency information against FDSH, SAWS, and MEDS (for examples) and have not received a response from the Administration. These systems could have an enrollee's address information and both FDSH and MEDS are already identified a databases to verify other eligibility factors (e.g., income and other health coverage).

Consequently, under the proposed process, individuals will *always* have to submit additional information prior to being determined eligible for MAGI Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It appears that DHCS's plan for MAGI Medi-Cal verifications may be inconsistent with the federal policy to only require paper documentation when electronic data matches are unavailable.

Furthermore, DHCS's policy decisions regarding verifications place additional burdens on individuals applying for Medi-Cal coverage and could increase county eligibility processing costs (compared to the county eligibility processing costs when this information is electronically verified), as county eligibility workers would generally be required to process (i.e., "touch") residency verification information for every MAGI Medi-Cal case.

It is recommended to hold this item open as more information becomes available.

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

1. Please provide an overview of DHCS's proposed MAGI Medi-Cal verification plan. What were DHCS's guiding principles when developing this plan?

2. Has CMS provided any feedback on this plan? What is the timeline for the approval of this plan?

3. Please provide an overview of how DHCS considered county eligibility processing costs as part of its MAGI Medi-Cal verification plan design process.

3. ACA – "Mandatory" Medi-Cal Expansion – LAO Analysis

Budget Issue. The Legislature was notified of the Administration's revised estimates related to the "mandatory" Medi-Cal expansion under the ACA in a Spring Finance Letter. These revised estimates project that the General Fund costs of the mandatory expansion will be $188.7 million in 2013-14, $659.6 million in 2014-15, and $729.1 million in 2015-16, when costs are fully phased in. (The January Budget included $350 million General Fund in 2013-14 as a placeholder for the costs.)

This revised estimate was discussed in great detail at the March 14th Subcommittee #3 hearing (see: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/03142013Sub3CalHEERS_EMSA_OSHPD_DPH.pdf).

The Administration's estimate, particularly in the out years, is significantly higher than other models, including the LAO's estimate and CalSIM (which was created by the UCLA Center for Health Policy and Research and UC Berkeley Labor Center for Labor Research and Education). See chart below for a high-level overview of these various estimates.

Table: Already Eligible/Mandatory Medi-Cal Expansion Estimates*

	DHCS	LAO Moderate	CalSIM Base	CalSIM Enhanced
Medical inflation	5%	5.1% Medicaid/ 4.2% CHIP**	2.30%	2.30%
Caseload growth rate	3%	1%	0.07%	0.07%
Take-up rate	N/A	20%	10%	40%
Full take-up achieved	Sept. 2014	July 2016	2018	2016
Total number eligible but not enrolled	N/A	2.5 million	2.5 million	2.5 million
Average monthly enrolled into Medi-Cal (Caseload)				
2013-14	239,283	154,016	200,000	440,000
2014-15	814,960	410,447		
2015-16	858,000	488,218	230,000	490,000
Medi-Cal Per Member Per Month (PMPM)				
2013-14	$136	$125	$135	$150
2014-15	$143	$131	$138	$153
2015-16	$150	$136	$141	$157
Healthy Families Program (HFP) PMPM				
2013-14	$93	$104	$129	$129
2014-15	$98	$109	$132	$132
2015-16	$103	$113	$135	$135
General Fund costs				
2013-14	$188,436,000	$103,844,679	$143,000,000	$378,000,000
2014-15	$661,461,000	$289,528,711		
2015-16	$732,111,000	$358,553,824	$125,000,000	$380,000,000

* For the purpose of creating this chart, certain generalizations were made for ease of comparison (e.g., the CalSIM estimates are based on a calendar year; whereas, the Administration's and LAO's estimates are based on the state fiscal year).
**CHIP is the Children's Health Insurance Program (formerly the Healthy Families Program and now the Targeted Low-Income Children's Program under Medi-Cal).

LAO Analysis. The Subcommittee requested that the LAO perform a detailed analysis of the revised estimates. The LAO's analysis can be found at: http://www.lao.ca.gov/laoapp/main.aspx

According to the LAO, the Administration's fiscal estimates are likely too high. One of the key variations between the LAO's estimate and the Administration's estimate relates to differing underlying assumptions about the number of additional enrollees under the mandatory expansion. The LAO is unclear on the basis for some of the Administration's assumptions in developing its estimates of additional enrollment, and finds that the Administration's enrollment estimates are likely high—particularly in the short term.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open to continue more in-depth discussions regarding these assumptions.

The Subcommittee has requested the LAO to provide an overview of its comprehensive review of the Administration's estimate.

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

Budget Issue. The Governor's January budget does not assume any savings associated with an increase in the federal funding percentage for Medi-Cal for preventative services and adult vaccines as provided under the ACA.

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open. Discussions with DHCS indicate that at least $2.5 million in General Fund savings would be realized as a result of this increased FMAP. This estimate is based on an analysis of only fee-for-service data. It is expected that additional savings would be realized as this analysis is performed on managed care data. It is recommended to hold this item open as more details become available and as the Administration considers its May Revise estimate.

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

1. Please provide an overview of this ACA provision.

2. When does DHCS anticipate having an estimate for the managed care-related savings as a result of this ACA provision?

5. ACA – Medi-Cal Enrollment Assistance and Outreach Grants

Issue. An effective and targeted outreach and enrollment strategy will be necessary to maximize Medi-Cal enrollment under the ACA. The Governor's budget does not include any funds earmarked for this purpose.

As part of its commitment to full and complete implementation of ACA in California, The California Endowment (TCE) Board of Directors has approved providing $26.5 million to the state for the purpose of Medi-Cal in-person enrollment assistance payments and targeted outreach and enrollment grants to community-based organizations. These funds could be used to draw down a federal match; thereby, providing $53 million (total funds) for these purposes.

Specifically, TCE has committed to providing:

- **Medi-Cal Enrollment Assistance - $14 million.** This funding would be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application.

- **Medi-Cal Outreach and Enrollment Grants to Community-Based Organizations- $12.5 million.** This funding would be used to target outreach and enrollment strategies aimed at persons with behavioral health needs; homeless persons; young men of color; persons who are in county jail or state prison, on state parole or county probation, and post-release community supervision; families of mixed-immigration status; school-age children through their educational institutions; and persons with limited English proficiency.

Covered California has received a federal grant and TCE funding for outreach and enrollment activities targeted at those individuals with incomes over 138 percent of the federal poverty level that could qualify for Covered California's health coverage programs. However, these outreach and enrollment strategies may not target individuals who would qualify for Medi-Cal and would not pay for enrollment into the Medi-Cal program.

Subcommittee Staff Comment and Recommendation. It is recommended to adopt placeholder trailer bill language to require DHCS to accept these contributions and seek matching federal funds for these purposes. See Subcommittee staff handout for placeholder language (found at end of agenda).

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

1. Please provide an overview of this issue.

6. Managed Care Organization Gross Premiums Tax

Budget Issue. The Administration proposes to reauthorize the gross premiums tax (GPT) on Medi-Cal managed care plans permanently on a retroactive basis starting July 1, 2012. Reauthorizing this tax would generate General Fund savings of $131 million in 2012-13 and $232 million in 2013-14. The Administration proposes to continue to use 50 percent of the gross premium tax revenue to draw down federal funds and make plans whole and 50 percent of the revenue to offset General Fund spending. Revenue projections for the Gross Premiums Tax fund are $364.6 million in 2012-13 and $485.0 million in 2013-14.

One of the components of the Administration's proposed $1 billion reserve, is $364 million from the gross premiums tax ($131 million from 2012-13 and $232 million from 2013-14).

In addition, the proposed trailer bill language includes a $125 million General Fund loan to the Managed Risk Medical Insurance Board as the GPT has been a funding source for the Healthy Families Program. Consequently, the Administration proposes to implement this trailer bill in the current year.

Background. In 2005, California enacted a quality improvement fee (QIF) on Medi-Cal managed care organizations.[1] Based on federal rules, the fee was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75 percent of the revenue generated was matched with federal funds and used for payments to managed care organizations and the remaining 25 percent was retained by the state General Fund. Under this arrangement, the managed care organizations received a rate adjustment (i.e., on the net, health plans gained).

Effective October 1, 2007, as part of the implementation of the state's new managed care rate methodology, this arrangement changed and 50 percent of the revenue generated by the QIF was matched with federal funds and used for payments to managed care organizations and the remaining 50 percent was retained by the state General Fund.[2] Under this allocation, managed care plans were made whole in that they were reimbursed the amount of QIF they paid, but no longer realized a net benefit.

Changes in federal law resulted in this fee sunsetting on October 1, 2009, as it no longer complied with federal requirements. New federal law required that provider fees be "broad based" and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

Gross Premiums Tax (GPT). Assembly Bill 1422 (Chapter 157, Bass, Statutes of 2009) extended the 2.35 percent premium tax imposed on all types of insurance to include all

[1] Assembly Bill 1762 (Committee on Budget, Chapter 230, Statutes of 2003)

[2] "Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes," California HealthCare Foundation, November 2009.

comprehensive health plans contracting with Medi-Cal. The revenues from this tax were directed to fund health coverage for children through the Healthy Families Program, provide a cost-of-living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates to health plans. Under this arrangement, 50 percent of the revenue was matched with federal funds to make health plans whole and 50 percent of the revenue was used to maintain the Healthy Families Program. This tax expired December 31, 2010 and was extended twice until it expired on June 30, 2012.

It should be noted that because the GPT is an existing tax on a broad group of insurers, the overwhelming majority of which are not health care insurers, it can be extended to Medi-Cal managed care plans without being considered a fee under federal law. As such, the state does not have to meet federal requirements for provider fees to obtain federal matching funds, using this source of revenues as the state match.

Last Year's Proposal. Last year, the Administration proposed to permanently extend the GPT. It was estimated that about $187 million from the GPT would be directed to the Healthy Families Program (and that Medi-Cal managed care plans would receive a rate adjustment to make them whole). The Senate Budget and Fiscal Review Committee approved a two-year extension of this tax; however, this proposal was not voted on by the Legislature. Consequently, this tax expired on July 1, 2012.

The 2012 Budget Act assumed reauthorization of the GPT, and, based on this assumption appropriated no General Fund to cover the Healthy Families Program. On January 7, 2013, the Administration notified the Joint Legislative Budget Committee of an unanticipated cost funding request of $15 million General Fund from the Managed Risk Medical Insurance Board. These requested funds would be used to cover the capitation and administrative vendor costs for the month of December 2012 for the Healthy Families Program.

Subcommittee Staff Comment and Recommendation—Hold Open. Key issues to consider when evaluating this proposal:

- ***Gross Premium Tax Brings In Additional Federal Funding to State.*** With the expiration of the GPT, the state is foregoing hundreds of millions of dollars in additional federal funding for the Medi-Cal program as the revenue from the gross premiums tax can be used as a match for federal funding for Medi-Cal.

- ***State Has One of Lowest Capitation Rates in Country.*** Medi-Cal capitation rates are among the lowest Medicaid rates in the country.[3] With the implementation of the ACA's Medicaid expansion, discussed earlier, it will be important to ensure that Medi-Cal rates are at a level to ensure provider participation in the program in order to ensure access to services. Consequently, as part of these discussions, it will be important to consider the cumulative impact of the AB 97 rate reductions, the managed care efficiencies proposal, and Medi-Cal expansion when evaluating this reauthorization and the

[3] "Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal," California HealthCare Foundation, October 2011.

allocation of the revenues generated from this tax. For example, should the revenues from the GPT be used to offset General Fund expenditures in Medi-Cal or should they be used to increase rates to Medi-Cal managed care plans given their important role in the Medi-Cal expansion. As noted above, when the QIF was first assessed on managed care organizations, it was used to provide a rate increase to managed care plans.

- ***GPT Revenue Does Not Account for Medi-Cal Expansion.*** The Administration's January estimated GPT revenues do not include the impact of the Medi-Cal expansion (related to health care reform). Accordingly, GPT revenues will be higher than projected in the Governor's budget as more people will be covered by Medi-Cal managed care. For the "mandatory" Medi-Cal expansion, the Administration projects an additional $4 million General Fund offset in 2013-14 and $14 million General Fund offset in 2014-15. These numbers are not reflected in the January budget.

- ***Permanent Extension Makes Evaluation Difficult.*** A permanent extension of this tax would make it difficult to periodically evaluate its effectiveness and its impact on Medi-Cal managed care.

Additionally, the Administration has proposed to adopt this trailer bill language in the current year to provide funding for HFP; however, the Administration has indicated that this proposal will change in the May Revision. Consequently, it is recommended to hold this item open. The Administration should submit a General Fund deficiency request to the Joint Legislative Budget Committee for current year funding for HFP.

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

1. Please provide an overview of this proposal.

2. Does the Administration plan to submit a deficiency request to the Joint Legislative Budget Committee for the current year funding for the Healthy Families Program?

7. Managed Care Efficiencies

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

The Administration indicates that this proposal does not require statutory authority, but it has not provided details on how this proposal may be implemented. Discussions with DHCS indicate that potential proposals may include changes regarding potentially preventable hospital admissions and emergency room visits and readmissions.

DHCS indicates that the basis for the amount of $135 million is that this is the amount of AB 97 retroactive savings that should be recouped from Medi-Cal managed care plans. However, since the state is legally not able to recoup from managed care plans for a retroactive period, it is submitting this proposal to achieve equivalent savings.

LAO Recommendation. The LAO recommends against approval of this proposal unless the Administration can provide additional detail about the proposal, including:

- How it plans to incorporate efficiency adjustments into managed care plan rates.
- How the changes will reduce General Fund costs.
- How the changes would potentially impact the quality of care and access to care for Medi–Cal enrollees.

Subcommittee Staff Comment and Recommendation—Hold Open. It is anticipated that more information on this proposal will be forthcoming in the May Revision. Consequently, it is recommended to hold this item open.

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

1. Please provide an overview of this proposal.

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

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

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

This proposal would result in $2 million ($1 million General Fund) savings in 2013-14. These savings come from the reduction in the number of health assessments and reduced mailing costs to implement annual open enrollment offset by one-time system update costs.

Background. Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month.

DHCS contends that a 12-month lock-in with an open enrollment period would bring Medi-Cal managed care in line with the health care industry and 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).

Under annual open enrollment, beneficiaries would receive a written notice prior to the end of an enrollment year, allowing them to change Medi-Cal plans during the open enrollment period. If the beneficiary does not elect to change Medi-Cal plans, he or she would be required to remain in their Medi-Cal plan for one year until the next enrollment period.

A new beneficiary would have the option to change to an alternate Medi-Cal plan within the first 90 days following the first time the beneficiary enrolls in a Medi-Cal plan and then be

subject to the annual open enrollment period for each year thereafter. Beneficiaries with fluctuating Medi-Cal eligibility would be re-enrolled into the Medi-Cal plan previously selected until the next annual open enrollment period.

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

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

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

1. Please provide an overview of this proposal.

9. Diagnosis Related Groups Payment System – Update & Position Request

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

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

Background. There are three main "types" of hospitals: private hospitals, Designated Public Hospitals (DPH), and Non-designated Public Hospitals (NDPH). These three types of hospitals are currently reimbursed for inpatient care using either 1) rates negotiated by the Selective Provider Contracting Program (SPCP), or 2) a cost based reimbursement methodology. DPHs are reimbursed based on certified public expenditures (CPEs).

The reimbursement methodology for private and NDPH hospitals will be changing in the near future. Per AB 1467 (a 2012 budget trailer bill), starting July 1, 2012, and subject to federal approval, NDPHs will be reimbursed based on CPEs, as discussed in more detail in the next item of the agenda. Starting July 1, 2013, private hospitals will be reimbursed using a new DRG methodology. SB 853 (Statutes of 2010) directed DHCS to move to a DRG payment method.

The DRG payment system, which will replace the current payment system for private hospitals, operates on a reimbursement related to the recipient's assigned diagnosis or diagnoses. Diagnoses and procedures must be documented in the patient's medical record. They are then coded in the claim using International Classification of Diseases (ICD-9-CM / ICD-10-CM) nomenclature. The coding process is extremely important since it essentially determines what DRG and reimbursement will be assigned for a patient. Each DRG category is designed to be "clinically coherent", and all patients assigned to a specific DRG are deemed to have a similar clinical condition requiring similar interventions. The payment system is based on paying the average cost for treating patients in the same DRG.

The DRG payment system is intended to help ensure and improve access by providing higher DRG-based payments for sicker patients and by setting payments based on acuity, to improve transparency and fairness compared to the contract-based system (which has confidential negotiated rates), to reward hospitals that reduce costs and complete coding of diagnoses and procedures, and to allow for future implementation of quality factors in payments.

California's DRG model is the All Patient Refined model and was developed by 3M and the National Association of Children's Hospitals and is intended to be suitable for all-patient populations, especially obstetrics, newborns, NICU babies, general pediatrics, and children with complex medical needs.

DHCS has indicated that it has submitted its state plan amendment to CMS to implement this change.

Transition Period. With the implementation of DRGs, DHCS proposes a three-year transition period. Medicare had a similar transition period when it moved to DRGs. The transition period is intended to limit an individual hospital's change in payment from baseline to a plus or minus of 5 percent in year one, 10 percent in year two, and 15 percent in year three. With full implementation of the DRG payment method occurring in year four. DHCS contends that this will provide hospitals with time to make adjustments as needed.

Stakeholder Concerns with DRG Implementation. Concerns have been raised by the hospital industry that the state is not ready to implement the DRG payment methodology. Specifically, for example, hospitals are concerned that the dataset (from 2009) being used to establish the baseline rate is outdated and flawed, that more time is needed to system test these changes with pilot hospitals, and a lack of transparency on how certain policy and casemix adjustor factors were determined.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a status update on DRG implementation.

2. Has testing with pilot hospitals begun? What has been the experience?

3. Please comment on the concerns raised by the hospital industry specifically addressing data validity and a lack of transparency on policy decisions and adjustment factors.

10. Non-Designated Public Hospital Program – Position Request

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

The six positions include the following:

- **Four Health Program Specialist I positions** – Responsible for all the administrative functions of implementing the payment mechanism for these facilities. Their duties would include development of waiver language and implementation of waiver provisions, development of Medi-Cal State Plan amendments and development and implementation of the cost reporting mechanisms for the CPEs.
- **One Medical Consultant II position** – Utilize medical training and knowledge to develop and assess the policies performance measures applicable for the 46 NPDHs participating in the NDPH-Delivery System Reform Incentive Pool program.
- **One Auditor III position** (4 total auditor positions are needed, three are being redirected internally) – Responsible for auditing the cost-reporting information.

Background. AB 1467 (a 2012 budget trailer bill) requires DHCS to change the reimbursement process for the 46 NDPHs to a Certified Public Expenditure (CPE) methodology. Under the CPE methodology, the NDPHs certify the cost of providing inpatient services to FFS Medi-Cal beneficiaries and receive as reimbursement the federal share of those expenditures. This is the same inpatient FFS reimbursement methodology under which the Designated Public Hospitals (DPHs) are reimbursed.

This change in the NDPH reimbursement methodology results in a net loss of funding for the NDPHs, therefore, AB 1467 also requires DHCS to seek approval of an amendment to the 1115 Bridge to Reform Waiver from CMS to increase Safety Net Care Pool Uncompensated Care (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding. The additional funds will be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve.

Prior to AB 1467, NDPHs received either 1) the California Medical Assistance Commission (CMAC) negotiated per diem rates, if they were a contract facility or 2) cost-based reimbursement, if they were a non-contract facility, for hospital inpatient costs for services rendered to Medi-Cal fee-for-services (FFS) beneficiaries. In addition, qualified NDPHs received supplemental reimbursement under the Non-Designated Public Hospital Supplemental Fund. The reimbursement for both their FFS rates and the NDPH supplemental fund was paid with 50 percent federal financial participation (FFP) and 50 percent General Fund. Additionally, NDPHs received other supplemental payments under the Non-Designated

Public Hospital Intergovernmental Transfer Program established in 2011 by AB 113 (Monning, Chapter 20, Statutes of 2011).

DHCS indicates that the increased workload associated with implementing AB1467 requires 1) conversion of six limited-term positions to permanent. Four of these staff will be redirected to NDPH work in the Safety Net Financing Division (SNFD), one position will be redirected to NDPH work in the Director's Office, and one position will be redirected to NDPH work in the Audits and Investigations Division (A&I). A&I needs four positions for NDPH work, but three of these positions are already being redirected internally.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this proposal.

2. Has this proposal been approved by CMS?

11. Hospital Quality Assurance Fee Extension

Budget Issue. The Governor's January budget includes $620 million in General Fund savings in 2013-14 as a result of the Hospital Quality Assurance Fee (QAF). This includes $310 million as a result of the existing fee, which sunsets on December 31, 2013, and $310 million as a result of the proposed extension of this fee.

One of the components of the Administration's proposed $1 billion budget reserve is $310 million from extending hospital QAF.

The budget projects that $3.1 billion in hospital QAF revenue will be generated in 2013-14.

As with past extensions of this fee, it is proposed that the budget score the savings resulting from this fee and that this fee be extended in a policy bill. SB 239 (Hernandez and Steinberg) has been introduced for this purpose.

Background. AB 1383 (Jones, Statues of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. The fee was deposited into the Hospital Quality Assurance Revenue Fund (HQARF), created by AB 188 (Jones, Statutes of 2009). This fund is used to provide supplemental payments to private and nondesignated public hospitals (NDPHs), grants to designated public hospitals (DPHs), and increased payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1653 (Jones, Statutes of 2010) and SB 208 (Steinberg, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383. AB 1653 altered the methodology, timing, and frequency of supplemental payments, increased capitation payments, and increased payments to mental health plans. AB 1653 also allowed the state to retain up to $420 million from the portion of the QAF fund set aside for direct grants to DPHs for the state's use while the bill is in effect. In exchange, a portion of federal flexibility funding was allocated to the DPHs and was identical to the amount of the sum retained by the state from the QAF fund. The department claimed these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and distributed those funds in conformity with the Hospital QAF payment schedule. SB 208 compressed the timeframe for collection of the QAF and distribution of supplemental payments, allowed accumulation of fees in the HQARF in order to make managed care payments, and altered the priority of payments.

SB 90 (Steinberg, Statutes of 2011) extended the QAF program established by AB 1383, for the period of January 2011 through June 2011. The extension provided for supplemental payments to private hospitals, increased payments to managed health care, and mental health plans if enough fees were collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

SB 335 (Hernandez, Statutes of 2011) creates a new QAF program for the period July 2011 through December 2013. This 30-month program was modeled on the original QAF program and two quarter extensions. This program provides for supplemental payments to private hospitals, grants to DPHs and NDPHs, increased payments to managed health care, and mental health plans if enough fees are collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

Structure of Fee. 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).

The table below summarizes the supplemental payments to hospitals, funding for children's health care coverage, and state administrative costs under SB 335. The figures for 2013-14 represent only six months of information, as the hospital QAF under SB 335 expires on December 31, 2013.

Table: Summary of Hospital Quality Assurance Fee, as authorized under SB 335 (Hernandez, Statues of 2011)

Year	Private	NDPH (2)	DPH (3)	Children Health Care Coverage	Admin. Cost	Total
2011-12						
Inpatient FFS	$2,236,944,675					$2,236,944,675
Outpatient FFS	$634,335,739					$634,335,739
Managed Care	$1,366,566,780		$80,000,000			$1,446,566,780
Grants		$18,600,000	$50,000,000	$340,000,000	$1,000,000	$409,600,000
LIHP OON ER (1)	$172,800,000					$172,800,000
Subtotal	**$4,410,647,194**	**$18,600,000**	**$130,000,000**	**$340,000,000**	**$1,000,000**	**$4,900,247,194**
2012-13						
Inpatient FFS	$2,457,121,764					$2,457,121,764
Outpatient FFS	$723,777,454					$723,777,454
Managed Care	$1,237,253,340		$80,000,000			$1,317,253,340
Grants		$18,600,000	$43,000,000	$537,000,000	$1,000,000	$599,600,000
LIHP OON ER (1)	$172,800,000					$172,800,000
Subtotal	**$4,590,952,558**	**$18,600,000**	**$123,000,000**	**$537,000,000**	**$1,000,000**	**$5,270,552,558**
2013-14 (six months)						
Inpatient FFS	$1,395,593,507					$1,395,593,507
Outpatient FFS	$381,615,414					$381,615,414
Managed Care	$651,550,502					$651,550,502
Grants		$9,300,000	$0	$310,000,000	$500,000	$319,800,000
LIHP OON ER (1)	$86,400,000					$86,400,000
Subtotal	**$2,515,159,423**	**$9,300,000**	**$0**	**$310,000,000**	**$500,000**	**$2,834,959,423**
Total	**$11,516,759,175**	**$46,500,000**	**$253,000,000**	**$1,187,000,000**	**$2,500,000**	**$13,005,759,175**

Notes:

(1) LIHP OON ER: Low Income Health Program Out-Of-Network ER Supplemental Payments for Private Hospitals

(2) NDPH: Non-designated Public Hospital

(3) DPH: Designated Public Hospital

DPHs provide Intergovernmental Transfers to fund a portion of the LIHP OON ER Supplemental Payments for Private Hospitals

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this proposal.

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

Oversight Issue. AB 1489 (a 2012 budget trailer bill) requires DHCS, in collaboration with the Department of Public Health, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. Additionally, this analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report.

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

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. It is recommended to hold this item open.

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

1. Please provide an overview of this issue.

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

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

4. Please describe other tools the department is developing to facilitate the referral of nursing home residents to community-based services.

13. Medi-Cal Adult Quality Care Improvement Project – Federal Grant

Budget Issue. DHCS has been awarded a federal grant of $2 million by the Centers for Medicare and Medicaid Services (CMS), for the period of December 2012 to December 2014, with funding made available under the Affordable Care Act (ACA).

For the DHCS project, titled *Medi-Cal Adult Quality Care Improvement (MAQCI): Diabetes Management, Maternal Health and Birth Outcomes, and Mental Health Medication Management,* DHCS requests six two-year, limited-term positions over the life of the grant, $530,000 expenditure authority in 2012-13, $937,000 in 2013-14, and $533,000 in 2014-15 to increase DHCS capacity for reporting on quality measures and performing associated quality improvement activities.

A current year request for increased federal fund expenditures of $530,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

Background. DHCS will undertake coordinated activities to improve capacity for standardized collection and reporting of data on the quality of health care provided to approximately four million adults covered by Medi-Cal. These activities will focus on collection, analyzing and reporting on 16 of the 26 Initial CMS Core Adult Quality Measures that describe the quality of care in three major areas: (1) Diabetes management; (2) Maternal health and birth outcomes; and (3) Mental health medication management.

Each of these three areas is of critical importance to DHCS because they: (1) are linked to significant morbidity and mortality when care is suboptimal; (2) represent significant health care costs; and, (3) have available, evidence-based interventions to improve quality, outcomes, and population health.

The core MAQCI staff will be in the Office of the Medical Director (OMD), and include: (1) the Project Manager (Research Scientist Supervisor I), who will be responsible for the overall project including the deliverables, contracts, activities, and staff supervision; (2) the Project Assistant (Staff Services Analyst), who will assist the Project Manager and will have primary responsibilities to manage the contracts (Interagency Agreements), budget and compilation of reports due to CMS; and (3) four Research Scientists (levels II and III), who will work with programs to analyze the data and develop the quality measures and reporting methods. In addition to coordinating quality measure development within DHCS, the OMD will manage interagency agreements and contracts with external organizations that will: (1) contribute to the preparation of the quality measures; (2) provide technical support for staff development in the area of clinical quality; and, (3) provide assistance with the implementation of the identified QI projects.

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

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

1. Please provide an overview of this proposal.

2. Please describe how the department plans to incorporate this project with other quality measurement projects.

14. Every Woman Counts Program Fiscal Estimate Information

Budget Issue. The budget proposes $48.6 million (about $14 million General Fund) for the Every Woman Counts (EWC) program and projects that 313,548 will be served in 2013-14. This is an increase of $9.7 million and 11,788 compared to the current year.

Background. The EWC program provides cancer screening services for low-income, under-insured and uninsured women. Through EWC, women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvis exams, and Pap tests, with the intended outcome to reduce breast and cervical cancer deaths. EWC enrolls women age 25 and older for cervical cancer prevention screening and women age 40 and older for breast cancer screening and diagnostic services.

The 2012 budget transferred EWC from the Department of Public Health (DPH) to DHCS as this program more closely aligned with the responsibilities of DHCS to provide direct health care services to individuals and, as federal health care reform is implemented, the transferring of these programs to DHCS could facilitate a more seamless transition to Medi-Cal enrollment and maximize opportunities to leverage federal Medicaid funds to cover the costs currently supported with state funds.

EWC Fiscal Information. The EWC budget documentation does not include previously included fiscal information, such as expenditures for various clinical service activities, that was provided when DPH completed the estimate. This information provided transparency as to how much EWC funding was allocated for office visits and consults, screening mammograms, diagnostic mammograms, case management, and other services.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- **Hold open** the EWC funding proposal as updated information will be provided at May Revision.

- **Adopt placeholder trailer bill language** to require supplemental EWC fiscal information regarding clinical service activity expenditures be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

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

1. Please provide an overview of the EWC program and budget.

15. AB 97 (Statutes of 2011) – Medi-Cal Provider Rate Reductions

Budget Issue. The January budget assumes implementation of the AB 97 Medi-Cal provider rate reductions and the resulting ongoing annual savings of about $855.4 million ($428 million General Fund).

However, since the January budget, certain provider associations have petitioned for a rehearing of the December 13, 2012 Ninth Circuit Court decision that vacated the preliminary injunction of these rate reductions. Consequently, most of these rate reductions are not in effect.

Background. As a result of the state's fiscal crisis, AB 97 (Chapter 3, Statutes of 2011) required the department to implement a 10 percent Medi-Cal provider payment reduction starting June 1, 2011. This 10 percent rate reduction applies to all providers with certain exemptions and variations, exempted providers include: distinct part adult subacute, distinct part pediatric subacute, hospital inpatient, hospital outpatient, crucial access hospitals, federal rural referral centers, federally qualified health centers/rural health clinics, services provided by the Breast and Cervical Cancer Treatment program, Family Planning, Access, Care, and Treatment programs, hospice services, payments funded by intergovernmental transfers and certified public expenditures, in-home supportive services, and pediatric day health centers. (Some of these exemptions are specified in AB 97 and others are a result of an access and utilization assessment.)

Other provider types have a varied implementation of the 10 percent rate reduction, for example, not all Intermediate Care Facility/Developmentally Disabled (ICF/DD) providers receive a 10 percent rate reduction, as a calculation based on cost data is performed each year to determine which ICF/DD facilities receive the reduction.

Additionally, AB 97 requires the 10 percent rate reduction for distinct part skilled nursing facilities to apply to the rates in effect in 2008-09 and freezes rates for rural swing beds to the 2008-09 level

Federal Approval and Access Monitoring. On October 27, 2011, the federal CMS approved California's State Plan Amendment (SPA) containing this proposal to reduce Medi-Cal provider reimbursement rates for various healthcare services. Prior to implementing the provider rate reductions, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services (based on geographic location) would not be impacted and (2) develop and implement a healthcare access monitoring system (for ongoing evaluation).

Consequently, DHCS developed an access monitoring plan that contains 23 measures that will be reported annually, with a subset of four measures to be reported on a quarterly basis. The first annual report will be available in June 2013 and the last quarterly monitoring report was posted on October 2012. The 23 access measures were selected to provide a comprehensive

portrayal of healthcare access in the Medi-Cal program. See following table for listing of the 23 measures.

Table: Medi-Cal Access Monitoring Metrics

Beneficiary Measures
1. Percent Change in Medi-Cal Enrollment 2. Percent Change in Dental Enrollment
Provider Availability
3. Primary Care Practitioner Supply Ratios 4. Provider Participation Rates 5. Concentration of Medi-Cal Beneficiaries among Providers 6. Dental Provider Ratios 7. Pharmacy Participation Rates 8. Long Term Care (LTC) Provider Participation Rates 9. Ratio of Medi-Cal LTC Occupied Bed Days to State-wide LTC Occupied Bed Days 10. Medi-Cal LTC Bed Vacancy Rates 11. Medi-Cal Beneficiary with a Usual Source of Care 12. Medi-Cal Beneficiary and Provider Language Discordance
Service Use and Outcomes
13. Percent of Enrollees with at least one Physician Visit during the Past 12 Months 14. Mean Number of Physician Visits during the Past 12 Months 15. Percentage of Children with at least One Dental Visit During the Last 12 Months 16. Service Rates per 1,000 Member Months 17. Emergency Department Visits 18. Medi-Cal Beneficiary Perceived Timely Access to Care 19. Timely Prenatal Care 20. Preventable/Avoidable Hospitalization Rates 21. Rate of Low Birth Weight for Full Term Births 22. Percent Preterm Births 23. Help Line Calls Categorized by Reason for Call and Geographic Location

Court Injunctions. After CMS approval of the rate reductions, a U.S. District Court issued preliminary injunctions preventing DHCS from implementing most of the provider payment reductions. On December 13, 2012, a Ninth Circuit Court of Appeals panel reversed the district court's decisions and vacated the preliminary injunctions. On January 28, 2013, the California Medical Association, California Hospital Association, California Dental Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, AIDS Healthcare Foundation, and American Medical Response

petitioned the court for a rehearing and; consequently, the state is currently prohibited from implementing the reductions.

Retroactive Savings. Federal approval of the AB 97 rate reductions was obtained in October 2011; however, since the state has been prevented from implementing most of these rate reductions due to court injunctions, there is a retroactive period of savings (generally from June 1, 2011 to present) in addition to the ongoing out-year savings achieved by these rate reductions.

The total amount of fee-for-service savings to be recouped is $998.6 million from the retroactive period. Retroactive savings to managed care cannot be applied.

Federal CMS regulations require that the state pay providers “using rates determined in accordance with the methods and standards specified in an approved State plan” (42 C.F.R. §447.253(i)) and since this reduction is specified in the approved State plan, the state is obligated to pay this rate or would have to use state funds to make up the difference.

See following table for a summary of the AB 97 savings.

Table: Summary of AB 97 Savings as Projected in January Budget

Provider Type	Retroactive Savings Period	Total Retroactive Savings	2013-14 Annual Savings
Nursing Facilities	6/1/11-6/30/12	$327,692	$338,080
ICF/DD	8/1/12-1/31/13	$423,847	$1,010,543
ICF/DD-Habilitative	8/1/12-1/31/13	$2,961,067	$7,059,827
ICF/DD-Nursing	8/1/12-1/31/13	$1,894,921	$4,517,903
Freestanding Pediatric Subacute	6/1/11-2/28/13	$5,549,351	$3,387,923
Distinct Part Nursing Facilities*	6/1/11-5/31/13	$72,160,485	$38,261,127
Phase 1 Providers	6/1/11-12/20/11	$31,322,606	$70,726,223
Physician (services for persons > 21 yrs.)*	6/1/11-5/31/13	$132,757,891	$72,831,847
Medical Transportation*	6/1/11-5/31/13	$29,365,407	$15,842,365
Medical Supplies & Durable Medical Equip.*	6/1/11-5/31/13	$37,549,012	$20,296,763
Dental*	6/1/11-5/31/13	$90,620,783	$45,310,391
Clinics*	6/1/11-5/31/13	$61,571,171	$33,335,772
Pharmacy*	6/1/11-5/31/13	$528,547,024	$271,942,284
Phase 3 Providers	6/1/11-8/31/12	$3,569,620	$3,087,640
Managed Care			$267,490,240
Total Savings		**$998,620,877**	**$855,438,928**
General Fund Savings		**$499,310,438**	**$427,719,464**

Notes:
(1) *Enjoined provider
(2) ICF/DD – Intermediate Care Facility/Developmentally Disabled

(3) The November 2012 Estimate assumed that the AB 97 injunction would be lifted in March 2013 and the reductions for fee-for-services providers will be implemented June 2013 and April 2013 for managed care providers. There is no recoupment for managed care.
(4) In April, DHCS withdrew the State Plan Amendment to implement payment reductions for Freestanding Pediatric Subacute facilities. The May 2013 Estimate will reflect this change.
(5) Phase I includes all subject providers, including the PDHC program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.
(6) Phase III includes the CHDP program providers.

Generally, DHCS has proposed to recoup the retroactive savings over a 24 month period. However, DHCS has indicated that it is willing to work with individual providers to develop a schedule to recoup the savings (as long as it falls within the federal CMS requirements regarding recoupments).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as estimates will be revised to reflect when DHCS is able to implement these reductions and changes on how AB 97 is implemented (e.g., exempting Freestanding Pediatric Subacute facilities).

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

1. Please provide an overview of this issue.

2. What is the status of the rehearing of the December 13, 2012 Ninth Circuit Court decision?

3. Please explain how DHCS continually performs access monitoring to ensure that these provider rate reductions do not impact access to services.

4. How does DHCS assess the impact of these rate reductions on (1) particular geographic areas and (2) specialty services (e.g., pediatric dental surgery centers)?

Subcommittee Staff Handouts

ACA – Medi-Cal Enrollment Assistance and Outreach Grants Placeholder Trailer Bill Language (agenda item number 5 under 4260 Department of Health Care Services)

Medi-Cal Assister Language

Of the amount appropriated in the Medi-Cal General Fund and Federal Fund items, $14 million shall be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application and payment processing costs.

(a) Entities and persons that are eligible for this fee shall be those trained and eligible for in-person enrollment assistance payments by the California Health Benefits Exchange. The payments may be made by the State Department of Health Care Services or through the California Health Benefits Exchange in-person assistance payment system.

(b) The Department shall accept contributions by private foundations in the amount of at least $14 million for this purpose and shall immediately seek an equal amount of federal matching funds.

(c) Enrollment assistance payments shall be made only for Medi-Cal applicants newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act or those who have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

(d) The commencement of enrollment assistance payments shall be consistent with those of the California Health Benefits Exchange.

(e) The department or the California Health Benefits Exchange shall provide monthly and cumulative payment updates and number of persons enrolled through in-person assistance payments on their website.

Medi-Cal CBO Grant Language

Of the amount appropriated in the Medi-Cal General Fund and Federal Funds items, $12.5 million shall be used for Medi-Cal outreach and enrollment grants to community-based organizations (CBOs).

(a) The grants shall be apportioned geographically according to the estimated number of persons who are eligible for Medi-Cal but not enrolled and who will be newly Medi-Cal eligible as of January 1, 2014. The department may determine the number of grants and the application process.

(b) The department shall give special consideration to outreach and enrollment proposals targeting the following populations:

a. persons with behavioral health needs;
b. homeless persons;
c. young men of color;

d. persons who are in county jail or state prison on state parole or county probation and post-release community supervision;
e. families of mixed-immigration status;
f. school-age children through their educational institutions; and
g. persons with limited English proficiency.

(c) The Department shall accept contributions by private foundations in the amount of at least $12.5 million for this purpose and shall immediately seek an equal amount of federal matching funds.

(d) The department shall begin the payment for the CBO grant outreach program by January 1, 2014.

(e) Grantees may not receive in-person assister payments for potential Medi-Cal enrollees assisted under the terms of this grant.

(f) Data shall be collected and made publicly available by the department that identifies outreach, enrollment, retention and utilization activities from CBO grantees using a web-based reporting system that would compile, by grantee, demographic and geographic information of population assisted with enrollment, outreach activity numbers by type of strategy, enrollment applications completed, successful enrollment in Medi-Cal and assistance with retention of coverage at annual renewal.