**Senate Budget and Fiscal Review – Mark Leno, Chair**
**SUBCOMMITTEE #3 on**
**Health & Human Services**

**Chair, Senator Holly J. Mitchell**

**Senator William W. Monning**
**Senator Jeff Stone, Pharm. D.**

**March 19, 2015**

**9:30 a.m. or Upon Adjournment of Session**

**Room 4203, State Capitol**

# Agenda

(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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## 4150 Department of Managed Health Care

### 1. Overview

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all HMOs and some PPOs in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the millions of Californians who are currently enrolled in these types of health plans.

**Budget Overview.** The budget proposes expenditures of $68.2 million and 417 positions for DMHC. See table below for more information.

**Table: DMHC Budget Overview**

| Fund Source | 2013-14 Actual | 2014-15 Projected | 2015-16 Proposed |
|---|---|---|---|
| Federal Trust Fund | $1,584,000 | $518,000 | $0 |
| Reimbursements | $2,999,000 | $3,157,000 | $2,640,000 |
| Managed Care Fund | $38,388,000 | $61,984,000 | $6,551,000 |
| **Total Expenditures** | **$42,971,000** | **$65,659,000** | **$68,191,000** |
| | | | |
| **Positions** | **299.8** | **394.8** | **417.0** |

**Subcommittee Staff Comment.** This is an informational item.

**Questions.** The Subcommittee has requested DMHC respond to the questions below:

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

2. Please provide an update on DMHC efforts regarding stakeholder engagement.

## 2. Federal Mental Health Parity Rules

**Budget Issue.** DMHC requests 11.0 positions (5.5 permanent and 5.5 two-year limited term) to address workload associated with conducting medical surveys of the 45 health plans affected by the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, two additional positions are requested starting in 2016-17, providing 7.5 permanent positions ongoing.

The requested positions and proposed activities are as follows:

1. **Help Center – Division of Plan Surveys -** 11.0 positions (5.5 permanent, 5.5 two-year limited term), effective July 1, 2015.
    - 3.0 Attorney III (1.5 permanent, 1.5 two-year limited term)
    - 1.0 Staff Health Care Service Plan Analyst (permanent)
    - 6.0 Assistant Health Care Service Plan Analyst (2.0 permanent, 4.0 two-year limited term)
    - 1.0 Office Technician (permanent)

    Beginning January 1, 2016, the Help Center's Division of Plan Surveys (DPS) will conduct focused medical surveys of the 45 health plans required to comply with the MHPAEA, scheduled to be completed by December 31, 2016. According to DMHC, due to the complexity of the MHPAEA and its requirements and the large number of focused surveys to be conducted in twelve months, it is imperative that DPS has sufficient resources to efficiently plan and prepare to ensure that all 45 focused surveys are conducted and completed in 2016. Beginning July 1, 2015, DPS will begin the pre-survey planning necessary, including training new staff; drafting focused survey procedures and required documentation; researching outstanding legal, compliance, and regulatory issues; and, reviewing and analyzing health plan filings regarding their methodologies for complying with the MHPAEA.

    Once the focused MHPAEA surveys are completed by December 31, 2016, the DPS will be responsible for completing the post-survey workload, including reviewing all final reports and identifying uncorrected deficiencies that warrant referral to the Office of Enforcement (Enforcement); comparing and analyzing all final reports to identify trends or systemic issues that may exist across multiple health plans; and, conducting analysis to identify serious deficiencies for potential non-routine or expedited follow up surveys. All post-survey workload will be completed by June 30, 2017. In addition to the focused surveys and in support of the sustained compliance oversight of the 45 health plans, beginning in 2017-18, the DPS will perform a special and specific review of mental health benefits during each health plan's existing schedule of triennial routine medical surveys, which equates to 15 surveys per fiscal year. These surveys will continue to require the use of highly specialized medical, psychological, medical risk management and other clinical experts that will require the use of consulting services. Results will be reported in the final report for each routine survey.

2. **Office of Enforcement -** Two positions (permanent), effective July 1, 2016.
    - 1.0 Attorney III (permanent)

- 1.0 Senior Legal Analyst (permanent)

Enforcement expects a total of six MHPAEA compliance case referrals annually beginning in 2016-17 and ongoing, three from DPS and three from the Help Center's Division of Legal Affairs, with the DPS referrals being the most time consuming. According to DMHC, the MHPAEA compliance cases will be more complex than typical case referrals and the DMHC anticipates that enforcement of MHPAEA compliance cases will be more aggressive. MHPAEA legal issues are new and unique to the DMHC and the managed care industry and are expected to involve challenging legal matters including federal pre-emption issues.

3. **Clinical Consulting** - This request also includes $1.86 million for 2015-16; $2.22 million for 2016-17; and $166,000 for 2017-18 and ongoing for clinical consulting services for the medical health plan surveys and for expert witness and deposition costs for enforcement trials.

DMHC currently contracts for the specialized medical and mental health expertise that is required and not available through the civil service system. These consultants support the DPS in evaluating the specific elements related to the requirements of the MHPAEA. Conducting effective MHPAEA focused medical surveys will require the use of highly specialized medical, psychological, medical risk management and other clinical experts that are not available through the civil service system.

**Background.** In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health benefits do so in a manner comparable to medical and surgical (medical) benefits. After the enactment of the Affordable Care Act (ACA) in 2010, federal regulations and state statute implementing Essential Health Benefits (EHB) made the MHPAEA also applicable to individual and small group health care and health insurance products. As of July 1, 2014, the rules apply for all group products as employers renew or purchase coverage. For individual products, the rules apply to the new policy years beginning January 1, 2015.

Assessing compliance of health plans with the rules requires an analysis that is significantly different than the analysis the DMHC currently conducts to enforce state mental health parity requirements. The DMHC presently reviews health plans' Evidences of Coverage (EOC) for compliance with state law, generally focusing on whether analogous benefits for specific severe mental illnesses and serious emotional disturbances in children are subject to the same cost-sharing and utilization-management requirements as medical conditions.

In contrast, these rules require analysis of broader benefit classifications. Rather than a comparison of the applicable terms and conditions, the rules require extensive review of the health plans' processes and justifications for classifying benefits into six permissible classifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care

6. Prescription Drugs

After classifying all benefits into the six categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, coinsurance); quantitative treatment limitations (QTL) (e.g., number of visits, days of treatment) and nonquantitative treatment limitations. According to DMHC, the analyses of the health plans' methodology for determining compliance requires extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the rules are data-intensive and require information the health plans do not routinely file with DMHC (e.g., methodologies to determine benefit classifications, projected plan payments, and rationale for application of NQTL). As such, implementation and enforcement of health plan compliance with the MHPAEA require the DMHC to undertake both an initial focused analysis and continuing evaluation of a new depth and breadth due to the complexities of this law and the inter-relationship with existing California mental health parity laws and EHB requirements.

**2014 Budget Resources for Federal Mental Health Parity.** The 2014 budget included a one-time augmentation of $369,000 (Managed Care Fund) in 2014-15 for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the MHPAEA and five positions to enforce these requirements. (The Legislature augmented DMHC's budget by $4.2 million to add ten positions and consulting services to ensure enforcement of these requirements and the Governor vetoed five of the positions added by the Legislature, resulting in a net augmentation of five positions.)

**Findings from DMHC's Initial Front-End Reviews.** According to DMHC, it is still early in DMHC's review of the federal mental health parity compliance filings. Each plan is in a different point in the process, so it is not yet possible to make industry-wide assessments of compliance. DMHC has encountered a variety of compliance issues during all stages of the review process, some minor, some significant and/or complex. As an example, there are plans that need to adjust cost-sharing for specific services or refine language in their evidences of coverage to ensure consistency with the law. Further, some plans are still working to submit a complete compliance filing due to the complexity of the requirements. As the review team encounters compliance issues, DMHC's licensing counsel works with the plans to develop corrective actions to bring them in compliance.

As DMHC began developing the specific reporting criteria for the compliance project, DMHC determined that 26 full-service health plans would be required to submit filings. Specialized behavioral health plans under contract with full service health plans are required to include their filing information with the full service plans. While the total number of plans submitting filings is lower than DMHC originally anticipated, the complexity and length of each plan's filings is significant higher. Each plan was required to submit complete information for 15 separate products (to the extent they offer products in each market segment).

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to keep this item open as discussions on this proposal.

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

1. Please provide an overview of this proposal.

2. Please explain the findings from the initial front-end reviews that are being conducted.

3. When does DMHC anticipate that health plans will complete the initial front-end review?

4. Please explain how DMHC's recent findings regarding Kaiser's failure to provide patients with appropriate access to mental health care is distinguished from a health plan's compliance with federal mental health parity.

## 3. Additional Enrollment in Individual Market

**Budget Issue.** DMHC requests seven permanent positions and $1,134,000 for 2015-16 and $1,070,000 for 2016-17 and ongoing to address the increased workload resulting from the revised projected increase in enrollment in the individual market pursuant to SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session. This request includes $208,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

The requested positions are:

| Program/Classification | Number of Positions |
|---|---|
| **Help Center** | |
| Attorney I | 1.0 |
| Nurse Evaluator II | 0.5 |
| Associate Governmental Program Analyst | 1.0 |
| Consumer Assistance Technician | 1.0 |
| **Office of Enforcement** | |
| Attorney III | 1.0 |
| Legal Secretary | 0.5 |
| **Office of Administrative Services** | |
| Associate Governmental Program Analyst | 1.0 |
| **Office of Technology and Innovation** | |
| Associate Information Systems Analyst | 1.0 |
| **Total Positions** | **7.0** |

**Background.** DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

Existing federal law, the Affordable Care Act (ACA), enacts major health care coverage market reforms that take effect January 1, 2014. With the passage of SB 2 X1, California law now conforms to the ACA requirement that beginning January 1, 2014 health plans that offer health coverage in the individual market accept every individual that applies for that coverage.

As a result, DMHC is now responsible for providing consumer assistance and regulatory oversight to millions of enrollees and new health plans and products offered in Covered California.

In the 2014 budget, DMHC received 13.5 positions effective July 1, 2014, with an additional 5.5 positions effective July 1, 2015, for a total of 19.0 permanent positions for the workload associated with SB 2 X1. As part of the 2014 budget request, DMHC estimated that 90 percent of all new enrollees in individual market plans would be under the jurisdiction of the DMHC with the other ten percent under

the jurisdiction of the California Department of Insurance (CDI). However, in the past year it has been realized that the DMHC has jurisdiction over approximately 98 percent of the enrollees in Covered California individual market plans, with only two percent under the jurisdiction of the CDI. Because of this percentage increase, along with the revised enrollment projections of 1.9 million individuals enrolled in health plans—licensed by DMHC—in the individual market (compared to 1.7 million estimated in May), DMHC requests additional resources.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this proposal. Subcommittee staff notes that seven of the 13.5 positions requested last year remain vacant as DMHC has had difficulty filling these positions. DMHC notes that it has reclassified the difficult-to-fill positions and anticipates filling the vacant positions in the short-term.

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

1. Please provide an overview of this proposal and the growth in workload related to the individual market.

## 4. Large Group Claims Data Exposure (SB 1182, 2014)

**Budget Issue.** DMHC requests one permanent position (a senior legal analyst), effective January 1, 2016, and $85,000 for 2015-16 and $148,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 1182 (Leno), Chapter 577, Statutes of 2014, regarding large group claims data exposure. This request also includes $23,000 for 2015-16 and $45,000 for 2016-17 and ongoing for clinical consulting services to provide methodology and statistical sampling of the claims data provided.

**Background.** SB 1182 requires a health care services plan or health insurer to annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. Most health plans already provide some large group purchasers with some level of de-identified claims data about their employee populations. Ensuring that all health plans and insurers are subject to the same disclosure standards promotes a level playing field, enables purchasers to better negotiate rates, and also assist efforts to improve the health of employees in large groups through disease management programs and other mechanisms aimed at improving the health of a large group membership.

The Office of Enforcement expects to see complaints from large group employers regarding a health plan's failure to provide de-identified claims data or failure to provide complete data. As purchasers receive and analyze this information it is expected that disagreements between large group plans and large group purchasers will arise over whether the health plan has satisfactorily provided required information. It is also expected that disagreements will arise between consumer advocacy groups and health plans as to whether the information is sufficiently de-identified so that an employer group cannot identify an employee based off of the claims data provided.

The requested positions would sort, organize, review, and summarize the documents submitted by a health plan and large group purchaser, as well as the documents provided in response to the DMHC's discovery requests. This position would also identify the issues presented and provide a written evaluation to an attorney as to whether a health plan met statutory and regulatory standards regarding provision of de-identified claims data. This evaluation will be necessary for each referral and will require a comparison between established standards and submitted documents as well as identification of deficiencies.

In addition, the requested funding for clinical consulting services would be used to provide methodology and statistical sampling of the claims data provided. The consultant will also be responsible for advising the Office of Enforcement on the sufficiency of the claims data provided and for establishing baselines of what constitutes a sufficient submission of information by a large group plan.

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

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

1. Please provide an overview of this proposal.

## 5. Dental Plans Medical Loss Ratio (AB 1962, 2014)

**Budget Issue.** DMHC requests 1.5 permanent positions and $189,000 for 2015-16 and $173,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of AB 1962 (Skinner), Chapter 567, Statutes of 2014, regarding dental plan medical loss ratios (MLR).

**Background.** AB 1962 requires health plans that issue, sell, renew, or offer specialized dental plan contracts to file a report with DMHC that contains the same information required in the federal MLR Annual Reporting Form. This report is due to DMHC on an annual basis beginning no later than September 30, 2015. The bill declares the intent of the Legislature that the data reported pursuant to these provisions be considered in adopting an MLR standard that would take effect no later than January 1, 2018. AB 1962 requires DMHC to make available to the public the MLR data received, and allows DMHC to issue guidance outside the Administrative Procedures Act. Identical provisions apply to health insurers regulated by the California Department of Insurance.

DMHC reviews all health plan filings related to health coverage, including health plan subscriber contracts and evidence of coverage documents, resolves inquiries and complaints from enrollees with health coverage, conducts financial oversight, and takes enforcement action when health plans fail to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. In addition, the DMHC oversees dental care products both inside and outside California's Health Benefit Exchange (Exchange), Covered California.

DMHC regulates health plans, including specialized health plans such as dental plans, under the KKA. While the KKA historically did not include an MLR requirement for any health plans, Public Health Service Act (PHSA) Section 2718, added by the Affordable Care Act (ACA), requires that individual and small group plans provide an annual rebate to each enrollee if the percent of premium spent on claims and quality improvement activities is less than 80 percent (unless a state determines a higher percentage) of the plan's MLR. AB 51 (Chapter 644, Statutes of 2011) incorporated this requirement into the KKA. However, the ACA's MLR provision does not apply to stand-alone dental plans, which are "excepted benefits" under PHSA Section 2791 (c)(2)(A), and the KKA similarly exempts dental plans from the ACA's MLR requirement.

Existing state law requires a health care service plan or health insurer to comply with specified MLR requirements and requires a plan or insurer to provide an annual rebate to enrollees and insureds if the ratio of the amount of premium revenue expended by the plan or insurer on specified costs to the total amount of premium revenue is less than a certain percentage. Existing law specifies that these requirements do not apply to specialized health care service plan contracts or specialized health insurance policies, such as dental plans.

For 2014, inside the Exchange, five dental plans offered stand-alone dental products in the individual market: Anthem Blue Cross, Blue Shield of California, Delta Dental, Liberty Dental, and Premier Access. Nine plans offered stand-alone dental products in the small group market: Access Dental, Blue Shield of California, Delta Dental, Guardian, Liberty Dental, Managed Dental, MetLife, Premier Access, and SafeGuard. For 2015, Covered California anticipates offering a wider range of dental care products that are overseen by the DMHC: (1) stand-alone dental plans covering pediatric oral care and

family dental plans (covering both pediatric and adult oral care), and Qualified Health Plans (QHPs) that offer 10 Essential Health Benefits (EHBs) inside the Exchange, (2) stand-alone dental plans covering pediatric oral care and family dental plans (covering both pediatric and adult oral care) that are bundled with a QHP that offers ten EHBs, and (3) QHPs with pediatric dental benefits embedded.

The Department of Health Care Services (DHCS) requires a 70 percent MLR for all Medi-Cal Dental Managed Care plans. DHCS currently contracts with three Dental Managed Care plans (Access Dental Plan, Health Net of California, Inc., and Liberty Dental Plan of California, Inc.) and DMHC conducts MLR reviews of these plans on behalf of DHCS. DMHC also conducts MLR reviews of all full-service medical plans, pursuant to Health and Safety Code section 1367.003 and its attendant regulation, California Code of Regulations, Title 28, Rule 1300.67.003.

The requested positions would be used to (1) acquire permission to use the federal MLR reporting form and then implement an MLR reporting form, (2) determine whether the DMHC should adopt federal MLR standards and definitions, or use the KKA's MLR standards and definitions for the new dental MLR annual reports, (3) develop a new examination program and training procedures for dental plan MLR examinations, (4) perform three additional examinations each year to assure the accuracy of the financial reporting, (5) review of 18 additional MLR reports on an annual basis, and (6) potentially assess MLR for dental products embedded in full service plans. DMHC indicates that it is unable to absorb this new workload.

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

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

1. Please provide an overview of this proposal.

## 4260 Department of Health Care Services

### 1. Overview

The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner. DHCS programs include:

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 12 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and, as of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services.*** The Children's Medical Services coordinates and directs the delivery of health services to low-income and seriously ill children and adults; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations, and it includes: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 budget acts, the DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs.*** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

See following table for DHCS budget summary information.

**Table: DHCS Fund Budget Summary (dollars in thousands)**

| Fund | Actual | Estimated | Proposed |
|---|---|---|---|
| | 2013-14 | 2014-15 | 2015-16 |
| General Fund | $16,692,207,000 | $18,167,875,000 | $19,041,233,000 |
| Federal Trust Fund | 32,814,407,000 | 56,192,246,000 | 61,364,918,000 |
| Special Funds and Reimbursements | 8,636,020,000 | 14,019,575,000 | 17,642,975,000 |
| **Total Expenditures (All Funds)** | **$58,142,634,000** | **$88,379,696,000** | **$98,049,126,000** |
| **Positions** | **3337.6** | **3678.2** | **3720.6** |

**State Auditor – DHCS a High-Risk State Agency.** On March 5, 2015, the State Auditor notified the Legislature that DHCS remains a high-risk agency due to its increased responsibility under the Affordable Care Act and the state Mental Health Services Act, as well as outstanding audit recommendations regarding other programs.

**Subcommittee Staff Comment—Information Item.** This item is for informational purposes.

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

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

2. What is DHCS's response to the State Auditor's notification that DHCS remains a high-risk agency? What is DHCS doing to address these recommendations?

## 2. Medi-Cal Estimate and Caseload

DHCS administers the Medi-Cal program (California's Medicaid health care program). This program pays for a variety of medical services for children and adults with limited income and resources. The Governor proposes total expenditures of $95.4 billion ($18.6 billion General Fund) which reflects a General Fund increase of $770 million above the Budget Act of 2014. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government. See following table for a summary of the proposed Medi-Cal budget.

**Table: Medi-Cal Local Assistance Funding Summary**

| | 2014-15 | 2015-16 | |
|---|---|---|---|
| | **Revised** | **Proposed** | **Difference** |
| Benefits | $81,242,000,000 | $91,331,800,000 | $10,089,800,000 |
| County Administration (Eligibility) | $3,981,500,000 | $3,617,300,000 | -$364,200,000 |
| Fiscal Intermediaries (Claims Processing) | $524,200,000 | $463,300,000 | -$60,900,000 |
| | | | |
| **Total** | **$85,747,800,000** | **$95,412,400,0000** | **$9,664,600,000** |
| | | | |
| General Fund | $17,839,700,000 | $18,610,500,000 | $770,800,000 |
| Federal Funds | $56,977,500,000 | $61,637,100,000 | $4,659,600,000 |
| Other Funds | $10,930,500,000 | $15,164,700,000 | $4,234,200,000 |

**Caseload.** The Governor's budget assumes total annual Medi–Cal caseload of 12.2 million for 2015-16. This is a two percent increase over the revised caseload estimate of 12 million for 2014-15.

- ***ACA Caseload.*** The budget assumes that compared to 2013-14, which reflected the first six months of implementation for ACA-related expansions, the combined annual caseload from the optional and mandatory expansions will have tripled in 2014-15. Following this steep climb, the budget assumes that in 2015-16, the optional and mandatory expansions will remain flat at two million and one million enrollees, respectively. The budget estimates that combined caseload from other ACA-related policies, such as express lane enrollment and hospital presumptive eligibility, will be 250,000 in 2014-15 and 220,000 in 2015-16.
- ***Non–ACA Caseload.*** The Administration projects that annual Medi-Cal caseload in the base forecast—absent the effects of the ACA—will be 8.8 million in 2014-15 and 8.9 million in 2015-16, a two percent year-over-year increase. Between the two years, the budget also implies that the underlying trend for both seniors and persons with disabilities (SPDs) and families and children is two percent growth.

**Uncertainty Regarding CHIP Funding.** The ACA-appropriated federal funding for the Children's Health Insurance Program (CHIP) through federal fiscal year (FFY) 2015, which ends September 30,

2015. In order for states to receive annual CHIP allotments beyond FFY 2015, Congress must appropriate additional funds for the program. The Medi-Cal estimate assumes that the state would continue to receive the same federal matching rate for CHIP as it does today. However, this is dependent on Congress to appropriate additional funds for CHIP. Currently, the federal government provides a 65 percent federal matching rate for CHIP coverage (roughly a two dollar match for every dollar the state spends). Whereas for other Medi-Cal-covered children, California generally receives a 50 percent federal matching rate (a one dollar match for every dollar the state spends). DHCS estimates the state will draw down nearly $2.1 billion in federal CHIP funding in 2015-16 (most of which is matched with General Fund).

**Medi-Cal Caseload Estimate Does Not Reflect Minimum Wage Increase.** Additionally, the Medi-Cal estimate does not reflect any adjustments to caseload as a result of the minimum wage increase pursuant to AB 10 (Alejo) Chapter 351, Statutes of 2013. Generally speaking, since eligibility for Medi-Cal is based on income level (among other factors), as wages increase, it is likely that some individuals may no longer qualify for Medi-Cal. It should be noted that the CalWORKs estimate reflects savings of $11.4 million in 2014-15 and $20.3 million in 2015-16 as a result of AB 10. The Medi-Cal estimate does reflect increases to provider rates ("add ons") to account for increases in salaries as a result of AB 10. AB 10 increased the minimum wage from $8.00 to $9.00 per hour on or after July 1, 2014 and a second increase (to not less than $10.00 per hour) will go into effect on January 1, 2016.

**LAO Comments on Medi-Cal Caseload Estimate.** The LAO has the following comments related to the Medi-Cal caseload estimate:

- ***Senior Trend Raises Questions.*** DHCS projects the senior caseload to increase 5.7 percent in 2014-15, yet only 2.3 percent in 2015-16. The spike has a material impact on spending in 2014-15. Most seniors enrolled in Medi-Cal are dually eligible for Medi-Cal and Medicare. For 2014-15, the budget's updated estimate of the number of dual eligibles enrolled in the Medicare prescription drug benefit is higher by five percent, leading to a $95 million increase in General Fund spending compared to the 2014 budget act.

  In terms of underlying trends, seniors represent the fastest–growing segment of Medi-Cal caseload, due to the state's large cohort of baby boomers passing age 65. Over the two-year period, DHCS's implied annual growth rate for seniors is four percent, which is more in line with our expectations. As suggested by the department, the delay in redeterminations, modified renewal process, or other temporary factors could explain the 2014-15 spike as a one-time anomaly. However, without more current data on enrollment, the LAO cannot rule out the other possibility that the spike could signal an upward shift in the underlying trend for seniors, due to demographic changes or other fundamental factors.

- ***Assumes Underlying Growth for Families and Children, Despite Improving Economy.*** Excluding the caseload associated with the ACA, the budget implies one percent growth in base caseload for families and children in 2014-15, rising to two percent growth in 2015-16. However, Medi-Cal enrollment among families and children has moved countercyclical to the economy. (This means that families enrollment tends to go up during an economic downturn and go down during an economic expansion.) The LAO notes that caseload for California Work Opportunity and Responsibility to Kids (CalWORKs)—a means–tested program that overlaps with Medi-Cal in terms of the families enrolled—has declined steadily since 2011-12.

The LAO expects the *underlying* trend for Medi-Cal's families caseload (absent ACA impacts) to transition to a slight decline as the economy expands. Historically, there has usually been some lag between the onset of an economic recovery and a turning point in the families caseload for Medi-Cal. However, the economy is well into the sixth year of the current expansion. All else equal, the LAO would have expected the underlying trend for families to be declining—particularly since the trend showed signs of leveling off just prior to the beginning of ACA–related enrollment.

Consequently, the LAO recommends:

- ***Require Administration to Resume Monthly Caseload Reports.*** Prior to 2014, DHCS released monthly reports on Medi-Cal caseload levels and trends. Although these reports came with certain caveats, they were useful for keeping abreast of the overall direction of statewide Medi–Cal enrollment. In March 2014, the department announced the temporary suspension of its monthly caseload reports. The LAO recommends the Legislature require DHCS to report at budget hearings on options for releasing statewide monthly enrollment data, aggregated at the level of families and children, SPDs, and childless adults. Since the LAO's report, DHCS has resumed posting this information on its website.

- ***Ask Administration About Future Treatment of Mandatory Expansion.*** The LAO recommends DHCS report at budget hearings about its forecasting decision to continue to parse out the ACA "mandatory" expansion population instead of including as part of the base Medi-Cal estimate. The LAO finds that continuing attempts to parse out this segment from the overall caseload estimate seem abstract and potentially misleading, as more data accumulate and any definable distinction between mandatory and nonmandatory caseload fades. This forecasting decision impacts the ability to project the underlying trend in families and children caseload.

- ***In Addition to ACA, Begin Refocusing on Underlying Trends.*** While the ACA has had an important and sudden impact on total Medi–Cal enrollment, the LAO also raises the issue of *underlying* enrollment trends. The LAO recommends the Legislature explore this issue in more depth during budget hearings.

**LAO Assessment on CHIP Funding.** The LAO finds that the Governor's approach to budgeting CHIP funding is reasonable since it assumes a "middle-of-the-road scenario." However, the LAO notes that federal CHIP funds available to California in 2015-16 may be more or less than assumed in the Governor's budget. Additionally, the LAO indicates that there are also longer-term implications for children's health coverage given that CHIP may not continue beyond the next several years, even if Congress appropriates funding for CHIP beyond FFY 2015.

**Subcommittee Staff Comment and Recommendation.** It is recommended to:

**a. Hold Open Caseload Estimate.** It is recommended to hold the Medi-Cal caseload estimate open as discussions continue and updates are reflected in the May Revision. As noted above, several assumptions included in the Medi-Cal caseload estimate suggest that the Administration has taken a conservative approach to projecting caseload and expenditures. As the LAO notes, caseload estimates are important not only for budgeting purposes, but also to understand access and capacity in the program.

**b. Adopt Placeholder Trailer Bill Language To Eliminate Nonemergency Emergency Room Copay.** It is recommended to adopt placeholder trailer bill language to eliminate the statutory references implementing a nonemergency emergency room copay in Medi-Cal, as this assumption has been removed from the Medi-Cal estimate. As part of the Medi-Cal estimate, the Governor's budget removes the assumption that the state would implement a copayment for nonemergency emergency room usage pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011 and AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 which was expected to result in about $34 million ($17 million General Fund) savings. This copay has never been implemented as it had not received approval from the federal Centers for Medicare and Medicaid. While the budget discontinues this assumption, the Administration did not propose trailer bill language to delete this provision from statute.

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

1. Please provide a brief overview of the Medi-Cal caseload estimate.

2. Please respond to LAO's findings regarding the Medi-Cal caseload estimate.

3. How is DHCS planning for contingencies regarding CHIP funding?

4. Does DHCS conduct or plan to conduct a demographic analysis of Medi-Cal enrollees to identify and report on disparities by managed care plan and region? Does DHCS find that this type of information would help identify quality improvement initiatives aimed at reducing health disparities in the state and potentially reduced Medi-Cal expenditures? Does DHCS plan to make this information public?

5. It is estimated that one million Medi-Cal renewals will be processed every month. Given that the 2015 renewal process includes pre-populated applications and electronic verification, how is DHCS monitoring the processing of Medi-Cal renewals? Are counties reporting this information to DHCS? How does DHCS estimate for the number of individuals that will be discontinued during the annual review process?

## 3. CalHEERS Oversight

**Oversight Issue.** Concerns have been raised regarding the processes by which stakeholder input is provided to and considered by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) project to aid decision-making, coordination, and rollout of system changes.

In February, a 24-month roadmap for CalHEERS changes was released and it appeared that changes to implement requirements of the Affordable Care Act (ACA) and state law regarding Medi-Cal continued to be delayed without any insight or justification for the delays provided to external stakeholders. For example, under the ACA, former foster youth qualify for Medi-Cal coverage until age 26, regardless of their income. This law, which has been in effect since January 1, 2014, is still not programmed accurately into CalHEERS resulting in enrollment delays, enrollment in the wrong affordability program, or denial of Medi-Cal for these former foster youth.

In response to these concerns, on March 13, 2015, DHCS released a revised 24-month roadmap and indicated that the functionality to determine former foster youth eligibility and the functionality to incorporate the Medi-Cal Access Program (formerly Access for Infants and Mothers-AIM) will be included as part of the September 2015 CalHEERS release. Previously, this functionality was projected to be included no sooner than February 2016 (and no date-certain for incorporation of AIM functionality).

The Medi-Cal budget includes $128.6 million ($25.7 million General Fund) for CalHEERS development in 2015-16.

**24-Month Roadmap.** Recently, CalHEERS established a 24-month roadmap of mission-critical automation needs. This roadmap is intended to be a comprehensive plan delineating major CalHEERS system initiatives and related partner's system critical events to enable overarching strategic and tactical planning by each system organization and sponsors. The business goals developed as a guide for roadmap efforts are:

1. Ensure consumers receive accurate and timely eligibility determinations and correct plan enrollment, initially and during any change or renewal event.
2. Ensure business partners are able to receive, exchange, and reconcile appropriate consumer information on a timely basis.
3. Appropriately equip authorized end users with tools necessary to serve consumers effectively and to handle exception situations.
4. Provide consumers and end users with an improved consumer experience.
5. Ensure the technical infrastructure is properly maintained, current, secure, and supports capacity demands and completion of business goals.

**Background.** The ACA requires a single, accessible, standardized paper, electronic, and telephone application process for insurance affordability programs, which require a joint application for Medi-Cal and Covered California. The joint application is required to be used by all entities authorized to make an

eligibility determination for any of the insurance affordability programs. (Medi-Cal and Covered California with a premium or cost-sharing subsidy are "insurance affordability programs.")

CalHEERS is the information technology system that is used to support this application process. The primary business objective of CalHEERS is to provide a 'one-stop shop' to determine eligibility for California's health coverage programs offered by the Exchange and the Department of Health Care Services.

The CalHEERS Project is jointly sponsored by the Exchange and the Department of Health Care Services (DHCS). The CalHEERS Project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

**Required Stakeholder Input Regarding CalHEERS.** AB 1296 (Bonilla), Chapter 641, Statutes of 2011 requires DHCS, Covered California and the California Health and Human Services Agency to provide:

> a process for receiving and acting on stakeholder suggestions regarding the functionality of [CalHEERS], including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

**Office of Systems Integration Recommendations Regarding CalHEERS Governance.** At the March 5, 2015 Subcommittee No. 3 hearing, the issue of the Office of System Integration's (OSI) role in the CalHEERS project was discussed. Subcommittee staff requested the list of OSI recommendations regarding improvements to the CalHEERS governance structure. These include:

- *Those parties with accountability for the outcomes of the CalHEERS project should retain final authority for making decisions. Other advisory members should be included in the governance structure in non-voting capacities to provide input, insights, and counsel to inform the decisions.*

- *Establish a CalHEERS Project Steering Committee comprised of Deputy Director-level representatives from the Sponsor organizations and corresponding leaders from partner entities to provide counsel, advice, and input for Sponsor decision-making.*

  *Consider a layered committee structure to garner input while retaining appropriate accountability and authority, for example:*

  - *Voting members could include designated DHCS and Covered California deputy directors who are accountable for budgets and outcomes related to the Insurance Affordability Program needs of the sponsor organizations.*

  - *Advisory members could include designated executives from CDSS, OSI, and CWDA.*

- *There is an opportunity to realign the Program Coordination Committee to retain a focus on refining, reinforcing, and updating the 24-Month Roadmap initiatives including addressing necessary changes, resolving conflicts, and planning for business resource needs to support timely design decisions.*

- *Confirm the Program Coordination Committee includes the appropriate individuals to represent the business, technology, and project needs of DHCS, Covered California, CWDA/Counties, SAWS, and CalHEERS. Representatives should be at a level sufficiently close to program delivery that they have a thorough working knowledge of business execution, and possess the authority to make recommendations on behalf of their organization.*

- *The project team should extend the use of priority-balancing criteria established for the 24-Month Roadmap initiative to help evaluate the timing and relative value of changes proposed for the CalHEERS system.*

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions on this topic continue.

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

1. Please describe the governance structure of CalHEERS and the criteria CalHEERS project sponsors use in establishing the release schedule.

2. Please discuss how the "lessons learned" in 2014 are being applied to CalHEERS planning in 2015. What happened in 2014 that delayed the release of Medi-Cal functionality in CalHEERS?

3. Given that the first business goal related to the 24-month roadmap is "to ensure consumers receive accurate and timely eligibility determinations," why is functionality related to former foster youth eligibility for Medi-Cal and the Medi-Cal Access Program not expected to be included in CalHEERS until later in 2015?

4. Is DHCS confident that the current workarounds for former foster youth and the Medi-Cal Access Program are ensuring that individuals that qualify under these categories are gaining easy access to the Medi-Cal program?

5. Please explain how the AB 1296 stakeholder workgroup suggestions are considered as part of establishing the release schedule.

6. Has there been an increased workload on the county eligibility workers as a result of some of the functionality problems over the original estimates? If so what accommodations have been made?

7. How is DHCS working with county eligibility workers to solicit feedback on improvements to CalHEERS?

8. Does DHCS commit to including optional demographic questions regarding sexual orientation and gender identity on the paper and online application for 2016 open enrollment for Covered California?

## 4. CalHEERS Electronic MAGI Determination Trailer Bill Language

**Budget Issues.** DHCS proposes trailer bill language to remove the sunset provision to allow for continued electronic verification of Medi-Cal eligibility information.

**Background.** As part of the Affordable Care Act, the Department of Health Care Services (DHCS) and the California Health Benefit Exchange (Covered California) built the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is the system that assesses an individual's eligibility for insurance affordability programs, including eligibility for modified adjusted gross income (MAGI) Medi-Cal and to purchase health insurance through Covered California.

If an applicant can be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS determines MAGI Medi-Cal eligibility and the case information is sent to the applicant's county of residence for ongoing case management services. If an applicant cannot be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS electronically sends the case information to the applicant's county of residence for a MAGI Medi-Cal eligibility determination. Upon receiving the MAGI Medi-Cal case, the counties collect necessary information to complete the applicant's MAGI Medi-Cal eligibility determination. This process, codified in Section 14015.5 of the Welfare and Institutions Code, sunsets on July 1, 2015. The purpose of this trailer bill language is to remove the sunset provision.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions on this topic.

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

1. Please provide an overview of this proposal and why a sunset was originally included.

## 5. Dental Services in Medi-Cal

**Budget Issue.** The Governor's budget includes proposals related to dental services in Medi-Cal, these are:

1. **Child Health and Disability Prevention (CHDP) Program Dental Referral –** DHCS proposes trailer bill language requiring CHDP programs and providers to refer all Medi-Cal-eligible children participating in CHDP who are one year of age and older to a dentist participating in the Medi-Cal program, rather than at age three.

   The budget assumes annual costs of $808,000 ($404,000 General Fund) for additional dental services for children referred to a dentist at one year of age or later.

2. **Allied Dental Professionals Enrollment –** DHCS proposes to include allied dental professions employed by a public health program (registered dental hygienists, registered dental hygienists in extended functions, and registered dental hygienists in alternative practice) in the Medi-Cal dental services program. A State Plan Amendment is under development to implement this change.

   The budget assumes annual costs of $2 million ($925,000 General Fund) for the increase in dental services as a result of these professionals providing services.

**Oversight Issue.** A December 2014 California State Auditor (CSA) audit of the Denti-Cal program found that, while the number of active providers statewide appears sufficient to provide services to children, some counties may not have enough providers to meet the dental needs of child beneficiaries. CSA reported five counties may lack active providers, an additional 11 counties had no providers willing to accept new Medi-Cal patients, and 16 other counties appear to have an insufficient number of providers.

CSA found the utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. CSA's analysis of federal data from federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the data, only 43.9 percent of California's child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6 percent. Denti-Cal statewide utilization rates for child beneficiaries for 2013 were 41.4 percent.

CSA stated a primary reason for low dental provider participation rates is low reimbursement rates compared to national and regional averages and to the reimbursement rates of other states CSA examined. For example, California's rates for the 10 dental procedures most frequently authorized for payment within the Medi-Cal program's FFS delivery system in 2012 averaged $21.60, which is only 35 percent of the national average of $61.96 for the same 10 procedures in 2011. DHCS indicates that it is currently assessing reimbursement rate adequacy and plans to complete this by July 2015.

Consequently, CSA recommended the following:

- Establish criteria for assessing and monitoring beneficiary utilization, access to services, and provider participation in the program, and take corrective action on any identified declining trends to ensure that the influx of beneficiaries is able to access services.
- Perform annual reimbursement rate reviews and ensure beneficiaries have reasonable access to dental services and ensure that Delta Dental performs all its contract-required outreach activities to improve participation.
- Establish the provider-to-beneficiary ratio statewide and in each county as a performance measure to evaluate access and availability of dental services and capture needed data about dental services for reporting purposes.

Additionally, CSA found that California's reimbursement rates for Denti-Cal services were low. These rates were last increased in 2000-01.

**CMS Direction on Improving Access to Dental Care for Children.** On May 8, 2013, DHCS received a letter from the federal Centers for Medicare and Medicaid Services (CMS) setting forth two goals to improve access to dental care for children. These goals are:

1. Increase by ten percentage points, from federal fiscal year 2011, the percentage of children ages 1-20 enrolled in Medicaid for at least 90 continuous days that received a preventive dental service. The target date for this goal is federal fiscal year 2015 (September 30, 2015). CMS indicates it will assess if the state meets this goal in April 2016 after the data has been reported. CMS identifies the following baseline and target goal percentages:

| | California | National |
|---|---|---|
| **2011 Baseline** | 37% | 42% |
| **2015 Goal** | 47% | 52% |

2. Increase by ten percentage points the percentage of children ages 6-9 enrolled in Medicaid for at least 90 continuous days that received a sealant on a permanent molar. Federal fiscal year 2010 is the baseline and federal fiscal year 2015 is the target year.

**DHCS Efforts to Increase Utilization of Dental Services.** To meet these goals, DHCS indicates that it has taken several steps (in addition to the proposals included as part of the budget). These include:

- DHCS has targeted the use of mobile dentistry vans initially in Alpine, Amador and Calaveras counties. The state's dental fiscal intermediary (Delta Dental) is currently finalizing a contract with a mobile van and is in negotiations with another mobile van. These initial contracts should be executed in March-April of 2015. According to DHCS, in an effort to maximize the potential for success with these mobile vans, the mobile dentistry van staff will work closely with local entities (First 5, Head Start, schools and stakeholders). DHCS is also looking to expand these efforts into other counties. The mobile vans will service all children (not only Medi-Cal children) and will provide the full range of preventive services and basic restorative services.

- Last year's budget included $643,000 ($190,000 Proposition 10 funds and $453,000 federal funds) for outreach activities targeted at increasing pediatric dental utilization. DHCS sent a

letter to about 500,000 families who had a child age 0-3 who has not seen a dentist in the last year. DHCS also plans to do follow-up calls with these families and assist in connecting the family to a provider.

Finally, DHCS also notes that as part of the state's 1115 Medicaid waiver renewal, it plans to include proposals regarding providing provider incentives to increase preventive dental services in Denti-Cal. DHCS plans to make public and submit its waiver renewal proposal to the federal Centers for Medicare and Medicaid by the end of March.

**Dental Services Provided Under General Anesthesia.** In Medi-Cal, dental services provided under general anesthesia are provided via Medi-Cal fee-for-service (FFS) and through Medi-Cal managed care. Concerns have been raised that access to general anesthesia for dental services for FFS Medi-Cal enrollees who are regional center clients is very limited. According to DHCS, it is currently monitoring access to these services through a review of FFS historical claims and consumer calls and it is not aware of any access concerns regarding these services. Additionally, concerns have been raised regarding the differential between general anesthesia and dental anesthesia and that this differential is impeding access to dental anesthesia.

For Medi-Cal managed care, DHCS is in the process of establishing departmental policies and procedures for dental services provided under general anesthesia through Medi-Cal managed care. These policies and procedures are currently in the internal review phase. DHCS indicates it will continue to engage stakeholders to ensure that all members who are in need of hospital dentistry services will have timely access to care, and that the provider and stakeholder communities are educated in the updated policies and procedures upon implementation. Anecdotal access complaints have been received by the Legislature. These include complaints by dental providers in Sacramento and San Diego that there are four or more month waits for operating room or surgery center slots to perform urgent dental procedures.

**Background.** DHCS delivers dental services to Medi-Cal beneficiaries through two different models: Dental Managed Care (DMC) and Denti-Cal fee-for-service (FFS). DMC is carried out through contracts established between DCHS and dental plans licensed with the Department of Managed Health Care, whereas, Denti-Cal FFS provides services through enrolled providers, who are directly contracted with the program. DMC is offered only in Los Angeles County and Sacramento County. Between these two counties there are approximately 672,000 enrollees received care under DMC.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, requires DHCS to provide an annual report to the Legislature on DMC in Sacramento and Los Angeles. On March 14, 2015, this report was due to the Legislature and has not yet been received. Last year's report can be found at: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Dental%20Managed%20Care/2014_M-C_Dental_MgdCareReport.pdf

SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, requires DHCS to monitor Denti-Cal FFS using program metrics and to post this information on the department's website at least on an annual basis. This information can be found at: http://www.denti-cal.ca.gov/provsrvcs/managed_care/FFS_perf_meas_2013.pdf

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions on this topic. The Governor's budget makes very minor investments in increasing access to Denti-Cal and it is unlikely that these minor investments would have substantive impact on improving utilization of these services.

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

1. Please provide an overview of the budget proposals related to dental services.

2. Please provide an update on the steps DHCS is taking to meet the goals identified by CMS's to improve access to dental services for children. Will the state meet these goals?

3. How will DHCS measure the impact of the letter outreach campaign?

4. At previous Subcommittee hearings, DHCS has stated it is unclear the degree to which rate increases would increase utilization. Consequently, it has focused on other, less-costly, initiatives (besides rate increases). Given CMS's direction for a ten percentage point increase in utilization, at what point would DHCS think that rate increases would be part of the solution?

5. How does DHCS ensure that Medi-Cal enrollees have timely access to Denti-Cal?

6. Please provide an update on DHCS's efforts to address the CSA's findings:

    a. Establish criteria for assessing and monitoring beneficiary utilization, access to services, and provider participation in the program, and take corrective action on any identified declining trends to ensure that the influx of beneficiaries is able to access services.

    b. Perform annual reimbursement rate reviews and ensure beneficiaries have reasonable access to dental services and ensure that Delta Dental performs all its contract-required outreach activities to improve participation.

    c. Establish the provider-to-beneficiary ratio statewide and in each county as a performance measure to evaluate access and availability of dental services and capture needed data about dental services for reporting purposes.

7. Has DHCS explored the option of using Medi-Cal funding for the California Dental Disease Prevention Program? Is this possible?

8. What is the status of the Dental Managed Care report due to the Legislature on March 15, 2015?

## 6. Medi-Cal Payment Reductions, Rates, and Access

**Budget Issue.** The Governor's budget continues the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions and assumes total fund savings of $550 million ($275 million General Fund). See table below for a summary of the savings the Governor's budget associates with AB 97.

**Table 1: AB 97 Medi-Cal Provider Payment Reduction Summary in January Budget***

| AB 97 Payment Reductions (Total Fund) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| (dollars in thousands) | | | | | | | | |
| Provider Type | Retroactive Savings Period | Total Retroactive Savings | On-Going Annual Savings | Nov. 2014 Estimated Savings from AB 97 Reduction (1) (2) | | | | Remaining Retro Recoupment |
| | | | | FY 2014-15 | | FY 2015-16 | | |
| | | | | On Going | Retro | On Going | Retro | |
| Nursing Facilities - Level A | 6/1/11-6/30/12 | $246 | $254 | $254 | $92 | $254 | $0 | $0 |
| ICF/DDs | | $0 | $5,413 | $5,413 | $0 | $5,413 | $0 | $0 |
| FS Pediatric Subacute | Exempt | | | | | | | |
| AB 1629 Facilities (3) | N/A | | | | | | | |
| DP/NF-B | 6/1/11-9/30/13 | $83,437 | | | $3,793 | | $15,170 | $49,304 |
| Phase 1 Providers (4) | 6/1/11-12/20/11 | $21,286 | $44,776 | $38,793 | $0 | $44,776 | $0 | $0 |
| Physician 21 yrs+ | | $0 | $49,746 | $49,746 | $0 | $49,746 | $0 | $0 |
| Medical Transportation | | $0 | $14,461 | $14,461 | $0 | $14,461 | $0 | $0 |
| Medical Supplies & DME | 6/1/11-10/23/13 | $39,428 | $17,394 | $17,394 | $2,503 | $17,394 | $7,510 | $19,402 |
| Dental | | $0 | $60,458 | $60,458 | $0 | $60,458 | $0 | $0 |
| Clinics | | $0 | $18,512 | $18,512 | $0 | $18,512 | $0 | $0 |
| Pharmacy | 6/1/11-2/6/14 | $296,621 | $113,718 | $113,718 | $17,977 | $113,718 | $53,931 | $170,782 |
| Phase 3 Providers | | $0 | $2,414 | $1,811 | $0 | $2,414 | $0 | $0 |
| Managed Care | | | $120,261 | $140,980 | $0 | $120,261 | $0 | $0 |
| **Grand Total** | | **$441,018** | **$447,407** | **$461,540** | **$24,365** | **$447,407** | **$76,611** | **$239,488** |
| | | | | | | | | |
| **AB 97 Rate Freeze (Total Fund)** | | | | | | | | |
| Provider Type | Retroactive Savings Period | Total Retroactive Savings | On-going Annual Savings | FY 2014-15 | | FY 2015-16 | | Remaining Retro Recoupment |
| | | | | On Going | Retro | On Going | Retro | |
| DP/NF-B | 6/1/11-9/30/13 | $144,229 | | $0 | $6,556 | 0 | $26,223 | $85,227 |

Note:

(1) Data Source: Nov 2014 Estimate

(2) AB 97 injunctions were lifted on 6/25/2013.

(3) AB 1629 facilities includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.

(4) Phase I includes all subject providers, including the Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.

*Please note these numbers will be updated at the May Revision.

The Governor's budget, and this chart, do not correctly reflect the savings associated with ICF/DDs. The corrected AB 97 savings for this provider type is $11.1 million (this will be reflected in the May Revision).

**Primary Care Rate Increase Expired.** The ACA required Medi-Cal to increase primary care physician service rates to 100 percent of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The state received 100 percent federal financial participation (FFP or federal funding) for the additional incremental increase in Medi-Cal rates determined using Medi-Cal rates that were in effect as of July 1, 2009. Consequently, on an annual basis, this brought in approximately $1.6 billion in additional federal funds (to reach the Medicare rate). Also, an additional $91.5 million ($45.8 million General Fund) on an annual-basis was budgeted in order to bring Medi-Cal rates to the level in effect as of July 1, 2009 (as required by the ACA).

**Background.** As a result of the state's fiscal crisis, AB 97 required the Department of Health Care Services (DHCS) to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

On October 27, 2011, the federal Centers for Medicare and Medicaid (CMS) approved California's proposal to reduce Medi-Cal provider reimbursement rates. As part of this approval, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services would not be impacted, and (2) develop and implement an ongoing healthcare access monitoring system.

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider ten percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

About 80 percent of Medi-Cal enrollees are enrolled in Medi-Cal managed care. The remaining 20 percent receive Medi-Cal through fee-for-service. Generally, those in FFS are persons with limited-scope aid codes, dual eligibles in the non-Coordinated Care Initiative counties, and persons who are exempt from managed care because of a medical exemption request.

**Recoupment of Retroactive Savings.** DHCS has begun the recoupment of retroactive savings for all affected providers except DP/NFs and Pharmacy. DHCS will give these providers 60 day notice prior to recouping these savings. According to DHCS, each provider will receive a recoupment notice. If the provider contests the amount reflected, they can contact a service center and submit documentation contesting the amounts. While there is no formal appeals process, the provider may also contact DHCS if they do not believe the amount is correct and they do not get resolution at Xerox (the state's fiscal intermediary). If a Medi-Cal provider no longer participates in Medi-Cal or in fee-for-service Medi-Cal, the department's Third Party Liability and Recovery Division will set up an accounts receivable and follow the customary collection procedures.

**Managed Care and Actuarial Soundness of Rates.** Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards *and* a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services). In the Governor's budget, the AB 97 reductions to managed care plans as a percentage of their base rates are 0.62 percent in 2014-15 and 0.45 percent in 2015-16. If the reductions applicable to the elimination of the primary care physician rate increase are considered, then the reductions as a percentage of health plan base rates are 0.76 percent in 2014-15 and 0.71 percent in 2015-16.

The Governor's budget includes a placeholder rate increase for managed care plans of 3.57 percent in 2015-16. This is a net rate increase. Since managed care plan rates must be actuarially sound, although they are reduced by AB 97, on the net, managed care plans generally receive a rate increase every year.

**Rate Freezes – ICF/DDs.** In addition to the AB 97 payment reductions discussed above, some providers are impacted by rate freezes. For example, rates for intermediate care facilities for the developmentally disabled (ICF/DDs), habilitative (ICF/DD-H), and nursing (ICF/DD-N) are frozen at 2008-09 levels. For ICF/DDs (all types), the budget assumes $11.1 million ($5.5 million General Fund) savings from the AB 97 rate reduction and $49.1 million ($24.5 million General Fund) from the rate freeze.

Beginning with the 2013-14 rates, effective for dates of service on or after May 27, 2014, ICF/DD, ICF/DD-H, and ICF/DD-N providers will be reimbursed at the facilities' rebased projected cost per day plus five percent, but no higher than the 65$^{th}$ percentile rate established in 2008-09, and no lower than the 65$^{th}$ percentile rate established in 2008-09, reduced by ten percent. DHCS will determine each facility's rebased projected cost by using cost or audited cost reports each year. The department has recently implemented a new rate methodology for these facilities which uses the most current facility-specific data.

Concerns have been raised by these providers that ICF/DDs are closing because of the low Medi-Cal reimbursement rates and transitioning to other types of homes (e.g., negotiated rate homes) overseen by the Department of Developmental Services which have higher reimbursement rates; thereby, resulting in increased costs to the state. According to the Administration, from 2010 to February 2015, 65 ICF/DD-Ns and ICF/DD-Hs have closed and 58 new ICF/DD-Ns and ICF/DD-Hs have opened. Additionally, according to the California Department of Developmental Services (DSS) of the 17 facilities that closed in 2014, DSS found no evidence of them converting to negotiated rate homes.

**LAO Findings and Recommendations.** Last year, the LAO reviewed DHCS's baseline access analyses and quarterly monitoring reports and came away with numerous concerns about the quality of the data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on access. In the LAO's view, these concerns are sufficient to render the Administration's public reporting of very limited value for the purpose of understanding beneficiary access in the fee-for-service (FFS) system. The LAO also found that much of the debate regarding the Medi-Cal provider payment reductions has focused mainly on FFS while access issues in managed care are gaining more importance

(as a majority of Medi-Cal enrollees are in managed care). Since dental care will remain primarily a FFS benefit for the foreseeable future, the LAO recommends the Legislature create meaningful standards for monitoring Denti-Cal (FFS) access. In addition, the LAO recommends future oversight focus on monitoring the managed care system. The LAO indicates that it plans to produce a more detailed analysis on this topic in the future.

**Stakeholder Concerns.** Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations. On March 4, 2015, the Senate Health Committee and Assembly Health Committee held a joint hearing on the question of whether Medi-Cal rates ensure access to care.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as updated information will be received at the May Revise and discussions continue on this topic.

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

1. Please provide an overview of this issue and a brief discussion of how managed care rates are set.

2. How does DHCS proactively evaluate the impact of the AB 97 reductions to each specific provider type to ensure that access is not compromised? Please explain what data sources and other information the department uses to evaluate access.

3. Please provide a brief overview of the department's Network Adequacy Monitoring Project. What is the timeline of this project? Prior to implementation of this project, how is DHCS comprehensively and proactively monitoring network adequacy?

## 7. Medi-Cal Annual Open Enrollment Period

**Budget Issue.** DHCS proposes trailer bill language (TBL) to establish an Annual Health Plan Open Enrollment process for specified Medi-Cal managed care health plan (MCP) beneficiaries who are enrolled in counties that have more than one Medi-Cal managed care health plan (MCP) option. DHCS estimates that this proposal would result in a net General Fund savings of $1 million (and a total fund savings of $2 million). This savings comes from the reduction in the number of initial health assessments (IHAs) and reduced mailing costs to implement Annual Health Plan Open Enrollment.

Under this proposal, beneficiaries subject to the Annual Health Plan Open Enrollment process would be allowed to change MCPs only during the Annual Health Plan Open Enrollment period, with a few exceptions. This Annual Health Plan Open Enrollment period would occur each year and would align with the open enrollment period relative to populations applying for health care coverage though the California Health Benefit Exchange (Exchange). This proposal does not prohibit eligible individuals from enrolling into Medi-Cal throughout the year. Enrolling onto the Medi-Cal program will continue to be available at any time during the year for those that are eligible, as it is currently.

The Annual Health Plan Open Enrollment process would only apply to those beneficiaries in affected counties in the Family and Child aid code categories. It would not apply to beneficiaries residing in counties where there is only one managed care plan choice, Seniors and Persons with Disabilities, beneficiaries dually eligible for Medicare and Medi-Cal (Duals), new adult beneficiaries under the Affordable Care Act Medi-Cal expansion, or any other category of mandatorily enrolled beneficiaries that the director of the Department of Health Care Services (DHCS), after receiving stakeholder input, determines should not be subject to the Annual Health Plan Open Enrollment process.

This TBL proposal would provide an exception to the Annual Health Plan Open Enrollment process for the following beneficiaries, who would have the option to change their initially selected MCP, with or without cause, within the first 90 days following enrollment in the MCP:

- A beneficiary that is newly enrolled in Medi-Cal managed care; and
- A beneficiary moving from one county to another.

This TBL proposal would require DHCS to conduct an assessment of the Annual Health Plan Open Enrollment process and report to the Legislature six months after the first calendar year of implementation. If the assessment indicates the Annual Health Plan Open Enrollment process is appropriate for other mandatory populations, the Administration may propose or seek future legislation to extend the Annual Health Plan Open Enrollment process to the additional mandatorily enrolled populations. In addition, the TBL would: 1) allow DHCS to implement the Annual Health Plan Open Enrollment process through expedited contracts and the use of plan letter, plan or provider bulletins, or similar instructions, until such time as final regulations are adopted; and 2) require regulations to be adopted no later than July 1, 2018.

**Background.** Current practice allows beneficiaries residing in counties with more than one MCP choice to change plans every month. DHCS notes that this current policy is not consistent with overall health care industry practice. Enrollees of Medicare Advantage (MA) and Part D Plans (except Dual-Eligible

Special Needs Plans), commercial, the California Public Employees' Retirement System, and Exchange plans are all subject to Annual Health Plan Open Enrollment periods.

According to DHCS, it submitted this proposal because it finds that frequent MCP enrollment changes can have a detrimental impact on patient care management and limit coordination of care with other programs. Additionally, DHCS argues that frequent changes can also impair quality monitoring and improvement activities because many MCP beneficiaries are not enrolled in an MCP long enough to assess the quality of their care. Lastly, DHCS states that this proposal would reduce the number of health assessments that MCPs must perform each time a beneficiary enrolls in a different MCP.

**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. Although this proposal includes the ability for someone to switch plans if they have "good cause," having to demonstrate this and go through this process could be a barrier to ensuring timely treatment. It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this proposal.

## 8. Managed Care Organization Tax

**Budget Issue.** The Administration proposes to create a new managed care organization tax. This tax is projected to generate about $1.72 billion in revenue and offset $1.13 billion in General Fund expenditures.

The Administration cites the following goals of this proposal: (1) raise the same amount of non-federal funding for the Medi-Cal program as the current MCO tax ($1.13 billion), (2) raise an additional $215.6 million in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours, and (3) meet federal broad-based and uniform provisions and no hold harmless requirements for health care-related fees/taxes. The Administration indicates that it will likely seek federal waiver of certain broad-based and uniform requirements in order to have the lowest net financial impact on health plans.

**Background.** California has had many variations of a tax on Medi-Cal managed care organizations (MCOs) over the last ten years. These include:

- **Managed Care Organization (MCO) Fee.** 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 and 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 (Bass), Chapter 157, Statutes of 2009, extended the 2.35 percent premium tax imposed on all types of insurance to include all 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-

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.

living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates paid 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.

- **Current MCO Tax.** The state's current MCO tax imposes a sales and use tax rate of 3.9375 percent on Medi-Cal managed care plans' gross receipts effective July 1, 2013 through June 30, 2016. This tax was approved by the federal government as a component of the state's Duals Demonstration Project (Coordinated Care Initiative). The revenues are deposited into the Childrens Health and Human Services Special Fund. Half of the MCO tax revenues are used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans in order to "make them whole". The other half of these funds is used to offset General Fund expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles. For 2015-16, the current MCO tax is projected to generate $1.13 billion in non-federal funding for the Medi-Cal program.

**Recent Federal Guidance on Health Care Related Taxes.** On July 25, 2014 the federal Centers for Medicare and Medicaid Services (CMS) issued guidance clarifying the treatment of health care-related taxes (provider taxes) and their effect on federal matching funding for Medicaid (Medi-Cal in California) and the Children's Health Insurance Program (CHIP). CMS clarified that provider taxes must:

- **Broad-Based -** Be broadly based, so as not to specifically target one group (must include providers that do not receive Medicaid funding).

- **Uniform -** Be uniformly imposed, meaning levied equally across all providers in that provider type.

- **No Hold Harmless -** Not hold providers harmless from the burden of the tax, meaning that states cannot guarantee taxed dollars will be returned to affected providers.

The provisions of broad-based and uniform requirements can be waived by the federal government if the tax program structure meets the standard to waive these requirements (referred to as the B1/B2 test). The hold harmless requirement cannot be waived.

States that have provider taxes that do not meet these criteria must take action in the state's next legislative session to redesign the tax to meet these requirements. California's current MCO tax does not meet these criteria because it is not broad-based as it applies to only Medi-Cal managed care plans and not all managed care plans in the state.

**In-Home Supportive Services (IHSS) Settlement Agreement.** As part of a 2013 settlement agreement between the Administration and labor unions and disability rights advocates regarding reductions in IHSS, the Administration is required to submit to the Legislature proposed legislation authorizing an assessment on home care services, including but not limited to home health care and IHSS. The new assessment would be used to offset the seven percent reduction in authorized IHSS service hours, which was authorized by the 2013 settlement agreement. (This settlement agreement was in response to lawsuits regarding IHSS budget reductions in the 2009, 2010, 2011, and 2012 budgets.) This assessment proposal was supposed to be submitted to CMS by October 1, 2014.

On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session.

In January, the Administration indicated that it seeks to enact this proposal by the end of March and submit the request to CMS by April 1 so that it can be implemented on July 1, 2015. See chart below for details on this proposal.

**Summary of Managed Care Organization (MCO) Tax Proposal**

**Effective Date of Tax**

- July 1, 2015 – no sunset

**Who is subject to this tax?**

- All full-service managed care plans regulated by the Department of Managed Care (DMHC) and the Department of Health Care Services (DHCS), except two plans that provide international coverage.
- There are about 45 plans that meet these criteria and would be subject to this tax, of which 22 are Medi-Cal managed care plans.

**How would this tax be calculated?**

- The tax would be assessed based on total plan enrollment.
- Medicare (including D-SNP) and plan-to-plan (for the subcontracted plan) enrollees would be excluded from this assessment of total plan enrollment.
- It is estimated that this would apply to 277 million member months or about 23 million MCO members.
- The tax would be assessed based on a tier-structure that is intended to ensure no plan has a disproportionate tax based on its relative size and that targets the tax on plans with higher numbers of Medi-Cal enrollees.
    - Taxing Tier 1 – For enrollment up to 125,000 member months at $3.50 per enrolled member month.
    - Taxing Tier 2 – For enrollment of 125,001 through 275,000 member months at $25.25 per enrolled member month.
    - Taxing Tier 3 – For enrollment of 275,001 through 1,250,000 member months at $13.75 per enrolled member month.
    - Taxing Tier 4 – For enrollment of 1,250,001 through 2,500,000 member months at $5.50 per enrolled member month.
    - Taxing Tier 5 – For enrollment greater than 2,500,001 member months at $0.75 per enrolled member month.

**How much tax revenue would be generated by this tax and how would it be used?**

- $1.72 billion in MCO tax revenue would be generated and deposited into the Health and Human Services Fund. This revenue would be used:
    - $371 million to pay Medi-Cal MCOs (matched to get an additional $371 million federal funds).
    - $215.6 million to restore the IHSS seven percent reduction (matched to get an additional $215.6 federal funds).
    - $1.13 billion in General Fund offset in the Medi-Cal program.

**Who would administer the tax?**

- DHCS and DMHC.

**How would this tax impact MCOs?**

- The Administration estimates that the net impact to MCOs, after accounting for the Medi-Cal reimbursement, is $658 million (0.48 percent of total plan revenue).

**LAO Findings and Recommendation.** Generally, the LAO is supportive of this proposal given that the state must restructure its existing MCO tax, but notes that the Legislature should carefully consider its impacts. Additionally, the LAO finds that such a tax should not be authorized on permanent basis.

**Subcommittee Staff Comments and Recommendation—Hold Open.** Subcommittee staff notes that a permanent extension of this tax would make it difficult to periodically evaluate its effectiveness and its impact on managed care plans in the state. Two of the state's other provider fees (the skilled nursing facility quality assurance fee and the hospital quality assurance fee) have sunset dates.

It is recommended to hold this item open as discussions continue on this proposal. DHCS notes that it is working with health plans on alternatives.

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

1. Please provide an overview of this proposal.

2. What is the status of the discussions with health plans regarding alternatives? Has DHCS set a timeframe for these discussions?

3. Are there any legal risks if the state does not submit an MCO tax proposal is to CMS by April 1, 2015 (in light of the IHSS settlement agreement)?

## 9. Eliminate Cost-of-Living Adjustment for County Eligibility Administration

**Budget Issue.** DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA) on a permanent basis. See table below for summary of county administration funding.

**Table: Summary of Proposed County Administration Funding**

| | 2014-15 | | 2015-16 | |
|---|---|---|---|---|
| | **Total Fund** | **General Fund** | **Total Fund** | **General Fund** |
| Base County Administration | $1,302,683,000 | $651,341,500 | $1,302,683,000 | $651,341,500 |
| Affordable Care Act Implementation | $390,000,000 | $195,000,000 | $120,000,000 | $240,000,000 |
| Other | $447,696,000 | $117,541,300 | $405,142,000 | -$61,762,200 |
| Enhanced Federal Funding | | -$371,022,000 | | -$271,693,000 |
| **Total** | **$2,140,379,000** | **$592,860,800** | **$1,827,825,000** | **$557,886,300** |

The Administration contends that this proposal is technical clean-up as county administrative funding has been adjusted due to implementation of new Affordable Care Act requirements in 2013-14 and 2014-15 and that the new budget methodology (discussed earlier) will be implemented for 2015-16.

**Background.** DHCS provides funding for county staff and support costs to perform administrative activities associated with the Medi-Cal eligibility process. Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with an annual COLA. Nevertheless, the COLA was suspended for the following four fiscal years: 2009-10, 2010-11, 2011-12, and 2012-13. Furthermore, AB 12 (Evans) Chapter 12, Statutes of 2009-10, 4th Extraordinary Session, added Government Code Section 11019.10 that prohibits automatic COLAs.

DHCS notes that county administration workload is experiencing multiple changes as part of ACA implementation and the Governor's budget provides significant resources to support county administration work through 2015-16. Once ACA implementation stabilizes, the state and the counties will work collaboratively to develop a new methodology for county administrative funding pursuant to SB 28 (Hernandez and Steinberg), Chapter 442, Statutes of 2013. SB 28 directed DHCS to convene a workgroup to create a new methodology for budgeting and allocating funds for county administration of the Medi-Cal program no sooner than 2015-16.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as updated estimates regarding county administration funding may be included in the May Revise. Additionally, it should be noted that this proposal was included as part of last year's budget and the Legislature adopted trailer bill langauge to suspend the COLA for the budget year only and not on a permanent basis.

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

1. Please provide an overview of this proposal.

2. Please provide an update related to developing a new methodology for county administrative funding.

## 10. Financial Audits Workload

**Budget Issue.** DHCS requests 21 positions (nine permanent and 12.0 two-year limited term) and expenditure authority of $3,094,000 ($844,000 General Fund , $1,544,000 federal funds and $706,000 reimbursements) to address new audit workload associated with Intermediate Care Facilities for the Developmentally Disabled Nursing/Habilitative (ICF-DDN/H) and AB 959 (Frommer), Chapter 162, Statutes of 2006, public clinics.

Specifically, the new workload stems from the following mandated work:

- **ICF-DDN/H -** Revisions made by State Plan Amendment (SPA) 13-019 which changed the reimbursement methodology for the ICF-DDN/H programs
- **AB 959 -** AB 959's expansion of Welfare & Institutions (W&I) Code, Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to state veteran homes and clinics operated by the state, a city, a county, the University of California system and public healthcare systems.

The resources will be utilized between three DHCS Divisions/Offices: Audits & Investigations/Financial Audits Branch (FAB), Office of Administrative Hearings and Appeals (OAHA), and Office of Legal Services (OLS). The chart below details the number of positions per division and fund source.

| Division/Office | Number of Positions | Total Expenditure Authority | Fund Split* |
|---|---|---|---|
| A&I/FAB | 11.0 | $1,486,000 | 27GF/50FF/23RF |
| OAHA | 6.0 | $988,000 | 19GF/50FF/31RF |
| OLS | 4.0 | $620,000 | 40GF/50FF/10RF |
| **Total:** | **21.0** | **$3,094,000** | |

*GF: General Fund; FF: federal funds; RF: Reimbursements

**Background-SPA 13-019 Facility-Specific Reimbursement Rates (ICF DDN/H).** Medi-Cal Long-Term Care reimbursement rates are established under the authority of Title XIX of the federal Social Security Act. The specific methodology is described in the State Plan, and when changes to such methodologies are requested, DHCS must submit a SPA for approval by the Centers for Medicare and Medicaid Services.

SPA 13-019, approved by CMS on December, 4, 2013, revised the way ICF-DDNs/Hs are reimbursed. Pursuant to the SPA, DHCS must use facility-specific audited costs to calculate the rates for audited facilities. The ICF/DD-H and the ICF/DD-N programs are now reimbursed by Medi-Cal with a methodology that is based on a per diem basis, also called a "client day." Prior to SPA 13-019, the facility payment rate per day was established by using the 65th percentile of the facility's respective peer group. Previously, the number of audits conducted was determined by statistical analysis, which equated to approximately 150 to 200 audits per year.

The new methodology creates facility-specific rates based on reported costs and sets a floor and a ceiling for the Medi-Cal per diem rate. A facility cannot be paid more than or less than the range specified by the established floor and ceiling. Any facility whose costs fall within the established floor and ceiling will have their reimbursement rate set based on the actual audited costs. If a facility's costs fall below the floor, they will receive the established floor rate. If a facility's costs are above the ceiling, they will receive the established ceiling rate. This facility specific methodology has created an increase in the number of audits performed as the new program is implemented, requiring new positions to perform the additional audit oversight and post-audit activities.

Moreover, when audit adjustments are issued, the providers are accorded both informal and formal hearing rights. In the past, reimbursement to ICF-DD-H/N was not based upon audited allowable costs of each specific facility, but rather on an applied statistical analysis that would establish a per diem rate. However, with the changes made to the reimbursement methodology by SPA 13-019, every facility now has a specific and direct interest in ensuring that its cost report is accepted as submitted. Consequently, DHCS anticipates a sharp rise in filed appeals. A conservative estimate is that DHCS will receive 165 informal appeal requests and 85 formal appeal requests.

To implement this methodology change, the number of audits DHCS must complete is expected to increase from approximately 150-200 audits pre-SPA 13-019 to approximately 300-350 audits per year. According to DHCS, the significant increase in the number of audits performed requires new positions to complete the additional audit oversight and post-audit activities.

**Background-AB 959 Supplemental Payment Audits (Public Clinics/Veteran Homes).** AB 959 expanded Welfare and Institutions Code (WIC) Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to:

- State veteran homes that provide services to Medi-Cal beneficiaries, and
- Clinics that are operated by the state, a city, a county, the University of California system or public healthcare systems that were enrolled as Medi-Cal providers retroactive to 2006-07.

AB 959 allows state veteran homes and public clinics to obtain increased federal funding reimbursement without the use of state General Funds. Based on current law, supplemental Medi-Cal outpatient payments are made from Medi-Cal federal funds that are available to AB 959 public clinics that provide local funding, referred to as Certified Public Expenditures (CPEs). The federal funds are drawn down by applying the clinic's CPEs. The AB 959 program is funded using 50 percent federal funds and 50 percent CPE. The eligible facilities will reimburse DHCS for the costs of administering the program.

AB 959 requires an eligible facility veteran home or clinic to reimburse DHCS for the cost of administering the expansion of WIC Section 14105.965 as a condition of receiving supplemental reimbursement. In enacting this section, the Legislature intended to provide the supplemental reimbursement described without any expenditure from the General Fund.

This proposal seeks resources related to the implementation of AB 959 regarding public clinics, as the implementation of AB 959 for veteran homes has already occurred. Although AB 959 was enacted in 2006, DHCS did not receive approval from CMS to implement it for public clinics until August 2012 and will be making payments retroactive to 2006. DHCS anticipates that this will result in short-term increase in work load and there is requesting that 12 of the 21 positions be two-year limited-term.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

2. Please explain the delay in the implementation of AB 959 for public clinics and the department's plan to become current in payments to clinics.

## 11. Health Care Reform – Workload Extension

**Budget Issue.** DHCS requests the extension of six limited-term positions and expenditure authority to support the continued implementation of and ongoing work required under the federal Affordable Care Act (ACA), including but not limited to the implementation of enhanced provider screening under the program integrity requirements and the support of the anticipated enhancements to the existing Medi-Cal Eligibility System (MEDS) and its sub-applications in order to meet the business needs of the health insurance-exchange, and county consortia including Electronic Health Information Transfer integration requirements.

The total limited-term expenditure authority request for 2015-16 is $716,000 ($129,000 General Fund and $587,000 federal funds) and for 2016-17 is $547,000 ($78,000 General Fund and $469,000federal funds). The following chart details the extension of limited-term positions for the CA-Medicaid Management Information Systems (CA-MMIS), Provider Enrollment Division (PED), and Information Technology Services Division (ITSD):

| Division/ Office | Classification | # of Positions | Term |
|---|---|---|---|
| CA-MMIS | Associate Information Systems Analyst (Spec) | 2.0 | 7/1/15-6/30/17 |
| CA-MMIS | Data Processing Manager I | 1.0 | 7/1/15-6/30/17 |
| PED | Staff Services Analyst | 2.0 | 7/1/15-6/30/16 |
| ITSD | Sr. Information Systems Analyst (Spec) | 1.0 | 7/1/15-6/30/17 |

**Background.** On March 23, 2010, President Obama signed the ACA into law, which impacts every sector of the health care system, including Medi-Cal. The law puts into place comprehensive health insurance reforms that seek to hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.

DHCS contends that these positions are needed to continue the ACA efforts related to:

1. **California Medicaid Management Information Systems (CA-MMIS)** - Extending the 3.0 limited-term positions will provide the continuity of the identification and development of the business rules of the CA-MMIS changes required or resulting from the ACA:
   - The positions will continue coordination efforts with other DHCS Divisions/Branches, and the fiscal intermediary contractor.
   - Address any anticipated workload activities and system changes associated with rate changes, reporting, increased eligibility, problem statements, and erroneous payment corrections.
   - Provide subject matter insight in their areas of expertise, ensure application and enforcement of the statewide standards for project management and oversight, review and adjudicate contractor invoices, review and adjudicate contractor deliverables, and work with the DHCS Office of Legal Services and state control agencies as needed.
   - Be responsible for reviewing and approving project plans, methodologies, and documentation; participating in and/or overseeing all development, system testing and

acceptance testing, including but not limited to the review of functional, technical, test, implementation, and post-implementation deliverables; conducting analysis of deliverables to ensure conformance to contract requirements, technical design standards, and end-user business objectives; and preparing reports, documents, publications, and presentations.

2. **Provider Enrollment Division (PED)** - The 2.0 requested positions will be required to handle new workload associated with:
   - Processing applications, including reviewing applications for completeness and consistency and identifying and notifying providers of errors.
   - Verifying the licensure and permit status of providers and search background verification database for information on the provider to analyze the data for consistency with the application.
   - Evaluating whether the provider meets statutory and regulatory requirements for participation, recommending approval/denial of the provider's application using known fraud risk factors and making investigation referrals when determined.

3. **Information Technology Services Division (ITSD)** - ITSG is requesting the extension of 1.0 Senior Information Systems Analyst (specialist) position through June 30, 2017, to continue the following activities to ensure compliance with ACA:
   - Interpret the policy guidance and rules on the required Medicaid interfaces, gather business requirements and participate with our Program Areas in any federal, county, and state policy discussions that affect the operational provisions, including the public website that enroll/re-enroll persons directly in to the Exchange.
   - Continue to conduct system analysis, produce technical requirements and design deliverables, develop test plans and scenarios, and oversee the implementation of the system enhancements and interfaces between MEDS, CalHEERS, and the county consortia.
   - Continue to participate as the technical liaison and Subject Matter Expert (SME) for the Program Area for any Statewide Automated Welfare System (SAWS) modifications that will affect MEDS. Ensure the changes are compatible to the existing MEDS interface standards and best practices.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

## 12. Health Care Reform Financial Reporting Resources

**Budget Issue.** DHCS requests expenditure authority of $1,959,000 ($980,000 General Fund and $979,000 federal funds) for 2015-16 and $1,797,000 ($899,000 General Fund and $898,000 federal funds) on-going for 18 three-year limited term positions. The resources will address the increases in federal Centers for Medicare and Medicaid Services (CMS) mandated reporting requirements.

As the single state agency which administers the Medicaid program and Children's Health Insurance Program, DHCS has full fiscal responsibility for CMS federal reporting. The table below illustrates the fiscal changes, specific to the Medi-Cal Program and Children's Health Insurance Program (CHIP), from 2012-13 to 2014-15.

**Table: Medi-Cal and CHIP Funding Summary** (dollars in thousands)

| Fiscal Year | General Fund | Federal Fund | Other Funds | Total Funds |
|---|---|---|---|---|
| 2012-13 | $14,707,722 | $36,192,651 | $8,787,620 | $59,687,993 |
| 2013-14 | $16,235,742 | $42,999,474 | $10,788,402 | $70,023,618 |
| 2014-15 | $17,433,680 | $58,907,705 | $14,460,362 | $90,801,747 |
| % of Change for Federal Reporting (2012-13 to 2014-15): | | 63% | | |

**Background.** DHCS is the single state agency which administers the Medi-Cal program. According to DHCS, the new financial reporting requirements associated with the Affordable Care Act (ACA) have expanded the Accounting Section beyond its current capacity. For example:

- New federal reporting requirements have doubled the current workload for Medi-Cal reporting. 8,100 forms were required for the financial reporting of Medi-Cal benefits prior to ACA; 16,200 forms will now be a required when ACA expansion is complete. The CMS-64 quarterly financial claim for March 2013 totaled 1,396 pages compared to March 2014 which totaled 2,122 pages. In a year's time, the quarterly federal financial claim form for federal funds (CMS-64) has increased by over 700 pages. DHCS expects continued growth due to the new expanded ACA reporting requirements. March 2014 included only the initial phase of ACA which began on January 1, 2014. The current staff of eight will not be able to sustain the level of reporting required by the ACA.

- Reconciliations of the benefit payments will be increased due to the high profile nature of the ACA. This will require additional staff dedicated solely to this project as the guidelines, population and modified adjusted gross income (MAGI) information are unique from the normal Medi-Cal benefit payments.

- The Governor's budget for local assistance in 2013-14 was $52,905,467,000 while 2014-15 is $72,233,221,000. This is an increase of $19.3 billion in benefit payments. For one DHCS program, eleven accounts payable staff currently receives an average of 800 monthly invoices. ACA doubles the workload to 1,600 monthly invoices while holding staff to the same deadlines.

- Reconciliations for drug rebates, overpayment collections, and False Claims Act for the new ACA population will increase the workload for accounting and the corresponding programs due to the complexity of the federal requirements. The current workload is being performed by two staff which will need to be increased to meet the new ACA requirements. The impact of not meeting the federal reporting requirements for these reconciliations can affect the receipt of the quarterly federal grant award for Medi-Cal, interest payments to the federal government for the collections of overpayments, drug rebates and settlements not meeting Code of Federal Regulations requirements, and failing to be in compliance with federal requirements.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

## 13. Hospital Quality Assurance Fee Resources

**Budget Issue.** DHCS requests extending 9.5 limited-term positions and expenditure authority, set to expire on December 31, 2015, to December 31, 2018. DHCS also requests $350,000 in additional limited-term expenditure authority for two contracts to calculate and actuarially certify increased capitation rates as well as for high level counsel and assistance for federal submissions associated with the Hospital Quality Assurance Fee (HQAF) program.

The HQAF program has been statutorily extended through December 31, 2016, with the option of extending the program another three years. The positions requested are necessary to facilitate the program. The total cost is $983,000 ($492,000 HQAF Fund and $491,000 federal funds) for 2015-16; $1,416,000 ($708,000 HQAF Fund and $708,000 federal funds) annually for 2016-17 and 2017-18; and $983,000 ($492,000 HQAF Fund and $491,000 federal funds) for 2018-19.

The previous HQAF programs covered the periods between April 1, 2009 and December 31, 2013, and provided supplemental payments in the amount of $23.4 billion to California hospitals. DHCS requests the extension of these positions due to the renewal of the program and to complete administrative duties that continue beyond the duration of the HQAF program on December 31, 2016.

**Background.** California's Medi-Cal program provides access to health care services to individuals with low income and limited resources under Title XIX of the federal Social Security Act.

In 2010, the department implemented California's first hospital provider fee and supplemental payment program under AB 1383 (Jones), Chapter 627, Statutes of 2009, for the period of April 1, 2009 through December 31, 2010. The program resulted in fee collections of $3.046 billion, hospital payments of $5.63 billion, and $560 million retained for health care coverage for children. This program requires most California's general acute hospitals (except county and UC general acute hospitals) to participate. However, the provider fee program requires only private hospitals that were not considered small and rural to pay the fee. Approximately 405 hospitals participated in this program, 318 were private hospitals. Both public and private hospitals received payments from this program. The program was extended under SB 90 (Steinberg), Chapter 19, Statutes of 2011, an additional six months for the period of January 1, 2011 through June 30, 2011.

In 2011, SB 335 (Hernandez), Chapter 286, Statutes of 2011, extended the HQAF program from July 1, 2011 through December 30, 2013 to draw down additional federal funds and increase supplemental payments to hospitals participating in the Medi-Cal program.

SB 239 (Hernandez) Chapter 657, Statutes of 2013, extended the HQAF program, and establishes the framework for a second phase and permanent continuation of the program under future legislation or a constitutional amendment. The first phase, January 1, 2014 through December 31, 2016, is estimated to generate $13.3 billion in funds from hospitals during the program period, of which approximately $12.5 billion would be used to draw down an equal amount in federal funds and used to increase Medi-Cal payments to hospitals. Generating these funds pay out an estimated $23 billion to the hospital community and $2.4 billion for health care coverage for children, a savings to the general fund. The

department resubmitted State Plan Amendments (SPA) 14-001 and 14-002 formally to the Centers for Medicare and Medicaid Services (CMS) on November 21, 2014, for CMS approvals.

According to DHCS, continuation of the HQAF program requires significant workload for DHCS, which is distributed to staff in limited-term positions in the Safety Net Financing Division (SNFD), Third Party Liability and Recovery Division (TPLRD), Capitated Rates Development Division (CRDD), and the Office of Legal Services (OLS). Additional actuarial contract resources are needed to continue support for the program and rate build through the new period of the HQAF. In addition, while the first phase of the program payment period ends December 31, 2016, the HQAF program workload extends further to December 31, 2018. There are significant work activities needed to settle HQAF program payments that extend after the HQAF program payment period, such as, obtaining CMS necessary approvals for capitation HQAF payments, collecting delinquent fees, and necessary reconciliations.

SNFD is responsible for significant workload involving negotiations with CMS for approval of the HQAF model, the upper payment limit (UPL) models, the SPAs, and the amendment to the hospital financing waiver (all required to implement the program). In addition to this workload, SNFD is responsible for calculating the HQAF, notifying the hospitals of the HQAF amounts owed, and issuing the grant payments. This work requires the implementation and maintenance of program structures, processes and procedures, and databases for tracking status correspondence, and communications with the hospitals and external stakeholders. DHCS also has to monitor and ensure the integrity of the Hospital Quality Assurance Revenue Fund.

In order to maintain the program, TPLRD performs administrative activities relating to accounting, monitoring, processing payments as well as collecting the HQAF. In addition TPLRD monitors for delinquent payments, and the requisite administrative remedies that will continue past the end of the program. TPLRD is also responsible for a system of checks and balances to ensure the integrity of the Fund.

CRDD validates timely and accurate distribution of funds to hospitals by reviewing the plans' records. The HQAF funds are built into the plans' capitation rates for the purpose of providing additional funding to the hospitals. Each separate QAF program requires new capitation rates. Ensuring that the plans receive the appropriate funding under this program and that the plans are appropriately disbursing funds to the hospitals is a critical and substantial ongoing workload.

OLS attorneys will be required to help draft the SPAs and related public notices, as well as assist with preparing responses to CMS' Request for Additional Information which routinely accompany the SPAs. OLS attorneys will also be required to participate in discussions with the participating hospitals regarding the implementation and ongoing administration of the Program. This is especially true given the nature of the fee model and the necessity of its compliance with federal regulations. Redirection of existing staff resources is not feasible.

In addition, DHCS requests funding for the following contracts:

- Covington and Burling Contract - Provide high level advice and counsel regarding development of quality assurance fees, SPAs, fee models, UPL calculation, the federal B1/B2 test, and conformance with federal regulations.

- Mercer Contract - Calculate and actuarially certify increased capitation rates that would be paid to managed care plans.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

## 14. Martin Luther King Jr. Hospital Resources

**Budget Issue.** DHCS requests two full-time permanent positions and $745,000 ($373,000 Federal Fund and $372,000 Reimbursement) including annual contract funding of $500,000. This request is needed to meet the department's workload requirements related to Welfare and Institutions Code (WIC) Section 14165.50 to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. This population was formerly served by the Los Angeles County Martin Luther King, Jr. – Harbor Hospital.

Statute requires reimbursement to this new hospital based on one hundred percent of Medi-Cal projected costs for inpatient services in fee for service (FFS) and managed care, subject to a variety of requirements outlined in the law. The statute provides for the County of Los Angeles to reimburse the state for the nonfederal share of staffing and administrative costs directly related to implementation of its provisions.

**Background.** Currently, Medi-Cal reimburses hospitals for acute inpatient services using a Diagnosis Related Group (DRG) methodology. The DRG payment system operates on a reimbursement related to the recipient's assigned diagnosis or diagnoses. The diagnoses and procedures must be documented in the patient's medical record. The information is then coded in the claim. 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 and the same number of days of inpatient stay. The payment system is based on paying the average cost for treating patients in the same DRG. This reimburses hospitals for actual services and resources utilized based on the acuity level of a patient.

Pursuant to WIC Section 14165.50, the cost-based reimbursement methodology for FFS and managed care Medi-Cal payments to the new MLK hospital will provide compensation at a minimum of 100 percent of the projected costs for each fiscal year, contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide each fiscal year through fiscal year 2016-17 a guaranteed level of 77 percent of the projected Medi-Cal cost for inpatient hospital services. Managed care rates must be adjusted to reflect the actuarial equivalent of those costs, subject to specified requirements. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77 percent of projected Medi-Cal costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77 percent of costs.

Beginning in fiscal year 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72 percent of projected Medi-Cal costs. If current Medi-Cal private hospital reimbursement methods results in funding that is less than 72 percent of projected Medi-Cal costs, the GF will be required to fund the non-federal share of the additional payments up to 72 percent of the costs.

In order to enable reimbursement for the new MLK hospital to reach 100 percent of projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary

intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the department shall seek further federal approval to enable MLK to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100 percent minimum funding requirement may be sought through additional supplemental programs upon federal approval.

The requested staff would be responsible for policy development and implementation of the FFS interim rate setting process for MLK, verification and acceptance of the projected costs submitted by the county on a yearly basis, as well as detailed monitoring to ensure funding requirements are met. These activities are vital so that the amount of funding from the GF is kept to a minimum. Additionally, the proposed staff would be responsible for the development of managed care policy as it relates to rate setting, and will be required to oversee the development of the methodology, data gathering process, and consultation with stakeholders, to ensure the appropriate cost methodology is captured and used for rate development purposes. The proposed contracted actuaries will be responsible for the development and adjustment of the rates to ensure compliance with the statute.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

## 15. MEDS and Securing Medi-Cal Eligibility Information Resources

**Budget Issue.** DHCS requests the conversion of ten limited-term positions to permanent and two-year extension of one limited-term position. The expenditure authority requested for the 11 positions is $1,497,000 ($714,000 General Fund and $783,000 federal funds). The resources are necessary to perform 1) the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, 2) ensuring compliance with requirements of the federal Social Security Administration (SSA), and 3) monitoring access to the Medi-Cal Eligibility Data System (MEDS). The 11.0 limited-term positions are scheduled to expire on June 30, 2015.

**Background.** DHCS is the single state agency which administers the Medi-Cal program, and as such, has interagency agreements in place with other departments to administer select components of the program. DHCS must authorize access to and monitor MEDS access by other departments and agencies. MEDS is a robust database containing over 25 million records which include SSA data, personal health information, and other confidential data. MEDS provides eligibility information to agencies including county welfare departments and other health and welfare agencies throughout the state. DHCS must ensure that no user has authorized access to MEDS or SSA data unless they have a verified and justifiable need directly related to the administration of the Medi-Cal program in compliance with SSA access requirements. DHCS' Information Security Office has investigated where unauthorized access either has occurred and where there was the potential for unauthorized access. Since MEDS is a key data repository for DHCS in terms of SSA data, the required SSA compliance review demonstrate we have high standards for tracking and monitoring MEDS access. MEDS is one of the most critical applications supporting Medi-Cal and numerous other public assistance programs. Many organizations, including other state departments and all 58 counties, require access to MEDS.

To obtain access to data from the SSA, DHCS must enter into a data-sharing agreement with the SSA and comply with all SSA requirements. In 2007, as a result of directives from the federal Office of Management and Budget (OMB), the SSA made substantial changes in the data-sharing agreement. This agreement focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

Since 2008-09, DHCS has received staffing authority to establish limit-term positions to perform the activities necessary to maintain compliance with the SSA agreement and retain access to SSA data. With this proposal, DHCS requests the conversion of ten limited-term positions to permanent, and the extension of one limited-term position for two years effective July 1, 2015. According to DHCS, the resources will ensure the privacy and security of Medi-Cal eligibility information and MEDS data. This work is ongoing and permanent in nature.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

## 16. Intergovernmental Transfer Program Resources

**Budget Issue.** DHCS requests two new permanent positions, the conversion of three limited-term positions to permanent, and $467,000 expenditure authority ($120,000 federal funds and $347,000 reimbursements). The requested staffing resources would address the additional and ongoing workloads from Medi-Cal managed care expansion and mandated statutory requirements to implement SB 208 (Steinberg) Chapter 714, Statutes of 2010. The three limited-term positions are set to expire on October 31, 2015. Starting in 2016-17, and on-going, the requested expenditure authority would be $540,000 ($164,000 federal funds and $376,000 reimbursements).

**Background.** DHCS is responsible for calculating and setting the capitation rates for managed care organizations, and ensuring certification that capitation rates for managed care health plans are determined in compliance with federal requirements. Managed care serves more than eight million Medi-Cal beneficiaries in 58 counties, which is more than 70 percent of the total Medi-Cal population. In California, there are six models of managed care: 1) County Organized Health Systems (COHS); 2) Two-Plan Model (TPM); 3) Geographic Managed Care (GMC); 4) Regional Model; 5) San Benito and 6) Imperial. There are currently more than 12 million Medi-Cal members.

**Background - Intergovernmental Transfer (IGT) Program.** According to DHCS, the rate range intergovernmental transfer (IGT) program, authorized by Welfare and Institutions (W&I) Code 14164 and 14301.4, has grown significantly as more health plans and eligible providers (also known as funding entities) have decided to participate in this voluntary program. An IGT is a transfer of funds from an eligible governmental entity such as a public hospital or county clinic to the DHCS for the purpose of providing the non-federal share of Medi-Cal payments. Federal law generally authorizes the use of IGTs. IGTs are currently used by the Medi-Cal program in a variety of areas, including the Disproportionate Share Hospital (DSH) program, and to finance portions of Medi-Cal managed care payments. The actuarially sound health plan capitation rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to, but not exceeding the upper bound of the range. Technical agreements between a health plan and the funding entity, as well as DHCS and the funding entity, are required for this purpose including supporting documentation that requires significant DHCS review. The rate range IGT program has substantially increased over the years as more health plans and funding entities have chosen to participate in an increasing number of counties. DHCS charges an administrative fee authorized by W&I Code 14301.4 to support program operations. The fee is 20 percent of the IGT contribution from the funding entity. The fee is expected to generate approximately $70 million in General Fund savings in 2014-15, for plan services in the 2012-13 rate year.

This IGT rate range program has grown significantly over time. When the program first began in 2006-07, only two health plans and two providers participated. Due to increased interest, DHCS expanded health plan participation to Geographic Managed Care (GMC) county plans and providers for the 2011-12 rate year. Today, a number of health plans and providers now participate. For example, the number of rate range IGT related plan-provider agreements from Two-Plan Models, increased from 17 for rate year 2010-11 to 35 for rate year 2011-12 (the last year for which complete IGT participation data).

DHCS anticipates continued growth in this program generally in existing participating counties as well as a result of managed care expansion in rural areas.

As a result of the growth of this program, DHCS requests two new permanent associate governmental program analysts who will review financial information to ensure appropriateness of reimbursement and reconciliations of contributions to outgoing capitation payments; conduct high level analysis of IGT transactions, provide technical assistance and policy review; and process submissions for federal approvals.

**Background - SB 208 IGT Program.** SB 208 authorized components of the state's 1115 Medicaid Bridge to Reform Waiver and many Medi-Cal programmatic changes including mandatory enrollment of seniors and persons with disabilities (SPDs) into managed care and a related IGT program. This SB 208 IGT program enables Medi-Cal health plans to compensate Designated Public Hospitals in amounts no less than what they would have received for providing services to beneficiaries under fee-for-service (FFS). Since the non-federal share of the funding related to the SPD population historically was financed through Certified Public Expenditures (CPEs), the IGT program was created to avoid a significant General Fund impact due to the transition of this population into managed care. Specifically, SB 208 permits IGTs to provide financial support of the non-federal share of risk-based payments to managed care health plans to enable those health plans to sufficiently compensate DPHs. DHCS staff continues to work on reconciling the IGT transactions, review the flow of funds between the plans and hospitals, ensure the accuracy of transactions, and respond to and collaborate with stakeholders regarding this complex program.

Three limited term positions were originally authorized for this IGT workload associated with implementation of SB 208 in 2011-12 and were extended in 2013-14 to align with the timing of the Bridge to Reform waiver. However, this is permanent workload required by statute that does not sunset with the waiver. Therefore, DHCS requests to make these positions permanent.

**Subcommittee Staff Comment and Recommendation—Hold Open.** It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

2. Can the department identify areas where this opportunity could be more fully utilized?