Senate Budget and Fiscal Review Committee
Senate Health Committee

Background Paper for October 16, 2012 Joint Hearing

Oversight Hearing on the

Transition of Children in the Healthy Families Program to Medi-Cal

OVERVIEW

The Governor's January 2012-13 budget proposed to shift children in the Healthy Families Program (HFP) to Medi-Cal over a nine-month period beginning in October 2012. The Legislature adopted a modified version of this proposed transition.

AB 1494 (Chapter 28, Statutes of 2012)[1] (a budget trailer bill) provides for the transition of children in the HFP to Medi-Cal starting *no earlier* than January 1, 2013. At the time AB 1494 was enacted, it was projected that this transition would result in $13.1 million General Fund savings in 2012-13, $58.4 million General Fund savings in 2013-14, and $72.9 million General Fund savings annually thereafter.

Children born to mothers enrolled in the Access for Infants and Mothers with incomes above 250 percent of the federal poverty level are exempt from this transition.

AB 1494 includes the following provisions:

- ***Strategic Plan for Transition.*** The California Health and Human Services Agency (CHHSA) is required to work with the Managed Risk Medical Insurance Board (MRMIB), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC) to develop a strategic plan for this transition of children from HFP to Medi-Cal no later than October 1, 2012. This plan must include at least the following information:
    - State, county, and local administrative activities that will facilitate a successful transition.
    - Methods and processes for stakeholder engagement to assist in the transition.
    - State monitoring of managed care health plans' performance and accountability for provision of services.
    - Health care and delivery system components, such as standards for informing and enrollment materials, network adequacy, performance measures and metrics,

[1] AB 1468 (Chapter 438, Statutes of 2012), a budget trailer bill, made technical revisions to this transition.

fiscal solvency and related factors that ensure timely access to quality health and dental care.
    - Operational steps, timelines and key milestones.

- ***Transition Phases***. The transition will occur in four phases.
    - Phase 1 - Begins no sooner than January 1, 2013 and includes about 415,000 children in a HFP health plan that matches a Medi-Cal health plan.
    - Phase 2 - Begins no sooner than April 1, 2013 and includes about 249,000 children in a HFP health plan that is a subcontractor of a Medi-Cal health plan.
    - Phase 3 - Begins no sooner than August 1, 2013 and transitions about 173,000 children enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with a Medi-Cal health plan into a Medi-Cal health plan in that county.
    - Phase 4 - Begins no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.

- ***Implementation Plans.*** DHCS is required to submit an implementation plan for each phase prior to transitioning children to Medi-Cal to ensure continuity of care with the goal of ensuring there is no interruption in services and there is continued access to coverage for transitioning individuals. AB 1494 requires the Administration to consult with stakeholders on the development of the implementation plans.

- ***Monitoring of Transition.*** Monthly status reports on the transition are required to be submitted to the Legislature. These reports must include information on health plan grievances related to access to care, continuity of care, requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment).

- ***Dental Coverage.*** For Sacramento and Los Angeles counties, dental coverage for individuals transitioning would continue to be provided by their current dental managed care plan if the HFP dental plan is a Medi-Cal dental managed care plan. For Sacramento County, if their plan is not a Medi-Cal dental managed care plan, the individual is required to be assigned to a plan, with preference to a plan with which their current provider is a contracted provider. For Los Angeles County, if their plan is not a Medi-Cal dental managed care plan, the individual may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal fee-for-service dental coverage. For all other counties, dental coverage for these children transitions to Medi-Cal fee-for-service dental coverage.

- ***Integration of Managed Care Plan Performance Measures.*** Requires that managed care plan performance measures be integrated and coordinated with the HFP performance standards, including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. This must occur prior to the implementation of Phase 1.

- ***Department of Managed Health Care – Consumer Assistance.*** Additional funding ($400,000 Managed Care Fund) was appropriated to the Department of Managed Health Care for administration of the call center to assist individuals with the HFP transition, and health plan readiness and coordination functions with DHCS.

- ***Contract Exemptions for Initial Transition Activities***. Provides DHCS with exemptions from contracting competitive bidding rules for purposes of Accelerated Enrollment application processing by the Single Point of Entry, non-eligibility-related case maintenance and premium collection, maintenance of the Health-E-App web portal, call center staffing and operations, Certified Application Assistant services, and reporting capabilities. Also permits DHCS to enter into a contract with the Health Care Options Broker of DHCS for purposes of managed care enrollment activities. These specified contracts may be initially completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Subsequent contracts for these purposes will use a competitive bid basis and will be subject to the Public Contract Code.

Additionally, AB 1494 specifies that if at any point during the transition, the Administration determines that this transition violates federal requirements or jeopardizes federal funding; children will be enrolled back into HFP.

Table 1: Key Requirements Prior to Phase 1 Transition

- ***Federal Approval.*** All federal approvals and waivers must be obtained prior to this transition.

- ***60-Day Notice.*** Individuals must be informed of this change at least 60 days prior to the transition. This notification must include, at a minimum, information on how an individual's systems of care may change, when the change may occur, and whom to contact for assistance.

- ***Network Adequacy Assessment.*** At least 60 days prior to the transition, findings from a network adequacy assessment of managed care health plans must be submitted to the Legislature.

- ***Performance Measures.*** Managed care plan performance measures must be integrated and coordinated with the HFP performance standards, including child-only measures.

Table 2: Key Reports to the Legislature

- ***Strategic Plan for Transition.*** Due to the Legislature on October 1, 2012, this plan provides an overall framework for all phases of the transition to ensure that state, county, and local administration activities are in place for a successful transition.

- ***Phase Implementation Plans.*** Due to the Legislature at least 90 days prior to the start date of each phase. These phase implementation plans would include specific information regarding state and county readiness, health plan network adequacy, and continuity of care.

- ***Monthly Status Reports***. Commencing no later than February 15, 2013, monthly status reports are due to the Legislature. These reports would include information on health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks (including provider enrollment and disenrollment changes), and eligibility performance standards.

- ***Network Adequacy Assessment***. At least 60 days prior to the transition of children in Phase 1, findings from a managed care health plan network adequacy determination must be submitted to the Legislature.

Strategic Plan for Transition Submitted to Legislature. On October 2, 2012, CHHSA submitted the required strategic plan for the transition to the Legislature. As reflected in Table 3, in this strategic plan, the Administration indicated that based on significant input from stakeholders, it proposes to separate Phase 1 into two distinct sub-phases (Phase 1a and 1b). The first group of children would transition to Medi-Cal effective January 1, 2013 and the second group would transition on March 1, 2013. According to the plan, the Administration will work collaboratively with Medi-Cal managed care plans and DMHC to assess plan readiness and network adequacy in order to determine which plans are most ready to proceed with the transition.

Table 3: Administration's Healthy Families Program Transition Timeline and Key Dates

	Phase 1a	**Phase 1b**	**Phase 2**	**Phase 3**	**Phase 4**
Begin Date	January 1, 2013	March 1, 2013	No earlier than April 1, 2013	No earlier than August 1, 2013	No earlier than September 1, 2013
Number of Children	415,000*		249,000	173,000	43,000
Who is Transitioned?	Children in HFP health plan that matches a Medi-Cal health plan.	Children in HFP health plan that matches a Medi-Cal health plan.	Children in a HFP health plan that is a subcontractor of a Medi-Cal health plan.	Children enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with a Medi-Cal health plan into a Medi-Cal health plan in that county.	Children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.
Implementation Plan Due Date	October 1, 2012	October 1, 2012	January 1, 2013	May 1, 2013	June 1, 2013
Network Adequacy Determination	November 1, 2012	November 1, 2012	January 1, 2013**	May 1, 2013**	June 1, 2013**
90-day Notice Date	Not Required	Not Required	January 1, 2013	May 1, 2013	June 1, 2013
60-day Notice Date	November 1, 2012	November 1, 2012	February 1, 2013	June 1, 2013	July 1, 2013
30-day Notice Date	December 1, 2012	December 1, 2012	March 1, 2013	July 1, 2013	August 1, 2013

*Specific criteria on which children would be transitioned in Phase 1a and Phase1b is unknown.

**Included in the Phase Implementation Plan.

BACKGROUND

Medi-Cal. In California, the federal Medicaid program is administered by DHCS as Medi-Cal. Medi-Cal provides health care services to qualified low income persons, primarily families with children, seniors, and persons with disabilities. In 2012–13, the Administration estimates a total Medi-Cal caseload of about 8 million beneficiaries.

Federal law establishes some minimum requirements for state Medicaid programs regarding the types of services offered and who is eligible to receive them. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government. Medi-Cal provides health care coverage through two basic types of arrangements—fee–for–service (FFS) and managed care. In a FFS system, a health care provider receives a payment from DHCS for each medical service provided to a Medi-Cal beneficiary. Beneficiaries generally may obtain services from any provider who has agreed to accept Medi-Cal patients. Under managed care, DHCS contracts with health care plans to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. DHCS then reimburses health care plans on a capitated basis. The health plans assume some financial risk, in that they incur costs to deliver the necessary care that are more or less than the capitated rate. No insurance premiums are collected from Medi-Cal enrollees under either managed care or FFS.

Even in counties with managed care, certain Medi-Cal services are provided outside the managed care system. These services are commonly referred to as "carve–outs." The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for example, is a federally mandated set of services and benefits for all individuals under the age of 21 who are enrolled in Medicaid. The treatment component of EPSDT is broadly defined to include necessary health care, diagnostic services, treatment, and other measures that are needed to correct or ameliorate physical and mental illnesses and conditions discovered by the screening services. The counties administer EPSDT and services provided under EPSDT are paid for by the counties and the federal government, with costs split about evenly between them.

Healthy Families Program. The federal Children's Health Insurance Program (CHIP) provides health coverage to children in families that are low–income, but with incomes too high to qualify for Medicaid. The HFP is California's CHIP and it provides health insurance for about 863,000 children up to age 19 in families with incomes above the thresholds needed to qualify for Medi–Cal but below 250 percent of the federal poverty level (FPL). (The FPL is $22,350 in annual income for a family of four.) For every dollar the state spends, the federal government provides roughly a two–dollar match.

The Managed Risk Medical Insurance Board (MRMIB) provides coverage by contracting with health plans that provide health, dental, and vision benefits to HFP enrollees. Under state law, the benefits that HFP provides to enrollees are required to be equivalent to benefits provided to state employees through the California Public Employees' Retirement System, with certain exceptions for mental health benefits.

The HFP has a tiered premium structure that specifies lower premiums for families below 150 percent of the FPL, and higher premiums for higher–income families. These premiums can vary between $4 to $24 per child per month depending on family income, with a maximum monthly family premium of $72.

States Have the Option to Combine Medicaid and CHIP Programs. A state may use federal CHIP funds to create a stand–alone program, such as HFP, or expand its Medicaid program to include children in families with higher income. In both options, states receive the two–dollar federal match for every state dollar to provide coverage for the CHIP population.

DMHC Regulation of Knox-Keene Licensed Managed Care Plans. The Knox-Keene Health Care Service Plan Act (Act) requires health plans to be licensed and regulated by DMHC. With the exception of some county organized health system plans, Medi-Cal managed care plans must be licensed under the Knox-Keene Act. The Act and its implementing regulations establish requirements for geographic access to health care and timely access to care. The model contracts DHCS uses to contract with Medi-Cal managed care plans also contain time and distance standards for access to care and physician and primary care physician to member ratios.

ISSUES TO CONSIDER

Combination Strategic Plan for Transition and Phase I Implementation Plan. On October 2, 2012, the Administration submitted the required strategic plan for the transition to the Legislature. This strategic plan serves as the overall guide for all phases of the transition and outlines components that the Administration finds would facilitate a successful transition. The Administration claims that the strategic plan serves as the required Phase I Implementation Plan (which is due 90 days prior to any transition). However, it is unclear how this strategic plan details county system readiness for Phase 1, health plan network adequacy (which is proposed to be submitted to the Legislature on November 1, 2012) for Phase 1, and provisions for continuity of care for Phase 1, as required by AB 1494 to be included in each phase implementation plan.

Contingency if Requirements Not Met Prior to Transition. AB 1494 requires that, before the transition of children from HFP to Medi-Cal, (1) the state must have secured federal Centers for Medicare and Medicaid Services (CMS) approval for these programmatic changes, (2) managed care health plan network adequacy must be assessed and reported to the Legislature 60 days prior to the transition, (3) HFP subscribers must receive a notification 60 days prior the transition, and (4) managed care plan performance measures must be integrated and coordinated with at least HFP child-only measures. If the Administration goes forward with notifying subscribers about the transition on November 1, 2012 (for a January 1, 2013 transition), it is unclear what the contingency plan is if the networks are inadequate or if CMS approval is not yet received, for example.

Transition Start Date Should Be Based on Readiness. The Administration appears intent on proceeding with the transition on January 1, 2013 and has not provided any rationale on why it is beginning the transition of children on this date, rather than ensuring that all necessary activities have occurred to ensure a smooth transition. The dates specified in statute reflect the *earliest* date by which the phased transition should occur. It is important to ensure that the transition of children between programs occur successfully and without any negative impact to children's access to health care services.

Federal Approvals Required for Transition of HFP to Medi-Cal. AB 1494 requires federal approval of several elements of the transition from the HFP to Medi-Cal, including the transition itself. These requirements include requiring DHCS to obtain federal approval to provide full scope no-share-of cost Medi-Cal benefits to children with family incomes below 200 percent of the federal poverty level (FPL), requiring DHCS to seek approval to "disregard" (not count) the family income of children in families with incomes between 200 and 250 percent of FPL (who are currently eligible for HFP), allowing DHCS or county human services departments to rely upon findings made by the MRMIB regarding one or more components of eligibility, and allowing DHCS to require premiums for children in families with incomes between 150 and 250 FPL.

AB 1494 prohibits DHCS from enrolling targeted low-income children currently eligible for HFP in the Medi-Cal program until all necessary federal approvals have been obtained. DHCS and MRMIB indicate a State Plan Amendment (SPA) is required for both HFP (CHIP) and Medi-Cal (Medicaid), and an amendment to the state's five-year Section 1115 "California Bridge to Reform" waiver from 2010 is needed.

General vs. Specific Notification to Children and Families. The Administration's proposed 60-day notice is a general informing notice to families about the transition of HFP to Medi-Cal. It does not contain specific information related to an individual child's transition, such as county-specific information for the transition of dental services (Los Angeles and Sacramento counties have dental managed care) and information on how a child who is receiving mental health or substance use disorder services would receive these services under Medi-Cal. The proposed notice would leave families on their own to figure out how to transition these services.

Generic vs. Targeted Outreach and Communication. The issue of targeted and appropriate outreach materials has continually been brought up for attention as stakeholders have learned from multiple past transitions that communication with subscribers, providers, health facilities, community groups, and families must be appropriately tailored to ensure that the right people have the right information. Although a "Communications Subgroup" has been established, the Administration has not followed-up or responded to suggestions for needed communications/materials.

For example, many stakeholders have suggested that a simple press release by the California Health and Human Services Agency (CHHSA) about this transition would be a very helpful resource to community groups and certified application assisters as misinformation about this transition is spreading through communities. This was raised at the September 13 and October 3

stakeholder meetings and CHHSA has yet to respond (affirmatively or negatively) on this request.

Provider Network Adequacy Unclear without Rate Information. While the Administration plans to submit its assessment of network adequacy (both health and dental) to the Legislature on November 1, 2012, it is difficult to ascertain provider participation without an understanding of the rates these providers will be paid. Additionally, health plans are still waiting on information from DHCS regarding primary care provider rate increases resulting from the Affordable Care Act. (The Affordable Care Act provides for primary care rate increases to Medicaid.)

Targeted Dental Services Transition Notification. As required by AB 1494, dental coverage for HFP children in Sacramento and Los Angeles counties would continue to be provided by their current dental managed care plan, if the HFP dental plan is a Medi-Cal dental managed care plan. For all other counties, dental coverage for these children transitions to Medi-Cal fee-for-service dental coverage. It is important that the notification to families about this change in coverage be tailored based on which county the child lives. This would provide the clearest message to families and reduce confusion about this transition.

Need for Coordination for Transition of Mental Health Services. As children transition from HFP to Medi-Cal, changes to how these children receive mental health services may occur. Although this varies by county, in many instances HFP plans provide certain mental health services. This will change under this transition because under Medi-Cal, specialty mental health services are provided by the county mental health plan. Consequently, communication between the Administration, health plans, and county mental health plans must occur to ensure that the transition of these services is coordinated and that children have uninterrupted access to mental health services. To date, there have been no meetings organized by the Administration with stakeholders to coordinate on this issue. While the Administration plans to hold stakeholder meetings, it is critical that this coordination occur before children are transitioned.

QUESTIONS

CHHSA

1. Please provide an overview of the transition plan and transition activities.

2. Please discuss Agency's rationale and justification for combining the Strategic Plan and the Phase I Implementation Plan.

3. Please discuss the Administration's stakeholder engagement process on planning for this transition.

4. Please discuss the Administration's communication strategy and materials, and how these materials have been targeted for the appropriate audiences.

5. According to the Strategic Plan, Phase 1 will have two transition dates, January 1, 2013 and March 1, 2013. What criteria will be used to determine which children transition on which date? Will children transitioning on March 1, 2013 receive a 60-day notice in November?

6. Which state department will send out the 60-day notice?

7. Does the Administration plan to send out the 60-day notice for Phase I prior to federal approval? If so, what is the contingency plan if the state does not receive federal approval for this transition? Are there other instances when subscribers/enrollees have been notified of a change to their program coverage prior to receiving federal approval for the change?

DHCS

1. Please provide a brief overview of DHCS' efforts in regards to this transition.

2. What federal approvals (such as Medicaid and Children's Health Insurance Program State Plan Amendments and waivers) are required prior to the implementation of the transition from the Healthy Families Program to Medi-Cal?

3. Please provide an update on the status of CMS' approval of the State Plan Amendments and amendments to the Section 1115 Bridge to Reform Waiver. When does the Administration expect final approval? What questions has the federal government asked about the shift of children from HFP to Medi-Cal?

4. The Affordable Care Act provides for primary care rate increases in the Medi-Cal program. However, the Administration has not been clear on whether or not these rate increases apply to HFP children transitioning to Medi-Cal. Do these rate increases apply to HFP children transitioned to Medi-Cal?

5. When will provider rates be determined? How can the state rely on network adequacy assessments prior to providers knowing their rates?

6. According to the transition plan, "If any of the medical or dental plan networks are found to not meet network adequacy standards, the departments will alert the plans to those areas where the network needs improvement and work with the plans to correct network inadequacies. The departments will work with the health and dental plans to correct any deficiencies and will re-assess health and dental plan networks before HFP subscribers' transition into the plan." Please discuss this process and what steps DHCS plans to take to help correct the inadequacies and how it interacts with the timing of notification to HFP subscribers about their transition (i.e., would subscribers be notified if the network is not adequate but the departments are working to correct deficiencies or would notification only happen once the network has been determined adequate?).

7. If a health plan in a particular county does not meet accessibility standards, what steps will DMHC and DHCS take to ensure children have access to care?

8. What is the status of the integration and coordination of the existing managed care plan performance measures with the HFP performance standards, including, but not limited to, child-only HEDIS measures?

9. Please describe how DHCS plans to monitor for continuity of care as part of this transition.

10. Please describe how DHCS is working with the counties to prepare for this transition.

11. How much health care provider network "overlap" is there in Medi-Cal and HFP where the same health care providers participate in each program?

12. How does DHCS intend to monitor the cap on family out-of-pocket spending in Medicaid? When a beneficiary reaches his or her out-of-pocket cap, can that information be programmed into the child's Medi-Cal beneficiary identification card?

13. If a child is undergoing treatment, has previously scheduled surgery, or is hospitalized during the transition, what steps are DHCS, and its contracting plans, taking to ensure continuity of care?

14. Does the Administration have a process or on-going means to receive and address feedback it receives from local stakeholders (such as legal aid attorneys, application assisters, children's health advocates, and health care providers) to address issues that arise during the transition from the Healthy Families Program to Medi-Cal?

15. Please explain the specific efforts made by DHCS in regards to the transition of dental services.

16. Does DHCS have a definition of Denti-Cal provider adequacy that defines how many providers are needed to provide timely access to quality dental care for Medi-Cal enrolled children?

17. Please explain the specific efforts made by DHCS in regards to the transition of mental health services.

MRMIB

1. Please provide an overview of MRMIB's proposed transition schedule and the rationale for this schedule.

2. Please describe the general notice that has been discussed at MRMIB meetings. What is the intent of this notice, and when does MRMIB plan to send it out?

3. Please describe what MRMIB would include in a 60-day notice to families about this transition.

DMHC

1. Please provide an overview of DMHC's process to assess network adequacy prior to the transition of children from HFP to Medi-Cal.

2. What criteria or standards are used to make an assessment on network adequacy?

3. According to the transition plan, "If any of the medical or dental plan networks are found to not meet network adequacy standards, the departments will alert the plans to those areas where the network needs improvement and work with the plans to correct network inadequacies. The departments will work with the health and dental plans to correct any deficiencies and will re-assess health and dental plan networks before HFP subscribers' transition into the plan." Please discuss this process and what steps DMHC plans to take to help correct the inadequacies and how it interacts with the timing of notification to HFP subscribers about their transition (i.e., would subscribers be notified if the network is not adequate but the departments are working to correct deficiencies or would notification only happen once the network has been determined adequate?).

4. If a health plan in a particular county does not meet accessibility standards, what steps will DMHC and DHCS take to ensure children have access to care?

5. Please describe how DMHC plans to monitor for continuity of care as part of this transition.

6. If a child is undergoing treatment, has previously scheduled surgery, or is hospitalized during the transition, what authority does DMHC have to ensure continuity of care?