Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Holly J. Mitchell, Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, March 17, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Michelle Baass

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4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 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 $76.6 million for DMHC. See table below for more information.

DMHC Budget Summary

Fund Source	2014-15	2015-16	2016-17
	Actual	Projected	Proposed
Federal Trust Fund	$461,000	$589,000	$0
Reimbursements	$1,861,000	$2,640,000	$1,609,000
Managed Care Fund	$52,316,000	$70,862,000	$75,038,000
Total Expenditures	**$54,638,000**	**$74,091,000**	**$76,647,000**

Timely Access Reports. The 2015 Budget Act included 25 permanent positions and $3,802,000 (Managed Care Fund) for 2015-16 and $3,594,000 (Managed Care Fund) for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 964 (Hernandez), Chapter 573, Statutes of 2014. SB 964 added the following new requirements:

- Review health plan compliance with timely access standards and make recommendations for changes on an annual basis.
- Review all full service and mental health plan networks for adequacy and availability of providers; separately for Medi-Cal, individual market, and all other markets.
- Review grievances submitted to health plans regarding network adequacy and timely access.
- Post approvals for waivers from, or alternate standards for, timely access requirements on website on and after January 1, 2015.
- Post findings from timely access compliance review on website beginning December 1, 2015.

DMHC's annual timely access report, required by SB 964, was not posted on DMHC's public website as of December 2015. According to DMHC, the report, which will include the DMHC's findings and recommendations with respect to health plans' compliance with the timely access appointment wait time standards from January 1, 2014 through December 31, 2014, is currently under review and will be shared publicly as soon as possible.

According to DMHC, this report analyzes a very large data set submitted by health plans. This data set includes the plans' assessment of whether enrollees are able to receive timely access to care, in compliance with the required standards. Almost all health plans collect this data by conducting surveys that measure the wait time for the next available appointment. DMHC's most recent timely access report will assess access to services based on health plan data that was submitted by health plans to the DMHC on March 31, 2015. However, following the March 31, 2015 submissions, the DMHC discovered that a large portion of the health plans had miscalculated their survey results. As a result, health plans were asked to re-calculate and resubmit their data to the DMHC and this caused in a delay in receiving the data. Given this delay, the DMHC required additional time to complete its report.

Subcommittee Staff Comment. This is an informational item.

Questions.

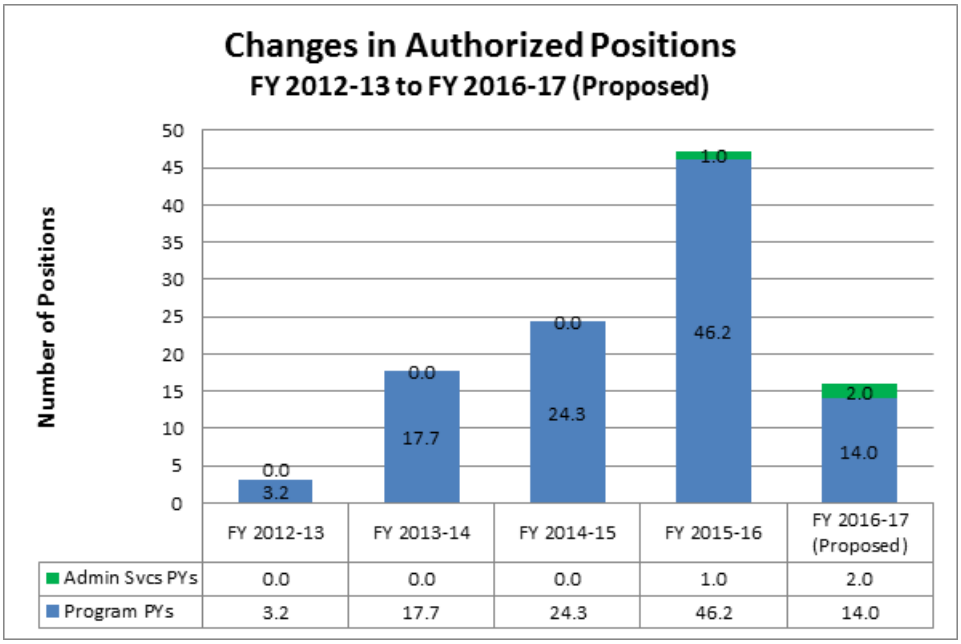
1. Please provide a brief overview of DMHC's programs and budget.

2. Please provide an estimated timeframe for the completion of the timely access report required by SB 964.

Issue 2: Infrastructure and Support Services

Budget Issue. DMHC requests two permanent positions and $247,000 for 2016-17 and $234,000 for 2017-18 and ongoing to ensure the DMHC can address the critical administrative workload resulting from program expansions resulting from the implementation of the Affordable Care Act (ACA) and conforming state legislation.

Since 2012-13, DMHC has grown from 349.6 to 442.0 authorized positions; an increase of 92.4 positions, a 26.4 percent increase. As shown in the chart below, the majority of the increase was for program staff and not administrative services staff (accounting, budgeting, human resources, business services, training). As of 2015-16, of the 92.4 positions, one position was for administrative services. If this proposal is approved, the percentage of administrative services staff granted compared to program staff over the last four fiscal years will increase to 3.2 percent.



	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 (Proposed)
Admin Svcs PYs	0.0	0.0	0.0	1.0	2.0
Program PYs	3.2	17.7	24.3	46.2	14.0

Background. As a result of the enactment of the ACA and other legislation, the DMHC's programs have grown in excess of 25 percent over the past four years, with staffing levels increasing from 352.0 to 442.0. While budget change proposals were submitted to address the increased programmatic workload associated with the expansion of DMHC's oversight of managed health care plans, according to DMHC, sufficient positions were not requested to address the correlated workload increases in support services. Of the 130 positions created in the past four years, one position was earmarked for the Office of Administrative Services (OAS). The considerable expansion in a rapid timeframe has strained existing departmental resources in OAS as there have been no additional positions created to support department-wide efforts.

In order to meet workload requirements resources were redirected from other areas and temporary help enlisted. Even with these resources, according to DMHC, OAS still experienced difficulties completing assignments within designated timeframes. While OAS has prioritized certain less crucial tasks, the workload must be addressed. With the requested resources, the DMHC will not be able to

address its critical administrative activities in a timely manner. This will have a direct and immediate impact throughout DMHC's programs.

OAS is responsible for supporting staff by providing a considerable array of personnel (i.e., recruitment, retention, training, benefits, leave, reasonable accommodation, discipline issues); accounting (i.e., travel expense claims, payroll warrants and checks); and facility (i.e., ergonomic evaluations, telecom and repair requests) services. In addition to employee services, OAS is responsible for ensuring that departmental resources are utilized appropriately, in part by managing budget allotments against expenditures and projections. This also includes the coordination, review and approval of all related contracts, purchases, invoices, receipts, timesheets, duty statements, and classification justifications.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide a brief overview of this request.

Issue 3: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DMHC requests two-year limited-term expenditure authority of $244,000 for 2016-17 and 2017-18 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, the End of Life Option Act.

Background. Existing state law authorizes adults to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of that adult's incapacity in accordance to a power of attorney for health care and guarantees terminally ill individuals certain care. When a health care provider diagnoses a patient with a terminal disease, the provider is required to notify the patient of his or her right to comprehensive information and counseling regarding legal end-of-life options, including (1) hospice care at home or in a health care setting; (2) a prognosis with and without the continuation of disease-targeted treatment; (3) the patient's right to refuse or withdraw from life-sustaining treatment; and (4) the patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care. Law also requires timely coverage of pain management drugs for terminally ill individuals and requires a plan that denies an experimental treatment to a terminally ill individual to provide information on covered alternative treatments and on the plan's grievance process, as well as an opportunity for the enrollee to attend a conference to discuss the matter with the plan. While existing California law requires all of the above components and options for end of life care, it does not authorize terminally ill individuals to obtain a prescription allowing them to self-administer aid-in-dying medications.

The End of Life Option Act authorizes adult California residents who meet certain qualifications and who have been determined by their primary care physician to be suffering from a terminal disease to, under specified conditions and procedures, request and self-administer an aid-in-dying prescription drug for the purpose of ending their life. AB 15 X2 also establishes the specified conditions and procedures that must be followed under this new law. The provisions of AB 15 X2 sunset on January 1, 2026.

AB 15 X2 does not specify whether health plans are required to cover aid-in-dying medication or how a health plan may decline to cover aid-in-dying medication. Due to the sensitive and controversial nature of aid-in-dying medication, DMHC expects a high level of public interest which, over the next two years, will result in its Office of Legal Service (OLS) conducting legal research, producing legal opinions, and promulgating one regulation package to clarify the issue of coverage.

To address this new workload, OLS requests limited-term expenditure authority so OLS may hire temporary help to perform the following short-term workload from July 1, 2016 through June 30, 2018:

- Attorney I - This position will review and process legal questions related to AB 15 X2. The review of legal questions encompasses all tasks necessary to compose the final determination and present to impacted or requesting divisions. In addition, this position will be responsible for the promulgation of regulations pertaining to AB 15 X2, which includes conducting stakeholder meetings, researching and analyzing policy concerns, drafting regulations, holding public hearings, and drafting the final rulemaking documents.

- Staff Services Analyst - This position will provide support and assist the Attorney I with tasks associated with AB 15 X2, such as promulgation of regulations and the drafting/filing of legal memoranda.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and evaluation phase. DMHC's projected timeline for regulations for this proposal is:

- By June 1, 2016—Complete research and evaluation.
- By June 1, 2016—Begin drafting regulatory language, if necessary.
- By July. 1, 2017—Begin formal rulemaking process, if necessary.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Federal Mental Health Parity Ongoing Compliance Review

Oversight and Budget Issue. DMHC requests $529,000 for 2016-17 and 2017-18 for clinical consulting services to design new compliance filing instructions and forms, conduct review of plans' classification of benefits and nonquantitative treatment limits (NQTLs), and for resolving clinical issues arising in compliance filings associated with performing ongoing oversight of compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its Final Rules. These resources would be used for the initial front-end compliance reviews for new plans and new products.

According to DMHC, clinical consultants provide the specialized medical, mental health, and substance use disorder knowledge that is not available through the civil service system but is necessary for reviewing critical aspects of MHPAEA compliance, including the classification of benefits and NQTLs. The classification of benefits is a threshold issue that must be determined in a plan filing before the actuary can evaluate compliance in the financial requirements and QTLs, and before the attorneys can evaluate compliance in EOCs and other enrollee disclosures. Generally the clinical consultant team consists of one lead that is a non-clinician reviewer who drafts comment letters to plans, based on the clinical review conducted by three to four clinicians. The lead reviewer also coordinates the consultant team's workflow with that of the attorneys and actuary and participates in the teleconferences with the plans to resolve compliance matters.

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, and (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 and 2015 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 10 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.)

The 2015 Budget Act authorized additional resources to further support onsite medical surveys of the plans affected by the MHPAEA. As a result, according to DMHC, sufficient resources exist to support the back-end component of MHPAEA compliance reviews; however, based on the results of the 2014-15 MPHAEA compliance project described below, existing resources will not be sufficient to perform the work attributed to the initial front-end reviews and associated actuarial duties.

The DMHC initiated monitoring of plan compliance with MHPAEA in the 2014-15 MHPAEA compliance project, which is anticipated to be completed during 2015-16. This project has been a focused review of one to fifteen standard individual and small group Exchange products and large group products to determine initial compliance within 26 plans' commercial coverage. One Attorney IV (the designated department-wide MHPAEA coordinator), one Attorney III, one Associate Governmental Program Analyst, and one Associate Life Actuary have been devoting time to this effort since 2014. Based on the results of this project to date, the DMHC anticipates a significant increase in workload associated with the ongoing monitoring and review of 28 complex filings and 125 routine filings of commercial products to ensure compliance with MHPAEA.

Status of Initial Front-End Reviews. Compliance reviews consist of two components: 1) front-end reviews, which are a review of documentation submitted by plans to ensure compliance with MHPAEA, and 2) back-end reviews, which are onsite reviews to verify plans are operating in accordance with compliance filings. As part of last year's proposal requesting resources, DMHC indicated that the initial front-end reviews would be completed by December 31, 2015. As noted in the chart below, six of the 25 plans have not yet completed this review. According to DMHC, these plans were far enough in the process to be able to address cost-sharing for mental health and substance use disorder services and disclose to enrollees any changes in cost share to ensure there is parity for these services as of January 1, 2016, as required by an all plan letter. Consequently, it has not taken any enforcement action again these plans.

Status of MHPAEA Initial Front-End Review Compliance Filings (as of March 7, 2016)

Health Plan	Status
Aetna Health of California	Open – May 2016
Alameda Alliance Joint Powers Authority	Closed – 11/5/2015
Blue Cross of California	Open – May 2016
California Physicians' Service	Open – April 2016
Chinese Community Health Plan	Closed – 12/11/2015
Cigna Healthcare of California	Open – May 2016
Community Care Health Plan	Closed – 12/11/2015
Contra Costa County	Closed – 12/28/2015
County of Ventura	Open – May 2016
Health Net	Closed – 7/21/2015
Kaiser Foundation Health Plan	Closed – 11/16/2015
LA Care Joint Powers Authority	Closed – 12/23/2015
Local Initiative Health Authority for LA County	Closed – 12/30/2015
Medi-Excel, SA de CV	Closed – 12/7/2015
Molina Healthcare of California	Closed – 1/15/2016
San Francisco Health Authority	Closed – 12/23/2015
San Mateo Community Health Plan	Closed – 12/11/2015
Santa Clara County dba Valley Health Plan	Closed – 12/29/2015
Santa Cruz-Monterey-Merced Managed Md. Care Commission dba Central California Alliance for Health	Closed – 12/11/2015
Seaside Health Plan	Closed – 12/24/2015
Sharp Health Plan	Closed – 1/29/2016
Sistemas Medicos Nacionales (SIMNSA)	Closed – 12/30/2015
Sutter Health Plan	Closed – 12/31/2015
United Healthcare of California	Open – April 2016
Western Health Advantage	Closed – 12/2/2015

Subcommittee Staff Comment—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please describe the status of the initial front-end reviews. Why has DMHC not taken any enforcement action against plans that have not completed their initial front-end reviews? How will this affect the timeliness of the next steps, including the back-end reviews?

3. Is the department on track to begin the second phase of the compliance review, on-site surveys, in April 2016?

4. Please provide an update on DMHC's engagement with mental health stakeholders.

Issue 5: Large Group Rate Review (SB 546, 2015)

Budget Issue. DMHC requests four permanent positions and $682,000 for 2016-17 and $644,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of SB 546 (Leno), Chapter 801, Statutes of 2015.

This request includes $106,000 for 2016-17 and $100,000 for 2017-18 and ongoing for contractor costs. In 2016-17, contractor costs consist of $6,000 for transcription services and $100,000 for actuarial consulting. In 2017-18 and ongoing, the contractor costs are for actuarial consulting.
The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney III	1.0
Staff Services Analyst	1.0
Legal Secretary	1.0
Office of Financial Review (OFR)	
Associate Life Actuary	1.0
TOTAL	**4.0**

Background. The federal Affordable Care Act (ACA) requires rate review of individual and small group rate filings, but exempts large group rate filings. Health plans set rates for large groups in one of two ways. For a "larger" large group – a group with more than 500 covered lives (and in some cases more than 1,000 lives) – a health plan may base rates entirely on the claims experience of that group. For a "smaller" large group – a large group with less than 500 covered lives – a health plan would set rates using a formula comprised of a standard risk for all large employers (e.g., the base rate), additional factors that affect the base rate that are specific to that employer group (e.g., geographic region, industry, etc.), and the claims experience of the specific employer group.

Pursuant to the ACA, health plans must file a justification for an unreasonable premium rate increase, prior to implementation, and publicly disclose the information. A rate increase is subject to review if it is 10 percent or more for a 12-month period (or a more stringent standard set by the state). However, under the May 23, 2011, Rate Increase Disclosure and Review Final Rule (Final Rule), this requirement applies only to non-grandfathered individual and small group contracts and does not apply to large group contracts. The U.S. Department of Health and Human Services (HHS), the federal agency implementing the ACA's rate review requirements, determined large group rate review unnecessary because large groups are sophisticated purchasers and the premiums for most large groups are experience rated, based on the group's own claims experience.

In 2010, SB 1163 (Leno), Chapter 661, Statutes of 2010, implemented the ACA's rate review provisions in California. These provisions require health plans to file individual and small group rate changes 60 days prior to implementation and submit justification for an unreasonable rate increase, as defined by the ACA. SB 1163 went beyond federal law by requiring plans to file any rate change for unreasonable rate increases for large group contracts 60 days prior to implementation. However, the Final Rule, which was published after SB 1163 was enacted, does not apply to the large group market nor does it contain a definition for unreasonable rate increase that applies to large group contracts.

Also related to California's rate review is SB 1182 (Leno), Chapter 577, Statutes of 2014. Under SB 1182, health plans and health insurers must annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. This data is restricted to: (1) large group purchasers with an enrollment of more than 1,000 covered lives, with at least 500 covered lives enrolled with the plan or insurer providing the claims data, or (2) multi-employer trusts with an enrollment of more than 500 covered lives, with at least 250 covered lives enrolled in the plan providing the claims data. The threshold is set at 1,000 and 500 covered lives because there must be a sufficient number of covered lives to de-identify the claims information to protect the confidential medical information of individuals.

SB 546 establishes additional rate review requirements for the large group market. These requirements include:

Effective on or before October 1, 2016, and annually thereafter, health plans must file the following information aggregated for the specific health plan's entire large group market:

- Weighted average increase for all large group benefit designs during the preceding calendar year;
- Number and percentage of rate changes, as specified;
- Factors affecting the base rate and actuarial basis for those factors, as specified;
- Plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category;
- Amount of the projected trend separately attributable to the use of services, price inflation, fees, and risk for annual policy trends by aggregate benefit category;
- Comparison of the aggregate per member per month costs over the prior five year period by specific category;
- Changes in enrollee cost-sharing, changes in enrollee benefits, and quality improvement efforts over the prior year; and
- Number of products covered by the information that incurred the excise tax. (The excise tax, otherwise known as the "Cadillac tax," refers to the requirement in the ACA that, effective for tax years after December 31, 2017, imposes a 40 percent federal tax on the aggregate cost of employer-sponsored coverage exceeding a statutory limit; $10,200 for individual coverage and $27,500 for self and spouse or family coverage.)

DMHC must conduct an annual public meeting regarding large group rates within three months of posting the aggregate information on DMHC's website to allow a public discussion of the reasons for the changes in the rates, benefits, and cost-sharing in the large group market.

Health plans must provide a written notice to a large group 60 days prior to a premium rate or change in coverage that includes the following:

- Whether the proposed rate is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange (Covered California) for the most recent calendar year for which the rates are final;
- Whether the proposed rate is greater than the average rate negotiated by CalPERS for the most recent calendar year for which the rates are final; and
- Whether the rate change includes any portion of the excise tax paid by the health plan.

In 2014, there were 8,872,834 enrollees in large group health plans regulated by the DMHC and there are currently 19 health plans participating in the large group market. Provisions of SB 546 require the DMHC to analyze data submitted by these health plans and conduct an annual public meeting to facilitate discussion around the changes in rates, benefits, and cost-sharing in the large group market.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and regulatory language development phase. In the interim, DMHC has issued informal guidance to the plans. DMHC's projected timeline for regulations for this proposal is:

- By Sept. 9, 2016—Publish notice of rulemaking.
- By Oct. 24, 2016—Public hearing (if requested).
- By Nov. 1, 2016—Approval by DMHC and send to Office of Administrative Law.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 6: Limitations on Cost-Sharing: Family Coverage (AB 1305, 2015)

Budget Issue. DMHC requests limited-term expenditure authority of $196,000 for 2016-17 and $188,000 for 2017-18 to meet the department's operational needs to implement AB 1305 (Bonta), Chapter 641, Statutes of 2015.

Background. DMHC regulates health plans under the provisions of the Knox Keene Health Care Service Plan Act of 1975, as amended (Knox Keene Act). As enacted by SB 639 (Hernandez) Chapter 316, Statutes of 2013, the Knox Keene Act requires non-grandfathered health plan contracts issued on or after January 1, 2015 in the small group market to include the annual out-of-pocket limit on Essential Health Benefits (EHB) described in the Affordable Care Act (ACA) and subsequent rules, regulations, or guidance. The Knox Keene Act also aligns the out-of-pocket cost limit for covered benefits that are EHB to this federal limit for non-grandfathered health plan contracts issued on or after January 1, 2015, in the large group market, to the extent that this limit does not conflict with federal law or guidance.

AB 1305 prohibits a health plan from imposing a maximum out-of-pocket limit for an individual within a family that is greater than the maximum out-of-pocket limit for individual coverage for that product. This provision aligns with and exceeds federal requirements.

AB 1305 also requires that if a non-grandfathered health plan contract for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible for individual coverage for that product, except for a high deductible health plan (HDHP). The requirement would apply to non-grandfathered family coverage in the small group market beginning January 1, 2016, and in the large group market beginning January 1, 2017. This provision eliminates health plan contracts with aggregated family deductibles, in which an individual with a family HDHP must meet the family deductible before the plan covers any services, other than preventive services, for that individual.

In the case of HDHPs, the bill includes an exception to allow individuals to continue to qualify for Health Savings Accounts (HSA). Under federal law, an individual may qualify for an HSA only if the individual is covered under an HDHP. A family HDHP is an HDHP covering an eligible individual and at least one other individual. As explained in Internal Revenue Service (IRS) Publication 969, if either the deductible for the family as a whole or the deductible for an individual family member is less than the minimum annual deductible for family coverage, the plan does not qualify as an HDHP. For calendar year 2015, the minimum annual deductible is $1,300 for self-only coverage and $2,600 for family coverage. Thus, in 2015, a family HDHP must have an individual deductible of at least $2,600 or the plan does not qualify as an HDHP. (Specific deductible amounts change in subsequent years.) A family HDHP with an individual deductible below $2,600 would cause individuals to lose HSA tax savings.

Accordingly, AB 1305 provides that, in the case of a health plan contract meeting the federal definition of an HDHP, the deductible shall be the greater of either of the following: 1) the deductible for individual coverage under the plan contract, or 2) the amount required under federal law to qualify for an HSA, as updated by the IRS annually as indexed for inflation. This language prevents, in the case of a family HDHP, the individual deductible from being lower than the amount required under federal law for an individual to qualify for an HSA.

To address the workload resulting from AB 1305, DMHC's Office of Legal Services requests limited-term expenditure authority to perform short-term work from July 1, 2016, through June 30, 2018. These resources will be used to review and process legal questions related to AB 1305. Reviewing legal questions encompasses all tasks necessary to compose the final determination and presenting the information to impacted or requesting divisions, including the drafting/filing of legal memoranda. These resources will also allow the DMHC to develop and promulgate a regulation package to implement the new provisions contained in the bill.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

Issue 7: Outpatient Prescription Drug Formularies (AB 339, 2015)

Budget Issue. DMHC requests limited-term resources of $733,000 for 2016-17; $700,000 for 2017-18; $558,000 for 2018-19; and $558,000 for 2019-20 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 339 (Gordon) Chapter 619, Statutes of 2015.

This request includes $196,000 in contracted consulting costs for 2016-17, 2017-18, 2018-19, and 2019-20 to assist DMHC offices with developing implementation standards and identifying health plan clinical standard deficiencies during the survey process.

Background. The passage of AB 339 builds on the federal guidance and existing general anti-discrimination provisions with more robust, specific, and enforceable parameters for drug benefit designs. AB 339 aligns with Covered California's current approach to address the high out-of-pocket costs for medically necessary drugs and incorporating a sunset date of 2020 for the out-of-pocket cost limitations and drug tiering provisions. AB 339 takes an appropriate measured approach in addressing the competing challenges of providing access to medically necessary drugs for consumers without severely hampering health plans' ability to contain costs through drug price negotiations. Moreover, AB 339 aligns with and incorporates new federal standards regarding the prescription drug Essential Health Benefits, including the requirements regarding pharmacy and therapeutics committees, formulary transparency, and reasonable access to retail pharmacies (rather than mail-order pharmacies). Adding these provisions to California law ensures they will be enforceable by the DMHC.

Additional provisions of AB 339 include:

- Requires health care service plan contracts (other than Medi-Cal managed care contracts) to cover medically-necessary prescription drugs, including medically-necessary single-tablet antiretroviral drug regimens for AIDS/HIV, except as specified.

- Limits cost-sharing for a 30-day supply of a prescription to no more than $250 (or $500 for a bronze-level plan or its actuarial equivalent for large group), except that an applicable deductible must be satisfied, as specified.

- Specifies formulary tier definitions for certain non-grandfathered individual or small group products.

The DMHC licenses and regulates health plans that provide full-service and specialty services to more than 25 million Californians. The DMHC regulates health plans under the provisions of the Knox Keene Act. To meet its mission of protecting consumer health care rights and ensuring a stable health care delivery system, the DMHC resolves grievances; conducts onsite medical surveys and financial exams; and reviews and approves plan contracts, disclosures, and vendor arrangements.

Currently, the DMHC regulates a total of 34 full service commercial and behavioral health plans that provide a prescription drug benefit. In order to implement AB 339, the DMHC is required to complete a compliance review of existing plans and any new license applicants as to their prescription drug formularies. Health plans may have a different prescription drug formulary for each of its product

types, which may result in each health plan submitting up to 15 different formularies. The extensive review of health plan filings will be performed by the DMHC's Office of Plan Licensing and Division of Plan Services. In addition, as a result of the passage of AB 339, DMHC's Office of Legal Services will need to draft new regulations to update the existing Title 28, CCR Section 1300.67.24, which imposes standards for outpatient prescription drug coverage, limitations, exclusions, and cost-sharing.

Office of Plan Licensing (OPL). OPL is responsible for assuring regulatory compliance of health plans with the Knox Keene Act and the Final Rules. This is accomplished by reviewing applications for licensure, material modifications to existing licenses, and amendments to existing licenses. This review includes requiring health plans to provide legally sufficient documentation of plan organization, disclosures, enrollee benefits, and other aspects of regulatory compliance.

The passage of AB 339 requires that each of the 34 affected health plans submit filings demonstrating compliance with its provisions. DMHC will need to analyze the various provisions of the bill, including whether the cost-sharing for this benefit is within the parameters set forth in the bill, the health plans' formularies do not discourage enrollment of individuals with health conditions or reduce the generosity of the benefit for enrollees with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practice, and verify that the health plans are defining the formulary tiers appropriately. In order to facilitate compliance with AB 339, OPL must review the health plans' Evidences of Coverage (EOCs), Disclosure Forms, combined Evidences of Coverage/Disclosure Forms that contain pharmacy benefits, policies and procedures, and prescription drug formularies for each of the health plans' products.

Ongoing workload consists of the oversight of health plans' compliance with the additional mandated prescription drug requirements and the review of any new license applications for compliance with the language of AB 339. To facilitate the compliance project and review the prescription drug benefit offered by full service health plans, OPL is requesting limited-term resources to perform the following workload from July 1, 2016, through June 30, 2020:

- 3.0 Associate Governmental Program Analysts (Temporary Help – July 1, 2016 to June 30, 2020). These analyst positions will be responsible for the creation and ongoing maintenance of the formulary template for health plans to utilize, filing tracking, serve as the DMHC liaison between clinical consultants and plans, coordinate transfer of documents to clinical consultants for review, coordinate filing teleconferences between the DMHC and clinical consultants, and conduct initial filing review of plan submissions to identify issues and deficiencies with the filings.

- Pharmacy or Clinical Consultant (Limited-term – July 1, 2016 to June 30, 2020). DMHC will need to retain either a pharmacy or clinical consultant to develop standards and communicate to health plans what constitutes reasonable cost-sharing and what must be provided to show it does not discourage the enrollment of individuals with health conditions nor reduce the generosity of the benefit for enrollees with a particular condition. Based on similar clinical consulting contracts, OPL estimates the ongoing costs to be approximately $46,000 per year.

Division of Plan Surveys (DPS). DPS, part of DMHC's Help Center, is responsible for conducting routine medical surveys of each licensed full service and specialty health plan as required by the Knox Keene Act, as well as non-routine investigative medical surveys as deemed necessary by DMHC's Director. DPS anticipates retaining a clinical consultant during the survey process to assess health plan

compliance related to the bill's clinical standards and to make revisions to the applicable audit tool or Technical Assistance Guide (TAG) and associated worksheets. DPS is requesting the following resources:

- Clinical Consultant (Limited-term – July 1, 2016 to June 30, 2020). The clinical consultant will be responsible for the one-time review and revision of the TAG and file review worksheets for use during routine medical surveys and dissemination of training materials to affected plans. The consultant will conduct an assessment of each health plan to verify that prescriptions for medical conditions are not all placed in the highest cost tiers within the formularies, draft deficiencies, and provide clinical follow-up to assess whether the plans corrected deficiencies. Based on similar consulting services contracts, DPS estimates contracting costs to be approximately $150,000 per year.

Office of Legal Services (OLS). OLS conducts legislative and legal analyses for the DMHC; leads rulemaking activities, including pre-notice stakeholder engagement, research and analysis, drafts regulatory language, conducts public hearings, responds to comments, and files regulation package(s) with the Office of Administrative Law; and responds to Public Records Act and Information Practices Act requests.

OLS anticipates conducting legal research and producing legal opinion memoranda pertaining to AB 339 between January 1, 2016, and June 30, 2018, as this bill is central to the DMHC's enforcement of anti-discrimination laws prohibiting prescription drug benefit designs that may potentially reduce the benefits for chronically ill individuals. OLS also anticipates promulgating one regulation package in order to update the existing regulation governing cost-sharing, limitations, and exclusions of coverage for prescription drugs (title 28, California Code of Regulations, Section 1300.67.24). OLS is requesting the following resource:

- Attorney I (Temporary Help – July 1, 2016 to June 30, 2018). This position will be responsible for reviewing and processing legal questions related to AB 339. The review of legal questions encompasses all tasks necessary to compose the final determination and present to impacted or requesting divisions. In addition, this position will be responsible for the promulgation of regulations pertaining to AB 339, which includes conducting stakeholder meetings, researching and analyzing policy concerns, drafting regulations, holding public hearings, and drafting the final rulemaking documents.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and evaluation phase. DMHC's projected timeline for regulations for this proposal is:

- By June 1, 2016—Complete research and evaluation.
- By June 1, 2016—Begin drafting regulatory language.
- By Jan. 1, 2017—Begin formal rulemaking process.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

Issue 8: Provider Directories (SB 137, 2015)

Budget Issue. DMHC requests eight permanent positions and $1,436,000 for 2016-17; $1,366,000 for 2017-18; and $1,181,000 for 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Hernandez) Chapter 649, Statutes of 2015.

This request includes $153,000 for 2016-17; $153,000 for 2017-18; and $77,000 for 2018-19 and ongoing for the Office of Enforcement's (OE) expert witness and deposition costs for enforcement trials. This request also includes limited-term expenditure authority of $89,000 for 2016-17 and 2017-18, enabling DMHC's Office of Technology and Innovation (OTI) to address short-term IT-related setup activities.

The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney I	1.0
Office of Plan Licensing (OPL)	
Attorney I	1.0
Associate Governmental Program Analyst	1.0
Division of Plan Surveys (DPS)	
Attorney I	1.0
Associate HCPSA	1.0
Office of Enforcement (OE)	
Attorney III	1.0
Office of Financial Review (OFR)	
Corporations Examiner	1.0
Office of Administrative Services (OAS)	
Associate Governmental Program Analyst	1.0
TOTAL	**8.0**

Background. Existing state law requires health care service plans (health plans) to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area. Since 2001, when AB 938 (Cohn), Chapter 817, Statutes of 2001, was enacted, state law has also included requirements related to health plans' provider directories. With the enactment of the Affordable Care Act (ACA), the accuracy of provider directories has never been more important as the ACA has enabled hundreds of thousands of individuals who formerly lacked health coverage to obtain health coverage for the first time. Since the ACA requires health plans to cover individuals who formerly could not obtain coverage due to their health problems, health plans have focused on other ways to control costs. One way health plans have attempted to control costs is to develop products with 'narrow networks,' which have fewer provider options, but still achieve network adequacy. Consequently, there may be even greater variation in a health plan's provider networks than in the past, with some networks having more limited provider options than others.

Understandable and accurate provider networks enable consumers to make important decisions and are fundamental components to allow enrollees timely access to health care services. SB 137, effective July 1, 2016, establishes clear and specific requirements for publishing and maintaining health plans' provider directories, including content, updating and reporting standards. To achieve this, SB 137 includes the applicable controls and requirements, and provides the DMHC and California Department of Insurance (CDI) with the responsibility to develop uniform provider directory standards that health plans and providers must follow. SB 137 also gives the DMHC the authority to enforce the law and take action if a health plan or provider is found to be non-compliant.

The requirements of SB 137 apply to all full service and specialty health plans including Medi-Cal managed care plans and includes the following provisions:

- Health plans must require their contracting providers, when they are no longer accepting patients, to direct potential enrollees to the health plan for additional assistance in finding a different provider and to inform the DMHC of the possible inaccurate information in the directory.
- Health plans must publish and maintain provider directories on their public website, with information on contracting providers that deliver health care services to the health plan's enrollees.
- Health plans must reimburse enrollees for any amount beyond what the enrollee would have paid for in-network services, if the enrollee reasonably relied on the provider directory.
- Mandates specific requirements and timelines for health plans to actively investigate reports of inaccuracies in their directories and sets forth triggers for when a provider must be removed from the directory. The specific requirements and timeframes include:
    - Health plans must update their provider directories throughout the year based on specified criteria.
    - Health plans must, at least annually, review and update all of their provider directories in their entirety. As part of the annual update, health plans are required to send notices to providers at least annually, or once every six months for individual health professionals who are not affiliated with a physician group. The notice must include all of the products the provider is contracted to provide services for as well as a warning that failure to respond may result in a payment delay.
    - Providers must respond within 30 days to notices from health plans confirming the information the health plan has for that provider is correct or with updated information.
    - If the provider does not respond to the health plans request for information within 30 days, the health plan has 15 business days to verify the provider's information in writing, electronically or by telephone.
    - If the health plan cannot verify the provider's information, they must notify the provider 10 days in advance that the health plan will be removing the provider from their directory. This 10-day notice will also contain a second warning to the provider that failure to verify their information may result in a payment delay.
- Based on the providers' responses as well as upon receipt and verification of information indicating that updates are necessary, health plans must revise provider information as part of their weekly online directory update and their quarterly updates for printed directories. Other triggers identified in SB 137 for such updates include:
    - Reports from enrollees or potential enrollees that the provider directory contains inaccurate information.
    - Changes from providers outside of the annual or semi-annual affirmation process discussed above, such as address changes.

- In addition to health plans removing providers from directories when they cannot verify the providers information, they must also remove providers when:
    - The provider has retired or has ceased to practice.
    - The provider or provider group is no longer contracted with the health plan.
    - The contracting provider group has informed the health plan that the provider is no longer associated with the provider group and is no longer under contract with the health plan.
- Instead of requiring a health plan to file its entire provider directory annually with the DMHC to review, it now requires health plans to annually submit their policies and procedures explaining how they will comply with the law and develop an accurate provider directory. This approach is consistent with how the DMHC currently reviews health plan requirements.

These provisions enable providers to receive information from the health plans to identify under which plan products they are contracted to provide services – an issue that providers have consistently raised with respect to their inability to ensure their information is accurate.

SB 137 requires the DMHC to create uniform standards for provider directories on or before December 31, 2016. Because these standards are expected to require health plans to make significant system changes, the provisions requiring regulatory guidance will go into effect by July 31, 2017, or 12 months after the provider directory standards are developed, whichever occurs later. One of the significant standards will include the process for referring a patient to hospitals and other providers and the way information is presented in the directories.

SB 137 also places a direct obligation on providers to report their information to the health plans and allows health plans to delay payment to incentivize provider responses when requested for the provider directory.

SB 137 allows health plans to delay payment for one month in the event the provider does not respond to the required request for directory information verification. For providers reimbursed by capitation, the health plan cannot delay more than 50 percent of the total capitation rate for the next scheduled capitation payment. For providers reimbursed via claims, the health plan can delay claims payments for up to one calendar month beginning on the first day of the following month.

In order to address the concern of compliance with the new authority to delay payment, SB 137 requires the DMHC to include a review of the health plan's compliance with this provision in its routine financial examinations of the health plans, which occur every three to five years.

Currently, the DMHC regulates a total of 74 full service and 49 specialized health plans that contract with providers to deliver services to enrollees and that maintain provider directories in accordance with current law. According to DMHC, implementation of SB 137 creates additional workload for all DMHC offices as its provisions require changes to existing departmental processes, such as routine medical surveys, financial reviews, and licensure. In addition to process changes, the DMHC anticipates additional workload resulting from SB 137 due to an increased number of requests for information and enforcement case referrals, additional staff, and the necessary completion of legal memoranda and regulation packages.

Office of Legal Services (OLS). OLS conducts legislative and legal analyses for the DMHC; leads rulemaking activities, including pre-notice stakeholder engagement, research and analysis, drafts

regulatory language, conducts public hearings, responding to comments, and files regulation package(s) with the Office of Administrative Law; and responds to Public Records Act and Information Practices Act requests. To perform the additional workload required by SB 137, OLS requests the following permanent positions:

- Attorney I. This position will be responsible for the promulgation of regulations and completion of legal memoranda and review of legal questions related to SB 137. The review of legal questions encompasses all tasks necessary to compose the final determination, including gathering data, researching applicable law, conducting staff meetings, crafting a position, briefing management, and presenting to impacted or requesting divisions.

Office of Plan Licensing (OPL). OPL is responsible for assuring regulatory compliance of health plans with the Knox Keene Act and the Final Rule, which includes licensing health plans and approving changes to the licensee and its operations such as provider, vendor, and subscriber contracts; provider networks; utilization management processes; quality assurance systems; and financial viability. In order to facilitate ongoing review of SB 137 compliance for each of the 74 full service and 49 specialized health plans, OPL is requesting the following permanent positions to perform the additional ongoing workload:

- Attorney I. This position will be responsible for conducting legal research to determine criteria and requirements for implementation of the provider directory process requirements; leading interdepartmental meetings related to implementation of the review process; developing and maintaining a structure for review of compliance of each health care service plan, including checklists, spreadsheets, and templates for use during filing reviews; designing and updating filing review guidelines for internal review; performing comprehensive review of submitted filings, including a summary of the filing, coordinating with other divisions (e.g., the OFR) to review submitted documents, preparation of appropriate comments, legal analysis of the filing for compliance, and compiling documentation support referrals to the OE.
- Associate Governmental Program Analyst. This position will be responsible for assisting with the analysis and implementation of provider directory process requirements, including developing and maintaining a structure for compliance implementation; creating and maintaining a weekly tracking report to document health plan compliance issues and status of completion of annual filings; coordinating the initial review of each health plan's initial filing and subsequent amendments for any administrative issues and deficiencies; assisting with compiling documentation in preparation for drafting referrals to the OE; and participating in trainings outlining compliance review processes and updates reflecting changes in the law.

Division of Plan Surveys (DPS). DPS, part of DMHC's Help Center, is responsible for conducting routine medical surveys of each licensed full service and specialty health plan on a triennial basis as required by the Knox Keene Act, as well as non-routine investigative medical surveys as deemed necessary by DMHC's director. As part of that survey, DPS conducts a review to assess if health plan processes ensure access and availability of health care services. Presently, DPS reviews health plan provider directories for compliance with existing laws as a part of this review. DPS anticipates the scope of this review will expand with the implementation of SB 137 and is requesting the following permanent positions to perform the additional ongoing workload:

- Attorney I. This position will be responsible for assisting with the survey process, including survey preparation, developing the survey strategy, and providing legal review of deficiencies; providing legal review of corrective actions during follow-up surveys; and reviewing revisions to the applicable audit tool or Technical Assistance Guide (TAG).

- Associate HCSPA. This position will be responsible for analyzing each of the health plan's processes and informational flows to facilitate compliance with SB 137 during the survey, monitoring corrective actions and conducting follow-up surveys, and drafting revisions to the applicable audit tool or TAG.

Office of Enforcement (OE). OE handles the litigation needs of the DMHC, representing the department in actions to enforce the managed health care laws and in actions that are brought against the department. Cases may be referred to OE by other DMHC programs that review the activities of health plans for compliance with the Knox Keen Act.

OE has historically received individual complaint referrals for an inadequate network from the Help Center and has treated these referrals as a "track and trend" opportunity, unless substantial harm was identified. DPS has also referred a small number of matters, which are more complex in nature. OE anticipates an increase of approximately 15 annual referrals in 2016-17 and 2017-18 from other DMHC programs as SB 137 provides specific provisions to compare a health plan's actions against to determine if a violation has occurred resulting in a more concise remedy, with one referral going to trial. Based on two provider network inadequacy cases OE is currently prosecuting and its experience prosecuting similarly large-scale cases, it is expected SB 137-related referrals will be complex as each case involves a review of each provider contract, database change process, and the protocols and procedures to change databases. These prosecutions can be extremely time and document-intensive.

According to DMHC, this workload cannot be absorbed by current staffing and will require the following permanent position and contract resources to perform the additional ongoing workload:

- Attorney III. This position will be responsible for evaluating enforcement referrals, drafting/sending investigative discovery, recommending a course of action based on evidence received and violations found, and all activities associated with trials/hearings. Trial/hearing activities include preparing course of resolution; preparing law and motion prosecution and defense; pre-trial preparation; researching applicable law, potential violations, and potential defenses to prosecute action; trial/hearing attendance; post-trial briefing; and enforcement of verdict/order.
- Expert Witness/Consultant and Trial Costs. OE anticipates at least three expert consultants will be needed to address the issues raised by these referrals at a cost of approximately $45,000 per contract for a total of $135,000 per fiscal year. These expert consultant contracts are not necessarily related to trial needs, but will be necessary to provide OE with expert opinions on new issues SB 137 raises. In addition to expert consultants, associated trial costs include payment of witnesses travel to and from court, trial resources (discovery expenses, court reporters, copying costs, exhibit preparation), and travel expenses. OE estimates the following associated trial costs: exhibit preparation at approximately $1,000; six administrative discovery depositions per year at approximately $2,000 per deposition (for a total of $12,000); and trial-related travel expenses of approximately $5,000. Total cost is $153,000 per year for 2016-17 and 2017-18. Beginning in 2018-19, a decline in SB 137-related referrals of approximately five to 10 per year is anticipated as the health plans become more familiar with SB 137 requirements. Conversely, trial expenses will level off to approximately $77,000 and remain steady at that rate thereafter. These estimates are based on actual costs incurred for similar trials OE has conducted.

Office of Financial Review (OFR). Division of Financial Oversight (DFO), part of OFR, monitors and evaluates the financial viability of health plans to facilitate continued access to health care services

for the enrollees/patients of California. This is accomplished by reviewing financial statements; analyzing financial arrangements and other information submitted as part of the licensing, material modification, and amendment process; and by performing routine and non-routine examinations.
In order to perform the additional ongoing workload involved with reviewing health plan compliance with SB 137, DFO is requesting the following permanent position to perform the additional ongoing workload:

- Corporations Examiner. This position will be responsible for performing claims sampling analyses, reviewing claims for compliance with SB 137, writing a final report on findings, and performing the review of capitation withholds and including any exceptions in a report for each health care service plan every three years. On an annual basis this position will review health plan records submitted to the DMHC regarding delay of payment of provider claims/capitation, review and approve/deny plan policies and procedures regarding the withhold of payments of claims/capitation to providers, and review plan records submitted to the DMHC each time a health plan withholds the payment of claims/capitation to a provider.

Office of Administrative Services (OAS). OAS encompasses all departmental support services functions with the exception of information technology. These functions include accounting, budgeting, human resources, training and organizational effectiveness, and business management. While the program areas of the DMHC expand, resources to support the programs should also increase. Program expansion due to the passage of SB 137 results in additional hiring activities; the processing of employee-related transactions, such as personnel transactions, travel expense claims, and trainings; contracts and procurements, etc. In order to obtain sufficient resources to handle the workload resulting from SB 137 and to support the additional positions requested in this proposal, OAS is requesting the following permanent position to perform the additional ongoing workload:

- Associate Governmental Program Analyst (AGPA). This position will address the increased workload in the support services functions, such as processing contracts and procurements, preparing budget allotments, managing expenditures, processing accounting transactions and related documents, coordinating job-related training, conducting tasks associated with hiring and human resources issues, and coordinating facility-related accommodations and requests.

Office of Technology and Innovation (OTI). The Division of Support Services (DSS), a division within the OTI, provides support services for and procurement of desktops, laptops, and the associated suite of productivity software. This division is also responsible for staffing the IT Help Desk to respond to both PC administrators and DMHC employees for problem resolution; providing administration for databases and the Exchange/Outlook email application; maintaining DMHC's network, file and printer servers, and application servers; and enabling the security of data through the implementation of virus detection software and intruder detection.

The implementation of SB 137 requires an increase in IT-related support services to address the needs of the additional positions requested in this proposal and related programmatic workload. DSS is requesting two-year limited-term resources to provide the DMHC with sufficient IT-related services to manage the increased workload resulting from SB 137. Resources will be used to support the IT Help Desk and respond to highly complex issues; prepare IT equipment for survey, refresh equipment, maintain the equipment storage room; support critical outages; maintain employee access; creating network accounts; and processing change requests, service requests, incidences and maintenance tasks.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates it is working with the California Department of Insurance (CDI) to

develop uniform provider directory standards. These standards will be Administrative Procedures Act-exempt until January 1, 2021. DMHC also indicates that it is preparing to start the informal stakeholder process. DMHC's projected timeline for regulations for this proposal is:

- By July 31, 2016—Complete informal stakeholder process.
- By Dec. 31, 2016—Develop uniform provider directory in conjunction with CDI.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

3. Has DMHC provided a "check list" to health plans providing guidance on what needs to be completed by the July 1, 2016 deadline to publish and maintain provider directories? If not, when does DMHC anticipate providing this guidance?

Issue 9: Vision Services (AB 684, 2015)

Budget Issue. DMHC requests two permanent positions and $308,000 for 2016-17 and $292,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of AB 684 (Alejo) Chapter 405, Statutes of 2015.

The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney I	1.0
Office of Plan Licensing (OPL)	
Attorney I	1.0
TOTAL	**2.0**

Background. AB 684 authorizes the establishment of landlord-tenant relationships between a registered dispensing optician (RDO), an optometrist, and an optical company, as long as the lease agreement includes specified conditions. Additionally, AB 684 authorizes an RDO or optical company to operate, own, or have an ownership interest in a health care service plan (health plan) licensed under the Knox Keene Health Care Service Plan Act of 1975 (Knox Keene Act), as amended, if the health plan does not directly employ optometrists who provide services to enrollees. This legislation establishes a three-year period for the transition from direct employment of optometrists to lease arrangements.

Optometrists are health care providers licensed under the California State Board of Optometry who perform eye examinations and write prescriptions for eyeglasses and contact lenses. After receiving a prescription, consumers may get their prescriptions filled by optometrists and ophthalmologists (medical doctors) who sell eyewear as part of their practice, or consumers may get their prescriptions filled by RDOs. RDOs are technicians licensed under the Medical Board of California who fit consumers with glasses and contact lenses.

AB 684 resolves long-standing legal disputes between optometrists and optical chain stores. Existing California law has strict prohibitions on relationships between optometrists and RDOs. California laws Business and Professions Code Section 655 currently prohibits optometrists and RDOs from having any financial interest or landlord-tenant relationship with each other and prohibits an optometrist from having any financial interest or landlord-tenant relationship with entities engaged in the manufacture or sale of lenses, frames, and other optical products. Business and Professions Code Section 2556 currently prohibits RDOs from advertising the services of an optometrist or ophthalmologist. It also prohibits an RDO from directly or indirectly employing, or maintaining on or near the premises used for optical dispensing, an optometrist or ophthalmologist. These Business and Professions Code prohibitions are intended to ensure that optometrists' professional decisions are not influenced by commercial interests.

National optical chain stores operate under a "co-location" business model where consumers can obtain an eye examination from an optometrist located at, or near, a retail store where eyeglasses or contact lenses may be purchased. In the 1980s, the parent companies of these optical stores created

affiliate companies which obtained Knox Keene licenses to provide optometric services. Health and Safety Code Section 1395 provides that a health plan licensed under the Knox Keene Act may employ, or contract with, health professionals licensed under the Business and Professions Code, and that a Knox Keene licensee may directly own and operate, through its professional employees or contracted licensed professionals, offices and subsidiary corporations to provide health care services to the plan's enrollees. Thus, optical store companies obtained Knox Keene licenses as a shield against Business and Professions Code Sections 655 and 2556. However, after years of legal challenges, California courts definitively ruled that a Knox Keene license does not exempt optometrists and RDOs from these Business and Professions Code prohibitions, and federal courts ruled that these prohibitions do not violate federal law. Although unsuccessful, these challenges resulted in a moratorium on enforcement of these Business and Professions Code prohibitions from 2006 until 2013.

In the past year, the DMHC has discovered that a number of Knox Keene Act licensed vision plans are currently operating in a manner that would violate the above referenced Business and Professions Code Sections. AB 684 allows these vision plans to continue to operate as health plans with little or no modifications to their current business models, thereby preserving the model of vision coverage that millions of Californians have come to rely upon with no reduction in consumer protections.

At present, the DMHC regulates three specialized vision plans that operate under a "co-location" business model. However, the "co-location" vision plan model does not completely fit the description of a Knox Keene health plan, which the Health and Safety Code defines as an entity that provides health care services in exchange for a prepaid and periodic charge. The three Knox Keene vision plans that operate under the "co-location" model assume little or no risk, and primarily serve individuals rather than groups.

AB 684 repeals existing Business and Professions Code prohibitions that cause optical companies operating under a "co-location" business model to be in violation of California law, allowing an RDO or optical company to operate or own a health plan as long as the health plan does not directly employ optometrists to provide services to health plan enrollees. The plan can employ an optometrist as a clinical director to conduct utilization review and quality assurance activities. Furthermore, a health plan, optometrist, RDO, or an optical company can execute a written lease with an optometrist, as long as the practice is owned by the optometrist, every phase of the practice is under the optometrist's exclusive control, and the optometrist's leased space is separate and distinct, in addition to numerous other requirements. The lease agreement could require an optometrist to provide optometric services at the leased space during certain days and hours, and the agreement could restrict the optometrist's sale of products (frames, lenses, contact lenses) offered by the leaseholder. AB 684 outlines detailed terms of a permissible lease agreement and provides that the Board of Optometry may inspect any individual agreement.

Until January 1, 2019, AB 684 prohibits an individual, corporation, or firm which was operating as an RDO before the effective date of the bill, or an employee of such an entity, from being subject to any legal or disciplinary action for engaging in the conduct prohibited by Business and Professions Code Sections 655 and 2556, except as specified. This provision offers a safe harbor for individuals and corporations now operating under the "co-location" business model and gives them time to adjust their current business models to conform to the provisions of the bill.

Currently, the DMHC licenses and regulates 12 vision plans that provide coverage to approximately 13 million Californians. The passage of AB 684 will require the DMHC to conduct an in-depth review to

ensure existing plans are in compliance with Business and Professions Code Sections 655 and 2556 as amended by AB 684.

In addition, the resolution of the longstanding legal conflict over the enforcement of these Business and Professions Code sections will result in additional plans seeking Knox Keene licensure. Under AB 684, if a RDO or optical company wants to operate or own a health plan, that health plan must be licensed by the DMHC under the Knox Keene Act. Given this requirement, over the next three years the DMHC expects to receive six to eight applications from entities wanting a specialized vision health plan license; to date, two pre-filing conferences have already been scheduled.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

0530 OFFICE OF SYSTEMS INTEGRATION (OSI)

Issue 1: CalHEERS

Budget Issue. OSI requests an increase of $8 million in expenditure authority and two permanent positions in 2016-17 related to the transfer of 58 California Healthcare Eligibility, Enrollment and Retention (CalHEERS) staff to OSI from Covered California. The costs will continue to be reimbursed by Covered California and the Department of Health Care Services (DHCS).
OSI proposes to increase its full day-to-day Project Management (PM) of the staff and activities and continue to provide oversight services for the design, development, implementation and operation and maintenance of the project.

Background. The federal Affordable Care Act (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. CalHEERS is jointly sponsored by the Covered California and 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.

Currently, Covered California retains the project staff for CalHEERS, including the recruitment and management of positions. Both program sponsors, Covered California and DHCS, have determined that having a third party, like OSI, manage the day-to-day activities of the project would be beneficial to both sponsors. OSI would be able to apply best practices and lessons learned from both current and prior engagements in order to provide greater efficiencies to the Project and allow the program departments to focus on the program needs and how best to accommodate those needs within the project.

The staff would become employees of OSI, but would remain at their current physical location at the project office and continue to perform the same functions. These 58 positions form the entire project team across the following functional areas and are in addition to the six project positions already authorized for OSI:

- Executive Management – 3.0 staff
    - Project Director
    - Assistant Project Director
    - Executive Assistant
- Operational Readiness - 12.0 staff
- System Development - 16.0 staff
- Operations - 9.0 staff
- Project Management Office - 13.0 staff

- Procurement - 5.0 staff

In addition, two positions and an increase in OSI expenditure authority of $265,201 is being requested to provide direct administrative support as a result of both the proposed addition of 58 new positions to the OSI organization and increased project workload.

24-Month Roadmap. In February 2015, 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. This roadmap was developed in response to concerns raised regarding the processes by which stakeholder input is provided to and considered by the CalHEERS project to aid decision-making, coordination, and rollout of system changes.

No Independent Validation and Verification (IV&V) Contract. In 2015, both CalHEERS project sponsors, Covered California and DHCS, began transitioning IV&V services to a combination of internal staff and external entities, as the project sponsors believed that such services could be adequately and competently performed by a mix of both civil service staff and independent contractors. To that end, the CalHEERS project established a quality assurance team that includes both external quality assurance consultants and state staff. Also in 2015, Covered California entered into a contract with an expert in cost estimation to perform independent verification of costs for change requests.

According to the federal Department of Health and Human Services, IV&V services should be performed by parties not directly engaged in the development of the project with the purpose of assessing the correctness and quality of a project's product. Typically IV&V reviews, analyzes, evaluates, inspects, and tests the project's product and processes. This analysis includes the operational environment, hardware, software, interfacing applications, documentation, operators, and users to ensure that the product is well-engineered, and is being developed in accordance with customer requirements. IV&V provides management with an independent perspective on project activities and promotes early detection of project/product variances. This allows the project to implement corrective actions to bring the project back in-line with agreed-upon expectations.

Subcommittee Staff Comment and Recommendation—Hold Open. Improvements in communication and stakeholder engagement have occurred in the last year, such as involving consumer advocates in user acceptance testing and conducting summits with relevant stakeholders before releases of new functionality into CalHEERS. However, concerns continue to be raised regarding the transparency with which project decisions are made and the identification of risks and schedule variances. For example:

- New 24 Month Roadmap Format Lacks Details. The most recent version of the 24-month roadmap only contains a timeline through September 2016 (i.e., it does not provide a 24-month projection of changes to CalHEERS). Consequently, it is unclear how the project is planning for changes post-September or what changes will not be completed by September 2016. Additionally, the newly formatted roadmap does not contain the level of detail needed to understand what is included in each release nor a section identifying pertinent stakeholder comments related to each change request. This new version of the roadmap is not as transparent and makes it difficult for stakeholders, including legislative staff, to quickly understand the status of implementation of new functionality into CalHEERS.

- End of IV&V Services Concerning. CalHEERS decision to end the IV&V contract is concerning in that the IV&V vendor provided an independent assessment of project status and risks. It is not clear how the quality assurance team or internal efforts are able to make this independent and transparent assessment. At the time this agenda was published, OSI was not able to provide information specifying how it was accomplishing this function.

  The Legislature recognized the need to design and implement CalHEERS within a short time frame. To facilitate its completion by the federal deadline of January 1, 2014, the Legislature approved a streamlined approach that expedited the implementation of the project, as opposed to requiring the project to comply to the typical information technology (IT) reporting requirements, such as maintaining an IV&V contract throughout the development phase for a project this size. However, given that that the state has met the deadline to develop this system, it is not clear if the project should continue to be exempt from the typical IT reporting requirements.

Questions.

1. Please provide an overview of this proposal.

2. Please explain how the transfer of these positions from Covered California to OSI will improve project management and oversight of CalHEERS. Please explain who will take responsibility for project outcomes.

3. Advocates have used DHCS stakeholder meetings and Covered California Board Meetings to attempt to obtain more details on the project schedule and to provide input on the order of programming priorities. Please explain how this will continue if CalHEERS oversight moves to OSI?

4. Why did the format of the CalHEERS 24 month roadmap change? Has OSI received any feedback about this format change? Why doesn't the 24 month roadmap project farther than September 2016? Shouldn't the roadmap be a dynamic instrument?

5. Did OSI have any role or recommendation in regard to Covered California and DHCS ending its IV&V contract? How is OSI ensuring that IV&V-like activities are occurring at CalHEERS?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 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.

DHCS Fund Budget Summary

Fund	Actual	Estimated	Proposed
	2014-15	2015-16	2016-17
General Fund	$17,443,508,000	$18,055,383,000	$19,556,037,000
Federal Trust Fund	53,049,859,000	61,266,825,000	54,669,584,000
Special Funds and Reimbursements	11,714,355,000	15,701,091,000	13,480,475,000
Total Expenditures (All Funds)	**$82,207,722,000**	**$95,023,299,000**	**$87,706,096,000**
Positions	**3455.4**	**3399.4**	**3342.9**

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

Questions.

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

Issue 2: Medi-Cal Estimate

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 $85 billion ($19 billion General Fund) which reflects a General Fund increase of about $1.4 billion above the Budget Act of 2015. See following table for a summary of the proposed Medi-Cal budget.

Medi-Cal Local Assistance Funding Summary

	2015-16	2016-17	
	Revised	**Proposed**	**Difference**
Benefits	$87,917,900,000	$80,481,300,000	($7,436,600,000)
County Administration (Eligibility)	$3,973,900,000	$4,100,400,000	$126,500,000
Fiscal Intermediaries (Claims Processing)	$485,500,000	$456,700,000	($28,800,000)
Total	**$92,377,300,000**	**$85,038,400,000**	**($7,338,900,000)**
General Fund	$17,645,900,000	$19,084,100,000	$1,438,200,000
Federal Funds	$61,036,400,000	$54,046,500,000	($6,989,900,000)
Other Funds	$13,695,000,000	$11,907,700,000	($1,787,300,000)

Caseload. The Governor's budget assumes total annual Medi-Cal caseload of 13.5 million for 2016-17. This is a 1.5 percent increase over the revised caseload estimate of 13.3 million for 2015-16.

Medi-Cal 2020. California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015. Medi-Cal 2020 will guide the state through the next five years to transform the way Medi-Cal provides services to its 12.8 million members, and improve quality of care, access, and efficiency. Some of the key programmatic elements of Medi-Cal 2020 are:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME). This program builds on the success of the state's Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five-years, federal funding for PRIME for DPHs is $3.27 billion, and for DMPHs is $466.5 million.
- Global Payment Program (GPP). This is a new program aimed at improving the way care is delivered to California's remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into

a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change, focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization.

- Dental Transformation Initiative (DTI). For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in annual funding is available under DTI.
- Whole Person Care (WPC) Pilots. Another component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to $1.5 billion in federal funding over the five-years; WPC pilot lead entities will provide the non-federal share.

In addition to these programs, Medi-Cal 2020 continues authorities for the Medi-Cal managed care program, Community-Based Adult Services, the Coordinated Care Initiative (including CalMediConnect), and the Drug Medi-Cal Organized Delivery System. The renewal also contains several independent analyses of the Medi-Cal program and evaluations of the waiver programs, including an assessment of access in the Medi-Cal managed care program and studies of uncompensated care in California hospitals.

LAO Findings on Medi-Cal Caseload and Estimate. The LAO finds that the Medi-Cal caseload projections appear reasonable. However, the LAO raises two budget issues related to Medi-Cal. First, the ACA makes the development of Medi-Cal caseload projections especially challenging. The LAO finds that with the caseload estimates are more uncertain than in the past, due to the ACA, and the Legislature should take this into consideration when reviewing the budget. The LAO also recommends that the Legislature require DHCS to report at May Revision hearings on how the most recent data on caseload and redeterminations have informed and changed caseload projections.

Secondly, various significant fiscal uncertainties might affect the overall Medi-Cal budget. The LAO includes detailed discussion of the potential fiscal impacts of: (1) the status of the Hospital QAF; (2) recently proposed federal Medicaid managed care regulations; (3) the new federal 1115 Waiver; (4) ACA expansion costs; and (5) the future of the federal Children's Health Insurance Program (CHIP) funding. The LAO recommends that the Legislature extend the Hospital QAF and generally consider these significant cost pressures and uncertainties in the course of analyzing and making decisions about the budget.

Number of Pending Medi-Cal Applications. In January 2015, a superior court judge ruled that DHCS had not complied with its duty to make Medi-Cal eligibility determinations within the required 45 day timeframe. At one point in 2014, over 900,000 Medi-Cal applications had not been processed. Since then, DHCS implemented improvements and received federal CMS approval to allow for an

accelerated enrollment process through August 2015. As noted below, there are now about 22,000 applications that have not been processed within the 45 day timeframe, which represents about 1.6 percent of the applications received during the time period noted below. It is unknown how this number compares to the processing timeframes prior to federal health care reform, as this information was not previously reported by counties.

Applications over 45 days from August 1, 2015 to March 2, 2016

	Count*
46 to 50 Days	3,478
51 to 55 Days	1,466
56 to 60 Days	1,067
61 to 75 Days	2,073
76 to 90 Days	4,485
91 to 120 Days	3,536
121 and higher days	6,574
Total	**22,679**
Adults (19 and older)	16,892
Children (under 19)	5,787
Total	**22,679**

*The number of pending applications reflected in this chart includes duplicates and non-responders.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item as updated caseload estimates will be provided at the May Revision.

Questions.

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

2. Please provide a brief overview of Medi-Cal 2020.

3. Please provide an update on the backlog of Medi-Cal applications.

Issue 3: County Eligibility Administration Funding and Trailer Bill

Budget Issue. The budget continues to provide an additional $169.9 million ($57 million General Fund) in 2016-17 and 2017-18 to counties to administer the Medi-Cal program. According to the Administration, this augmentation provides the funding to address the ongoing increased workload as a result of the significant caseload growth since the federal Affordable Care Act (ACA) implementation.

Additionally, the Administration proposes trailer bill language to suspend the cost-of-living adjustment (COLA) provided to the counties as part of the annual state budget allocation for county administration in 2016-17. The Administration finds that the COLA is not necessary given the augmentations (discussed above) provided in response to ACA implementation. The proposed trailer bill language also deletes outdated language referencing the Healthy Families Program which transitioned to Medi-Cal in 2013-14.

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. However, the COLA has been suspended since 2009-10.

The way in which the counties process eligibility determinations for the Medi-Cal program changed due to the implementation of the federal Affordable Care Act (ACA) beginning January 2014. The 2013-14 budget allocated $143.8 million (total funds) in additional funding to the counties for implementation of the new ACA requirements. The budget provides for county administration funding of $390 million total funds in 2014-15, $485.3 million total funds in 2015-16, and $655.3 million total funds in 2016-17 for the implementation of the ACA. These funds are allocated above and beyond the counties' baseline county administration funding, which is $1.3 billion in 2016-17.

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.

Questions.

1. Please provide an overview of this issue.

Issue 4: Medi-Cal Eligibility Systems Workload (AB 1 X1, 2013)

Budget Issue. DHCS requests $3,683,000 ($1,788,000 General Fund) to support the ongoing policy and system initiatives required by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013, the federal Affordable Care Act (ACA). This request includes three-year limited term funding of $3,047,000, and four permanent positions.

Background. The ACA implemented 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. As required by the ACA, states were to either create a health insurance exchange or use the federal exchange. The ACA require exchanges to be operational by January 1, 2014.

In 2012-13, DHCS obtained 12.0 two-year limited positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with the California Health Benefit Exchange and county eligibility consortia systems. In 2014-15, the 12.0 positions were extended for another two-year term. In addition, in 2014-15, DHCS received eight two-year limited term positions for other implementation efforts, such as the use of the Modified Adjusted Gross Income (MAGI) methodology; simplifications to the annual renewal and change in circumstances processes for Medi-Cal beneficiaries; the use of electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; and performance standards for DHCS, Covered California, and the Statewide Automated Welfare Systems (SAWS).

These resources (20 positions) are set to expire June 30, 2016. However, according to DHCS, these resources are needed in anticipation of the continuous workload resulting from CalHEERS system changes. Additionally, DHCS is responsible for the development of 16 regulatory packages over the next several years and accompanying policy guidance which continues to impact technology solutions for DHCS.

In addition, DHCS requests for permanent positions as part of contract conversion (of 23 contract consultants) related to information technology services. The contracted IT services have included business and systems analysis, design, testing, and project management support. Much of the work these consultants are performing today is ongoing workload and will continue permanently for DHCS. This workload will include batch processing, streamlining manual processes, automating to the furthest extent possible, ongoing data cleanup, and synchronization of data between CalHEERS and SAWS.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 5: Outreach and Enrollment Extension

Budget Issue. DHCS requests two-year limited-term special fund resources of $435,000 ($217,000 Special Deposit Fund and $218,000 federal funds) to address the workload performed by existing limited term positons that will expire on June 30, 2016. These resources are needed to support the implementation, maintenance and oversight of the Medi-Cal outreach, enrollment, and renewal assistance work that must be carried out to meet the requirements specified in AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, Sections 70 and 71, and SB 18 (Committee on Budget and Fiscal Review), Chapter 551, Statutes of 2014 and as extended by SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

The resources will be used to address workload related to collaborating with the counties, the County Medical Services Program (CMSP) Governing Board and community-based organizations in conducting outreach and enrollment activities for hard to reach populations that may be eligible for Medi-Cal, as well as renewal assistance for current Medi-Cal beneficiaries.

Background. The Affordable Care Act (ACA) changed the application and renewal process for the Medi-Cal program and implemented new coverage groups based on an income methodology referred to as Modified Adjusted Gross Income (MAGI). The ACA also mandated Medi-Cal application and renewal simplifications for individuals seeking and retaining coverage; however, Medi-Cal also continues to maintain policies and procedures based on rules that are unchanged by ACA and have been in place for several decades, generally referred to as non-MAGI. The existence of new eligibility groups subject to new eligibility rules while retaining existing Medi-Cal rules and coverage groups has resulted in challenges for individuals seeking and retaining coverage for which they were otherwise eligible. One new aspect of MAGI income methodology that has caused Medi-Cal applicants and beneficiaries some confusion is the need to provide information concerning their income, tax filing status, and tax dependent status.

In response to these changes, The California Endowment (TCE) provided funds, as described below, for the purpose of providing outreach and assistance to uninsured Californians seeking coverage, and retaining eligible individuals with in-person application and renewal assistance:

- Pursuant to AB 82, Section 70, funding in the amount of $28 million ($14 million Special Deposit Fund and $14 million federal funds) for the purpose of providing payments to application assisters as compensation for their efforts in assisting individuals apply and become eligible for Medi-Cal.
- Pursuant to AB 82, Section 71, funding in the amount of $25 million ($12.5 million Special Deposit Fund and $12.5 million federal funds) to the funds for the purpose of outreach to, and enrollment of, targeted Medi-Cal populations. DHCS provides counties with specified grant amount and requires the funded entities to partner with a network of community-based organizations to reach underserved communities.
- Pursuant to SB 18, funding in the amount of $12 million ($6 million Special Deposit Fund and $6 million federal funds) for the purpose of providing Medi-Cal renewal assistance to existing Medi-Cal beneficiaries.
- Pursuant to Section 5 of SB 101 (Committee on Budget and Fiscal Review), Chapter 361, Statutes of 2013, DHCS is authorized to use the funds available to cover the administrative costs.

Covered California had an Interagency Agreement with DHCS, that provides funding for the payments to Certified Enrollment Entities (CEEs) and Certified Insurance Agents (CIAs) for in-person enrollment assistance for individuals who enroll in Medi-Cal and for costs to administer the application assistance program. Beginning July 1, 2015, Covered California implemented a new payment model for the CIAs and will no longer be providing application assistance payments to CEEs and CIAs for applications with Medi-Cal eligible individuals received after June 30, 2015. Covered California currently holds contracts with more than 900 CEEs and nearly 15,000 CIAs. Because DHCS does not have resources to contract with individual CEEs and CIAs and has not fully expended the funds for application assistance for Medi-Cal eligible individuals, the remaining funds for the application assistance program will be transferred to the county outreach and enrollment grants and will be allocated to counties in a manner determined by DHCS.

Based on current enrollment trends, DHCS estimates it will pay out an additional $7.3 million through June 30, 2015. Approximately $2.5 million (9 percent) in remaining funding will be transferred to the county outreach and enrollment grants. These figures represent a portion of the total combined $28 million received from TCE and matching federal funds, which would provide additional funding for county outreach and enrollment grants currently performed by counties and community-based organizations (CBOs). In addition, recent legislation, SB 75, has further extended the timeframe for which DHCS may continue the two programs, from June 30, 2016 to June 30, 2018.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 6: Newly Qualified Immigrants

Budget Issue. The budget includes $83.9 million ($31.8 million General Fund) in savings related to shifting newly eligible New Qualified Immigrants (NQI) populations to Covered California beginning January 1, 2017 pursuant to SB X1 1 (Hernandez), Chapter 4, Statutes of 2013.

Background. The federal Personal Responsibility and Work Opportunity Act (PRWORA) specified that federal financial participation (FFP) is not available for full-scope Medi-Cal services for most qualified nonexempt immigrants during the first five years they are in the country. Currently, FFP is only available for emergency and pregnancy services. California law requires that legal immigrants receive the same services as citizens and pays for other services with 100 percent General Fund.

Effective January 1, 2014, the federal Affordable Care Act (ACA) allow states to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL), referred to as the optional expansion group. Additionally, the ACA established online health insurance exchanges. Covered California, California's health insurance exchange, determines an applicant's eligibility for federally subsidized health coverage. Individuals with incomes below 400 percent FPL are eligible for federal subsidies to help offset the monthly premium costs.

Beginning with the 2016-17 Covered California open enrollment, which is expected to start in October 2016, DHCS will begin transitioning optional expansion childless adult NQIs who have been in the country less than five years from Medi-Cal into Covered California. Coverage (under Covered California) is expected to begin in January 2017. DHCS will pay for all out-of-pocket expenditures and will provide Medi-Cal fee-for-services for services that are not covered by Covered California (such as dental care).

Covered California plans to design this health coverage similar to its implementation of the special ACA requirements related to American Indians and Alaskan Natives.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised by consumer advocates that DHCS has not provided sufficient opportunity to review the details of this transition implementation or sufficient opportunity to comment on notices of actions to individuals who will be impacted by this transition.

Questions.

1. Please provide an overview of this issue.

2. Please describe how the department is engaging with stakeholders on this transition.

3. Please provide a timeline for the activities needed to implement this transition.

Issue 7: Denti-Cal Oversight

Oversight and Budget Issue. DHCS requests four full-time permanent positions and $503,000 ($222,000 General Fund) to address current and anticipated increases in Denti-Cal workload due to ongoing efforts in connection with the findings and recommendations of the California State Auditor (CSA) and the federal Office of Inspector General audits regarding questionable billing for pediatric services.

California State Auditor Findings and Recommendations. 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 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.

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.

CSA made 24 recommendations to improve Denti-Cal. Since the release of this report, DHCS has fully implemented 15 of these recommendations. See table below for more information.

California State Auditor Recommendations, Status as of February 2016

#	Recommendation	Status
1	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: establish criteria for assessing beneficiary utilization of dental services.	Fully Implemented
2	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: establish criteria for assessing provider participation in the program.	Fully Implemented

3	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: develop procedures for identifying periodically counties or other geographic areas in which the utilization rate for child beneficiaries and the participation rate for providers fail to meet applicable criteria.	Fully Implemented
4	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: immediately take action to resolve any declining trends identified during its monitoring efforts.	Pending
5	To help increase the number of providers participating in the program's fee-for-service delivery system, Health Care Services should improve its identification and implementation of changes that minimize or simplify administrative processes for providers. These changes should include revising its processes pertaining to dental procedures that require radiographs or photographs.	Pending
6	To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should take these steps: continuously monitor beneficiary utilization, the number of beneficiaries having difficulty accessing appointments with providers, and the number of providers enrolling in and leaving the program.	Fully Implemented
7	To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should take these steps: immediately take action to resolve any declining trends identified during its monitoring efforts.	Pending
8	To ensure that Medi-Cal's child beneficiaries have reasonable access to dental services, Health Care Services should immediately resume performing its annual reimbursement rate reviews, as state law requires.	Fully Implemented
9	To make certain that access to dental services for child beneficiaries is comparable to the access available to the general population in the same geographic areas, Health Care Services should immediately adhere to its monitoring plan.	Pending
10	To make certain that access to dental services for child beneficiaries is comparable to the access available to the general population in the same geographic areas, Health Care Services should also compare its results for measuring the percentage of child beneficiaries who had at least one dental visit in the past 12 months with the results from the three surveys conducted by other entities, as its state plan requires.	Pending
11	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: direct Delta Dental to submit annually a plan that describes how it will remedy the dental access problems in the State's underserved areas and in California's border communities.	Fully Implemented

12	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: direct Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile clinics in underserved areas, as its contract requires.	Fully Implemented
13	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: increase Delta Dental's access to beneficiary address information and require it to contact beneficiaries residing in underserved areas directly to make them aware of the program's benefits.	Fully Implemented
14	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: review Delta Dental's outreach activities and implement measurable objectives for its outreach unit.	Fully Implemented
15	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: require Delta Dental to develop a dental outreach and education program and to submit an annual plan by the end of each calendar year.	Fully Implemented
16	To ensure that the State pays only for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately take these steps: ensure that the financial manual and invoices are consistent with contract language.	Fully Implemented
17	To ensure that the State pays only for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately take these steps: develop and implement tangible measurements to evaluate Delta Dental's performance of all functions under the contract.	Fully Implemented
18	To comply with state contracting laws that protect the State's interests, Health Care services should implement future contract amendments via appropriate channels, including state contracting procedures.	Fully Implemented
19	To ensure that it reports in the CMS-416 an accurate number of child beneficiaries who received specific types of dental services from the centers and clinics, Health Care Services should continue working on a solution to capture the details necessary to identify the specific dental services rendered.	Pending
20	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: establish the provider-to-beneficiary ratio statewide and by county as performance measures designed to evaluate access and availability of dental services and include this measure in its October 2015 report to the Legislature.	Will Not Implement
21	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: require that the provider field in its data systems be populated in all circumstances.	Fully Implemented

22	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: correct the erroneous data currently in its data warehouse and fix its process for transferring data from its mainframe to its data warehouse.	Fully Implemented
23	To ensure that Health Care Services and its fiscal intermediaries reimburse providers only for services rendered to eligible beneficiaries, Health Care Services should do the following: Obtain Social Security's Death Master File and update monthly its beneficiary eligibility system with death information.	Pending
24	To ensure that Health Care Services and its fiscal intermediaries reimburse providers only for services rendered to eligible beneficiaries, Health Care Services should do the following: Coordinate with the appropriate fiscal intermediaries to recover inappropriate payments made for services purportedly rendered to deceased beneficiaries, if necessary.	Pending

Dental Rate Review. DHCS must annually review reimbursement levels for Medi-Cal Dental Services (Denti-Cal). As noted by the CSA report, DHCS had not undertaken this review in several years. In response to the CSA report, DHCS published a rate review in July 2015. To undertake this analysis, DHCS compared reimbursement rates of the top 25 most utilized Denti-Cal Fee-For-Service (FFS) procedures, with other comparable states' Medicaid programs, in addition to the commercial rates from five different geographic regions around the nation. According to the rate review, Denti-Cal pays an average of 86.1 percent of Florida's Medicaid program dental fee schedule, 65.5 percent of Texas', 75.4 percent of New York's, and 129.2 percent of Illinois'.

2015 Denti-Cal Provider Outreach and Utilization Improvement Plan. In response to a CSA finding that DHCS develop measurements to evaluate Delta Dental's performance as the fiscal intermediary of Denti-Cal, DHCS and Delta Dental developed a provider outreach and utilization improvement plan for efforts in 2015-16. The outreach and recruitment efforts are focused on the following 23 counties that failed to meet the licensed dentist to general population ratio, consistent with the provider participation measurement developed through stakeholder consultation:

	County	Classification
Tier 1	Amador	Extremely Below Standard
	Humboldt	Far Below Standard
	Inyo	Far Below Standard
	Calaveras	Far Below Standard
	San Francisco	Far Below Standard
	Mendocino	Far Below Standard
	Marin	Far Below Standard
Tier 2	Tehama	Below Standard
	Contra Costa	Below Standard
	San Mateo	Below Standard
	Placer	Below Standard
	Nevada	Below Standard
	Del Norte	Below Standard
	Butte	Below Standard
	San Luis Obispo	Below Standard
	Monterey	Below Standard
	Shasta	Below Standard
	Mariposa	Below Standard
	Alameda	Below Standard
Tier 3	Santa Clara	Barely Below Standard
	Yuba	Barely Below Standard
	Napa	Barely Below Standard
	Siskiyou	Barely Below Standard

Counties that are classified as "Extremely Below Standard" are defined as meeting zero percent to 30 percent of the standard, "Far Below Standard" as meeting 31 percent to 60 percent of the standard, "Below Standard" as meeting 61 percent to 90 percent of the standard, and "Barely Below Standard" as meeting 91 percent to 99 percent of the standard. Based on the various levels below the general population standard, Delta Dental will take a "tiered" approach, initially targeting the top seven counties that fall into the "Extremely Below Standard" and "Far Below Standard" as Tier 1, counties "Below Standard" as Tier 2, and counties "Barely Below Standard" as Tier 3 during 2015-16. However, Delta Dental will be conducting outreach to all identified counties failing to meet the general population standard in 2015-16.

Delta Dental's general provider outreach strategy is designed as a multipronged approach. Delta's approach will include collaboration with the California Dental Association and local professional societies, specialist societies, state and county agencies, and health organizations to develop solutions

in provider shortage areas in California and to obtain possible recruitment venues for new providers. Moreover, Delta will work with dental schools and registered dental hygienist in alternative practice programs to encourage students to work in underserved communities and participate in the Denti-Cal program once they graduate and acquire the appropriate licensure. In addition, Delta will focus on educating the enrolled provider population of the support services available to them as enrolled providers.

Delta Dental and the Department of Health Care Services will evaluate progress towards meeting the goals established in the plan on a quarterly basis.

Elimination of Dental Provider Payment Reductions. The 2015 Budget Act included an augmentation of $60 million and trailer bill language to eliminate the ten percent Medi-Cal payment reductions pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, for dental providers effective July 1, 2015. The rate review noted above was completed before the implementation of this restoration. DHCS has seen a significant increase in the number of claims submitted (services rendered) since July 2015. For example, for children age 0 to 21, there were 525,915 FFS claims for June 2015 and 851,145 FFS claims in July 2015. See table below for summary of FFS monthly claims.

Dental FFS Monthly Utilization by Claims Count

	Ages 0-20	Ages 21+
September 2014	511,572	386,312
October 2014	671,249	532,281
November 2014	493,962	359,477
December 2014	449,610	329,239
January 2015	540,793	390,201
February 2015	516,293	358,942
March 2015	580,092	396,098
April 2015	576,920	382,952
May 2015	496,867	353,794
June 2015	525,913	366,276
July 2015	851,145	496,637
August 2015	821,587	481,960
September 2015	715,016	470,074
October 2015	746,225	474,794

New Fiscal Intermediary (FI) and Administrative Services Organization (ASO) Contract. DHCS released request for proposals (RFPs) for separate FI and ASO procurements for dental services. (Delta Dental is the current combined FI and ASO contractor. This contract is effective until July 1, 2017.) Proposals were due to DHCS on February 26, 2016. DHCS plans to make the award announcements in May 2016 so that "takeover" activities could begin July 1, 2016.

The selected FI contractor will be responsible for the takeover, operation, and eventual turnover of the California Dental Medicaid Management Information System (CD-MMIS), and for effective and efficient auto adjudication of claims and related documents for federal and state users of the system. DHCS intends for the selected contractor to take over the existing CD-MMIS and operate it to the satisfaction of state and federal regulations and requirements for FI services for Medi-Cal and other

state health programs that provide dental services. Programs that currently utilize CD-MMIS for dental claims, Treatment Authorization Requests (TARs) processing and other dental related services include Medi-Cal, California Children's Services Program (CCS), the Genetically Handicapped Persons Program (GHPP) and the Regional Center consumers.

The selected ASO Contractor will be required to operate with the dental FI contractor using the existing CD-MMIS. The ASO contractor will be responsible for the administrative functions that were previously done under the single contract with Delta Dental and consists of monitoring and maintaining systems related to the operations portion of providing services to Medi-Cal beneficiaries. Those responsibilities include TARs and adjudicated claim service lines processing, maintaining the telephone service center, and providing outreach efforts to both maintain and increase utilization.

Background. DHCS is responsible for overseeing the provision of dental services to Medi-Cal beneficiaries through two different delivery systems: Dental Fee-for-Service (FFS) and Dental Managed Care (DMC). Under the FFS model, DHCS contracts with a dental FI to provide dental care to over 11,500,000 Medi-Cal beneficiaries statewide. Under the DMC model, DHCS contracts with several DMC plans that provide dental care to over 800,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. The Medi-Cal Dental Program is funded at a minimum of 50 percent federal financial participation (FFP) for both the DMC and FFS contracts. FFP in the state Medicaid dental program is contingent upon compliance with CMS requirements. Additionally, Medi-Cal's dental program is working towards advancing the following CMS goals:

- Increase by 10 percentage points the proportion of children enrolled who receive a preventive dental service; and
- Increase by 10 percentage points the proportion of children age six to nine enrolled who receive a dental sealant on a permanent molar tooth.

The Medi-Cal dental program has continued to see an increasing number of beneficiaries enroll in the program particularly in connection with the Affordable Care Act that became effective January 1, 2014. Additionally, select adult optional dental benefits were restored effective May 1, 2014 for approximately 5,000,000 adults. As a result of these changes, expanded responsibilities have been required by CMS and the Legislature which include but are not limited to:

- Monitoring and reporting of 11 FFS performance measures. The 2014 FFS report, which was required to be posted by October 1, 2015, can be found at: http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=FFS_perf_meas
- Monitoring and reporting on dental managed care performance measures. The next report is due to the Legislature on March 15, 2016 and DHCS indicates that it is working toward releasing the report on April 1, 2016. Past reports can be found at: http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=dental_managed_care_plan_util
- Monitoring and reporting of grievances and outcomes.
- Monitoring and reporting on access to care.
- Regularly establishing and updating appropriate quality and access criteria and benchmarks.
- Consulting with the stakeholder community to ensure appropriate measures are being considered and that potential access issues are recognized and corrected proactively.

Budget Change Proposal Positions Requested. In response to the concerns raised by CSA, the following resources are requested:

- Beneficiary Services Unit (BSU). One associate governmental program analyst is requested to supplement BSU. This unit is responsible for tasks such as: monitoring the Beneficiary Dental Exception (BDE) phone line which provides assistance to Sacramento dental managed care beneficiaries who are unable to secure access to services through their dental managed care plan, processing and responding to general telephone and written correspondences from fee-for-service beneficiaries; processing and approving beneficiary state hearing cases pursuant to statute; processing and approving of beneficiary reimbursement cases (Conlan); analyzing access to care data and developing access and utilization reports for the department and its stakeholders; coordinating the department's beneficiary outreach campaign(s); and analyzing the fiscal intermediary and dental managed plans' adherence to contractual requirements related to beneficiary services.

  In its 2014 audit of the Medi-Cal Dental program, CSA recommended DHCS establish criteria for assessing beneficiary utilization, establish procedures for periodically identifying geographic areas where utilization fails to meet established criteria, and implement actions to resolve any declining trends identified during its monitoring efforts. The BSU is currently working with stakeholders to finalize the department's criteria for assessing utilization and will use the final criteria to perform ongoing monitoring of utilization throughout the state. As areas with low utilization rates are identified, the BSU will be responsible for establishing mitigation strategies to include targeted beneficiary outreach and education efforts within underserved areas to expand beneficiary knowledge of the Medi-Cal dental program and importance of timely dental care. The BSU will also be responsible for reporting utilization rates publicly on a quarterly basis.

  CSA also recommended that DHCS monitor the number of beneficiaries having difficulty accessing appointments with providers. The BSU will be responsible for performing this monitoring and reporting any issues identified to DHCS leadership and stakeholders. The BSU will need to develop survey instruments and processes for periodic data collection on beneficiary access and will also be responsible for performing monthly reporting of referral data on timely appointment access collected via the Denti-Cal Telephone Service Center.

- Provider Services Unit (PSU). One analyst is requested to support the expansion of the PSU, which is responsible for monitoring the provider network, including outreach, utilization review, monitoring of the Surveillance and Utilization Review Subsystem (S/URS), program integrity operations, provider enrollment functions, provider referral list operations, and provider support and training. An important responsibility of this unit is the ability to effectively counteract fraud within the provider network and ensure the timely enrollment of prospective providers, including the ability to immediately suspend and/or dis-enroll suspected fraudulent providers, and the option to re-enroll such providers after suspension.

- Analytics Group. Two positions are requested to increase the capabilities of the analytics group. The analytics group is responsible for performing Tableau software system revisions to facilitate ongoing reporting of beneficiary utilization data based on the newly developed criteria for assessing utilization (including modifications/additions to data stratification e.g. age/ethnicity/etc.). The analytics group will also be responsible for pulling data required for assessment of provider participation and regional deficiencies in the Denti-Cal network. This group will be responsible for the research, data pulling, and analysis of this rate study and will need to ensure that the factual comparative information put forth from the rate study not only

comply with the requirements of state law but also serves to inform and provide the Legislature with a clear picture of how California's rates compare to like states across a multitude of data sets.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please provide a brief status update on the corrective actions DHCS has already taken in regard to the CSA findings.

3. Please provide a review in the changes in utilization since the elimination of the AB 97 reductions in July 2015.

4. Please provide a brief update on Delta Dental's performance with regard to the outreach plan.

5. Please discuss how the Medi-Cal 2020 Waiver's Dental Transformation Initiative will address the concerns that have been raised regarding this program.

Issue 8: AB 85 Health Realignment

Budget Issue. DHCS requests one permanent position and expenditure authority of $845,000 ($423,000 General Fund), of which $734,000 would be three year limited-term, to address the ongoing administration of AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, as amended by SB 98 (Committee on Budget and Fiscal Review), Chapter 358, Statutes of 2013.

Background. With the implementation of federal Affordable Care Act (ACA) in January 2014, it was assumed counties would have fewer costs associated with providing care for low-income populations since the state was assuming responsibility for the administration of health care reform. It was further expected that state costs would increase, while county costs would decrease. To address this shift, AB 85 laid out a process by which transfer amounts were identified, and county health realignment funds were redirected from counties to the Department of Social Services (CDSS) to offset the cost of CDSS programs.

All counties were affected by this process and each county elected a one-time option to either accept a reduction of 60 percent, or show that a lesser reduction would be appropriate based on cost experience of the uninsured programs in their counties using a formula developed by the state and the counties. DHCS is required to use the formula to calculate an annual redirection amount, and to perform interim and final reconciliations of data. For the counties that elected the formula option, statute requires these calculations occur annually until 2023 or until the interim redirection calculation is within 10 percent of the final reconciliation amount and the final reconciliations for two years in a row are within five percent of each other.

Additionally, AB 85 placed specific member enrollment requirements on managed care plans to ensure continuity of care and post ACA monitoring. The bill requires DHCS to work with managed care plans to ensure Designated Public Hospitals (DPH) are paid at least cost for their new Medi-Cal eligible population.

DHCS is also required to provide a hearing process to adjudicate disputes from a variety of DHCS programs, and AB 85 allowed counties to appeal their final reconciliations. DHCS attorneys and analysts represent DHCS in virtually all Office of Administrative Hearings and Appeals (OAHA) cases. Workload related to AB 85 appeals is expected to continue along with final reconciliations.

The Safety Net Financing Division (SNFD). The SNFD administers fee-for-service Medi-Cal and supplemental payments for uncompensated care. The Hospital Uninsured Demonstration and Subacute Section (HUDSS) calculates the redirection of county health realignment funding, monitors subacute facilities, and administers some of the financing for the State's 1115 waivers. HUDSS requests one permanent position to continue calculating county redirection amounts.

According to DHCS, working with counties to identify transfer amounts is a sensitive process because it involves a shift of funds from counties to the state. This position would work to ensure there is an appropriate level of review and accountability in place. In order to do that, and in order to ensure that calculations and estimates are not delayed, HUDSS needs to maintain the three analyst positions currently working on this process (of which one is the limited-term position). With the assistance of auditors, these positions review county cost and revenue data three times a year. The analyst positions also calculate redirection amounts for all 58 counties three times a year during the interim process, the

interim reconciliation process, and the final reconciliation process. In addition to calculating the interim redirection amount for County Medical Services Program counties and for counties who did not choose the formula, the three analyst staff also split the 24 counties who chose the formula. The formula option requires extensive review of large amounts of data used in a technical and complex calculation. Existing staff are working at capacity to handle this workload.

Office of Legal Services (OLS). In order to continue to support OLS Health Care Financing and Rates (HCFR) and the increased workload due to the implementation of AB 85 Realignment, OLS requests three year limited-term resources to assist in the processing of legal work and documents. According to DHCS, the resources will assist HCFR not only in the development and maintenance of the necessary AB 85 Realignment financing structure, contract documents, and certifications required to meet federal requirements, but also the other Medi-Cal funding areas that are impacted by AB 85, such as the 1115 Demonstration Waiver, the Disproportionate Share Program, and the Safety Net Care Pool Funding for the Designated Public Hospitals.

Capitated Rates Development Division (CRDD). The CRDD requests three-year limited-term resources to perform rate development associated with AB 85. CRDD provides oversight for risk adjustment and rate setting involving Medi-Cal managed care beneficiaries. CRDD staff conducts and reviews the most complex data analyses and computations using advanced statistical methods. Staff research and develop default enrollment methodologies and maintain complex projection models used to analyze the impact of proposed default enrollment methodologies.

Managed Care Quality and Monitoring Division (MCQMD). The MCQMD requests three-year limited-term resources in the Plan Management Branch to address workload associated with the realignment of county funds. The resources will allow MCQMD to conduct research to determine the data requirements necessary for the implementation of AB 85, analyze available data and determine a process to procure data not readily available to DHCS. The resources will be used to meet division standards for accuracy, completeness and quality. The resources will allow MCQMD to respond to questions from counties related to AB 85, the transitioning of new beneficiaries into Medi-Cal and the process of assigning these individuals to a primary care provider. In addition, these resources will be used to monitor compliance with the new requirements and monitor the adequacy of the network.

Audits & Investigations (A&I). A&I requests three year limited-term resources for the Designated Public Hospitals (DPHs) P-14 workbook audits. The Financial Audits Branch (FAB) is responsible with ensuring the financial integrity of the DHCS health programs. Financial audits are conducted to ensure that institutional Medi-Cal providers claims for services that are appropriate and are in compliance with the federal Medicare and state Medi-Cal Program laws and regulations. An institutional provider is defined as; acute care hospitals, long-term care providers, federally qualified health centers, and adult day health care centers.

SNFD and the California Association of Public Hospitals (CAPH) developed the P-14 workbook to facilitate the claims through the "Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming." This claiming protocol is laid out in Attachment F of the Special Terms and Conditions of California's current Demonstration 1115 Waiver. The P-14 audits are integral to final reconciliation process as defined in AB 85 because all P-14 workbooks must be audited and approved before final settlements are made.

As of June 30, 2015, FAB has a six year backlog (fiscal years 09,10,11,12,13,14) of P-14 reconciliations that have not been completed. Without additional resources, FAB will be unable to eliminate the existing backlog. This could put future federal funds in jeopardy because CMS has requested that DHCS take steps to complete the final reconciliations in a timely manner. As the Public Safety Net System Global Payment for the remaining Uninsured proposal in Medi-Cal 2020 involves DSH and SNCP funding, A&I will need these resources to handle workload of the new waiver as well. If reconciliations for the current waiver cannot be completed, oversight and auditing will be delayed for Medi-Cal 2020, jeopardizing the success of the renewed waiver and its associated funds.

Use of the P-14 is expected to continue to track public hospital data for Medi-Cal 2020 proposals, specifically the global payment for the uninsured. Auditing workload for Medi-Cal 2020 is likely to be even more strenuous than the current workload as CMS has recently stressed closer regulation of Safety Net Care Pools. The requested resources will enable DHCS to claim current waiver and Medi-Cal 2020 funds in a timely manner. The resources will also assist in helping complete the waiver final reconciliations in a timely manner and help ensure other rate setting and cost settlement audits meet the department's quality standards and mandated due dates.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. With the proposed resources, how long will it take to address the backlog in P-14 reconciliations? Does CMS consider this timeline timely?

Issue 9: Federally Qualified Health Centers Pilot (SB 147, 2015)

Budget Issue. DHCS requests three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of SB 147 (Hernandez), Chapter 760, Statutes of 2015. One-time contract authority of $300,000 is requested in 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent federal funds and 50 percent reimbursement from a foundation. For 2017-18, DHCS requests expenditure authority of $540,000 ($120,000 General Fund, $270,000 federal funds, $150,000 reimbursement).

Background. In 1989, the U.S. Congress established FQHCs as a new provider type. FQHCs are public or tax-exempt entities which receive a direct grant from the federal government under Section 330 of the Public Health Service Act, or are determined by the federal Department of Health and Human Services to meet the requirements for receiving such grants. Federal law defines the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100 percent of their reasonable costs associated with furnishing these services. One of the legislative purposes in doing so was to ensure that federal grant funds are not used to subsidize health center or program services to Medicaid beneficiaries. State Medicaid programs must pay for covered services provided by FQHCs. There are over 820 FQHC locations (FQHCs may have more than one clinic location) in California. County health system clinics have also obtained FQHC status.

Federal Medicaid payments to FQHCs are governed by state (Medi-Cal in California) and federal law. In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to prospective payment system (PPS). This federal law change established (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services. States are required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate, increased each year by the Medicare Economic Index (MEI), and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC during that fiscal year. Under PPS, state Medicaid agencies are required to pay centers their PPS per-visit rate (or an APM, discussed below) for each face-to-face encounter between a Medicaid beneficiary and one of the FQHC's billable providers for a covered service.

For Medi-Cal patients, DHCS is required to reimburse an FQHC for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The wrap-around rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate and their Medi-Cal reimbursement.

FQHCs and Rural Health Clinics (RHCs) are both reimbursed under the PPS system. The average ($178.14) and median ($157.24) PPS rate paid to an FQHC and RHC in 2014-15 is considerably higher than the most common primary care visit reimbursement rates in Medi-Cal, but it also includes additional services not included in a primary care visit. Because FQHCs are required to receive an MEI adjustment to their rates under federal law, and because of their role in providing primary care access to the Medi-Cal population, FQHCs have been exempted from the Medi-Cal rate reductions.

SB 147 calls for a pilot project using an APM where FQHCs would receive per-member per-month (PMPM) payments from the health plan, and would no longer receive a "wrap around" payment from DHCS. CMS has indicated a state may accept an FQHC's written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC is entitled under the PPS.

The proposed APM pilot project will comply with federal APM requirements and DHCS will file a State Plan Amendment (SPA) and seek any federal approvals as necessary for the implementation. The SPA will specify that DHCS and each participating FQHC voluntarily agrees to the APM.

The clinic specific PMPM capitation payment would be determined by utilizing visits data from historical years for members who are assigned to the clinic as the primary care provider, in the Categories of Aid (COA) selected for the pilot. This rate setting methodology, which establishes a PMPM for assigned members based on average annual visits, has precedence in its similarity to a methodology agreed upon between the plans and DHCS in establishing initial rates for Community-Based Adult Services (CBAS) centers. These clinic specific PMPM capitation rates would be set according to actuarial principles that are used to set Medi-Cal managed care rates, which means using historical base year data, and applying appropriate trend rates and program changes, similar to how the FQHC component of the Medi-Cal managed care plan rates are set.

In accordance with SB 147, the department is mandated to apply for the pilot through a state plan amendment, oversee and administer the program over its three-year (at minimum) life, and assist in conducting an evaluation.

To implement SB 147, DHCS requests the following:

- $300,000 ($150,000 reimbursement and $150,000 federal funds) for an evaluation of the FQHC APM pilot. The evaluation shall be completed and provided to the appropriate fiscal and policy committees of the Legislature within six months of the conclusion of the pilot project in those counties that are included in the initial pilot project implementation. As mentioned, the evaluation will be funded by foundation funds and a foundation has already expressed an expectation in writing that they will continue to provide financial support to the state for this APM pilot project effort.
- Three-year limited-term resources to assist in the implementation and administration of the APM pilot. The workload supported by these resources will include:
  - Drafting and filing the state plan amendment (SPA) and seek any federal approvals as necessary for the implementation of the APM pilot; draft and prepare any follow-up legislative documents related to the pilot.
  - Establishing the APM pilot application and readiness process, prepare for deputy review, and send out application to potential clinic sites and plans.
  - Reviewing FQHC site applications and readiness submissions and provide detailed analysis and determination of qualification for pilot.
  - Participating in and prepare materials for APM pilot stakeholder workgroup meetings that concern but are not limited to policy, data, rate setting, alternative encounters, and contracting.
  - Notifying viable FQHC sites and plans of candidacy and coordinate their acceptance into the program, as well as any associated administrative needs.

- Coordinating with pilot plans, clinics, and consultants to receive and assist in analyzing data for purposes of rate development and any other aspects of the APM pilot.
- Working with the Department's Capitated Rates Development Division and Health Care Financing section to prepare and submit rates to the Centers for Medicare and Medicaid Services (CMS); send notifications to plans and clinics of the rate when approved by CMS.
- Assisting in any APM pilot payment adjustments that may occur, as well as adjustments to the PPS rate for participating FQHCs, including changes resulting from a change in the MEI or any change in the FQHC's scope of services.
- Assisting in obtaining contracting for the evaluation of the pilot and conduct research on transitioning the FQHC APM methodology from a pilot to a statewide program.
- Providing and assisting in any other department oversight and administration of the pilot as outlined in the SB 147.
- If needed, post information regarding the pilot on the DHCS website.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue, including information on the plans and clinics expressing interest in participating.

Issue 10: Health Homes Activities

Budget Issue. DHCS requests three-year limited-term expenditure authority of $1,031,000 ($516,000 federal funds, $515,000 Special Deposit Fund), in support of the Health Homes Program (HHP), beginning July 1, 2016. Included in the request is three-year, limited-term contract funding for a total of $775,000 ($275,000 for year 1, $275,000 for year two, and $225,000 for year three).

Background. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Affordable Care Act (ACA) Section 2703 Medicaid Health Home Program (HHP) Services benefit for members with chronic conditions with the goal of improved health outcomes from Medi-Cal's most vulnerable beneficiaries. The HHP will provide enhanced care coordination benefits. It is anticipated that implementing the HHP will reduce state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for vulnerable Californians. The authorization to implement is permissive, is not time-limited, and may be based on DHCS's determination of program fiscal and operational viability. DHCS began further analysis and development work on AB 361 in the spring of 2014. The earliest possible program implementation will be in 2016. Under ACA Section 2703, states may adopt the HHP benefit and receive a 90 percent federal match for program services for two years. After two years, the federal match converts to 50 percent.

AB 361 specifies that DHCS may only implement the HHP if prior and ongoing projections show no additional General Fund monies will be used to fund the program's administration, evaluation, and services. DHCS may use General Fund monies to operate the program if ongoing General Fund costs for the Medi-Cal program do not result in a net increase. In January 2013, The California Endowment (TCE), Board of Directors approved a $25 million commitment in each of the first two years to provide the 10 percent non-federal match for program services. TCE has not only agreed to provide funding for program services, but also funding for state operations activities. In addition, TCE is currently providing the non-federal matching funds for an ongoing $500,000 Title XIX grant from CMS for ACA Section 2703 Health Homes planning, received in 2011.

The California Health Care Foundation (CHCF) is fully funding the Center for Health Care Strategies (CHCS) to assist DHCS with technical assistance on national health home best practices, CMS policy, and a roadmap for program development and decision points.

SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015 established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for HHP implementation.

The following are the general DHCS work activity milestones for this project:

- August/November 2014, April/July-November 2015: Develop and conduct processes to ensure stakeholder engagement and participation. It is anticipated that stakeholder engagement will continue throughout the SPA development and initial phases of implementation in each geographic area. AB 361 allows for stakeholder participation in the department's design process for the required program evaluation, and requires the department to consider consultation with stakeholders on the development of the geographic criteria, beneficiary eligibility criteria, and provider eligibility criteria for any related SPAs.

- October 2015 – March 2016: Develop and obtain approval for any necessary waiver amendment or SPA. Submit the first proposed SPA, for implementation in a specified initial geographic region(s). Additional SPA submissions may be needed for each additional geographic program implementation.
- October 2015 – June 2016: Establish a contract and parameters for program evaluation. Per AB 361, DHCS must complete a HHP evaluation within two years after implementation, submit a report to the Legislature, and allow stakeholders to participate in the process to design the evaluation.
- January 2016: Ongoing rate development activities over at least three annual rate development cycles, depending on staging of geographic implementations; liaising with contractor as necessary.
- Mid 2016-17: Implementation of the health home optional benefit.
- Calendar year 2019: Adopt emergency regulations no later than two years after implementation of the HHP.

Subcommittee Staff Comment and Recommendation—Hold Open. The health home option, with a 90 percent match, was first authorized in 2010 under the federal Affordable Care Act (ACA). Senator (then Assembly Member) Mitchell first authored legislation to implement it in 2012, but did not move the bill forward to the Governor at the request of the Administration even though there would be no General Fund impact and a foundation had offered to put up the matching funds. The bill was reintroduced in the following year as AB 361.

Questions.

1. Please provide an overview of this issue.

2. Please explain why it has taken so long for DHCS to implement this and to agree to take advantage of the health home option.

Issue 11: Medi-Cal Electronic Health Records Staffing

Budget Issue. DHCS requests three-year limited-term resources of $403,000 ($41,000 General Fund) for the Medi-Cal Electronic Health Record (EHR) Incentive Program to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre- and post-payment audits and investigations for program eligible managed care and fee for service providers. The federal Centers for Medicare and Medicaid Services (CMS) has approved 90 percent federal funding participation (FFP) for these requested resources.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes the outlay of federal money estimated to be approximately $4.5 billion for California and $45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and meaningfully use electronic health records (EHR) in accordance with the Act's requirements. HITECH has resulted in a significant increase in provider adoption and use of EHR systems, leading to desired health care improvement, and an overall improvement in public health.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid EHR Incentive Programs. The state's Medi-Cal EHR Incentive Program is integral to patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way. On October 26, 2009, DHCS submitted a funding request to CMS that was approved for $2.8 million to establish Office of Health Information Technology (OHIT) and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for Eligible Hospitals, November 15, 2011 for Groups/Clinics, and January 3, 2012 for Eligible Providers. The Medi-Cal EHR Incentive Program is currently scheduled to operate through December 31, 2021.

DHCS OHIT has authorized more than 20,000 incentive payments to over 17,000 providers and 260 hospitals. This has resulted in more than $1 billion in 100 percent FFP incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program. Recently updated landscape assessment data indicate there are likely another 15,000 providers who are, or will become eligible for the program. DHCS has estimated approximately $2 billion will be distributed to providers and hospitals over the course of the program.

OHIT requests three-year limited-term resources equivalent to staffing of 3.0 positions. The requested resources would not result in an increase in General Fund expenditure, as these resources would be covered under the total annual general fund expenditure previously authorized under law for state administrative costs associated with implementation of the Medi-Cal EHR Incentive Program.

Recent Federal Notification On Expanded Availability of HITECH Funds. On February 29, 2016, CMS issued updated guidance indicating that HITECH federal funds would now be available to support Health Information Exchange (HIE) onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and others. These funds may also support the HIE on-boarding of laboratory, pharmacy or public health providers. DHCS indicates that it is assessing the recently released guidance and is evaluating next steps.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please provide a brief overview of the recent federal guidance expanding the incentive program. How is DHCS planning for this expansion?

Issue 12: Health Insurance Portability and Accountability Act Compliance and Monitoring

Budget Issue. DHCS requests the conversion of eight limited-term positions to permanent effective July 1, 2016. The requested expenditure authority for this conversion is $1,202,000 ($240,000 General Fund). The positions are necessary to continue existing efforts, maintain compliance with current federal and state regulations, address new Health Insurance Portability and Accountability Act (HIPAA) rules, provide support for growth in the Capitation Payment Management System (CAPMAN), and continue to strengthen oversight of privacy and security protections for members served by DHCS programs.

Background. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 have been updated repeatedly since their inception. The most recent changes demonstrate that HIPAA will continue to evolve as technology, policy capabilities, and standards are developed and refined in the health care environment. DHCS must respond to HIPAA changes with an ongoing process to evaluate and implement the latest industry standards for the safe and secure exchange of electronic health care information. DHCS has developed and maintained staffing levels to respond to HIPAA through a series of eight Budget Change Proposals (BCPs) or Spring Finance Letters (SFLs) that have continued to extend formerly approved limited-term positions since HIPAA efforts began at DHCS in 2000. HIPAA will continue to advance and grow in order to make health administration more efficient, secure, and standardized. DHCS needs an ongoing organization, with sufficient permanent staff and resources, to successfully lead and coordinate these efforts.

According to DHCS, recent federal directives have highlighted the need for permanent HIPAA resources, particularly in the areas of Medicaid Information Technology Architecture (MITA), new healthcare standards and operating rules, and capitation program system development, maintenance, and operations.

- MITA: The Centers for Medicare & Medicaid Services (CMS) introduced MITA in 2005 as an initiative to guide states to improve the operation of their Medicaid programs through the implementation of an enterprise framework of business, information, and technical standards. On April 14, 2011, CMS significantly elevated the importance of MITA by issuing new final regulations under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act. The final regulations contained new standards and conditions that must be met by states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced (90 percent) federal financial participation. To enable conformance to MITA, DHCS is required to submit an annual State self-assessment (SS-A) which includes a "Road Map" that outlines DHCS' progression and new initiatives that will lead to a higher level of MITA maturity. On April 14, 2015, CMS released proposed regulations that further strengthen MITA and place additional requirements on state Medicaid agencies, including: use of updated standards and additional conditions in order to obtain federal funds for Medicaid information technology; demonstrated progress toward seamless coordination and interoperability with other federal and state agencies; improved performance testing and demonstrated results; a requirement for mitigation plans for all major systems functionalities; and documentation that will enable re-use of software developed with federal funds.
- New Health Care Standards and Operating Rules: The Affordable Care Act (ACA) contained several significant and still to be implemented HIPAA-related changes, including more

frequent updates to HIPAA regulations, new operating rules, new transaction standards, new health plan certification requirements, and considerably higher penalties for non-compliance. Collectively, compliance with the new and existing HIPAA regulations requires significant efforts within DHCS to assess impacts, design and adapt policies and regulations, define business rules, test changes with providers and other business partners, and remediate information technology systems.

- Growth in CAPMAN: The DHCS Office of HIPAA Compliance (OHC) is responsible for the management of the CAPMAN system, which supports federal regulations that require California to maintain member benefit enrollment and accounting for all capitated payments made to managed health care plans. This is a very large and extremely complex IT system responsible for approximately 83 percent of all Medi-Cal payments per month. CAPMAN replaced a manual process to calculate and pay managed care plans in July 2011. Since the initial implementation of CAPMAN, Medi-Cal managed care has experienced phenomenal growth. This growth is attributed to two components: 1) Medi-Cal expansion emanating from the Affordable Care Act; and 2) moving Medi-Cal members from fee-for-service to managed care. When the system was developed there were approximately 3.5 million Medi-Cal members in managed care. Currently there are over 9 million Medi-Cal members in managed care, representing an increase of 257 percent. In addition to the growth in members, the complexity of payment methodologies has increased, and will continue to increase, as DHCS includes additional services in the premium (e.g., long term care services and support).

DHCS requests to convert eight limited-term positions to permanent to coordinate and carry out the workload required by HIPAA rules and updates. All of the requested HIPAA positions are eligible for enhanced federal financial participation. According to DHCS, failure to adequately staff for this workload has several negative implications, including the risk of significant federal compliance penalties, limited ability to respond to changes in managed care plan capitation payment policy, and inability to adhere to previous commitments around improved efficiency in DHCS technology systems that help administer California's Medicaid program.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised that Public Record Act requests have been delayed because of the workload related to HIPPA compliance review of these requests.

Questions.

1. Please provide an overview of this issue.

2. Does the department have sufficient resources related to HIPAA review of Public Record Act requests to meet the response timeframes specified in law (24 days)? Is there a backlog of these requests due to HIPAA review?

Issue 13: Third Party Liability Recovery Workload

Budget Issue. DHCS requests $1,136,000 ($284,000 General Fund) and 10.0 permanent, full-time positions to address a growing workload and to increase savings. Federal and state laws and regulations mandate that Medi-Cal recover expenditures in personal injury cases involving liable third parties so that Medi-Cal is the payer of last resort. (The state received an enhanced federal participation rate of 75 percent.)

According to DHCS, current staffing levels are insufficient to complete a thorough and timely analysis and processing of the growing case volume. Within one year of the January 1, 2014 implementation of the Affordable Care Act (ACA), Medi-Cal enrollment increased by 38 percent. This enrollment increase is correlated with the 70 percent increase in Casualty Insurance Operations (CIO) cases.

Background. Title XIX of the Social Security Act requires the State Medicaid agency (Medi-Cal) to seek reimbursement for beneficiaries whose medical bills were caused by a liable third party. Federal regulations require Medi-Cal to avoid payment of claims where third party coverage is available and to initiate post-payment recovery processes. State law requires the department to impose liens on a beneficiary's personal injury settlements and make recoveries, thereby, that Medi-Cal is the payer of last resort.

Attorneys, county welfare agencies, and insurance companies must notify the department of tort actions involving a Medi-Cal beneficiary. CIO staff review Medi-Cal expenditures paid for injury-related services, then file liens for recovery against any settlement, judgment, or award. The department has three years to obtain recovery from the notice of settlement, judgment, or award on CIO cases. All funds recovered through any of the Third Party Liability and Recovery Division (TPLRD) recovery programs are recycled back into the Medi-Cal program to assist in the care of other medically needy individuals, effectively abating General Fund expenses.

Following the implementation of the ACA, Medi-Cal enrollment increased from 8.6 million in December 2013 to 13.3 million in November 2015, a 54 percent increase. From July 2013 through December 2013, prior to ACA implementation, CIO received on average 3,536 new case referrals per month. The growth in incoming case referrals accelerated after the implementation of ACA. The average number of incoming case referrals reached 5,983 during the months of January through July 2015. This represents an increase of nearly 70 percent compared to the volume prior to ACA implementation.

All incoming cases are reviewed for eligibility and other factors. Those where recovery is deemed prudent and necessary are set up for processing by an analyst. From January 2014 through July 2015, CIO experienced 70 percent growth in its active caseload (cases in research status and those awaiting payment), increasing from 18,527 to 31,480 cases. The rapid growth created a "bottleneck" effect, which partly contributed to the increase in the caseload.

TPLRD requests 10.0 permanent full-time positions to address the increasing workload and to recover Medi-Cal expenditures in personal injury cases involving liable third parties, thereby ensuring that Medi-Cal is the payer of last resort, as mandated by federal and State laws and regulations.
CIO projects that, by June 30, 2016, caseload will increase to 35,856, or 48 percent beyond its current staffing capacity.

In 2012-13, CIO collection staff collected $33.4 million ($16.7 million General Fund). Assuming the average collections hold, according to DHCS, adding 10.0 additional positions to CIO should result in an additional $7.8 million ($3.9 million General Fund) in annual CIO recoveries. The recovery for 2014-15 was $35.8 million. If the requested positions are approved, the additional revenue would be acquired gradually, as the collection efforts are increased and cases reach settlements and come to a resolution in the form of payment. CIO estimates that the entire projected additional revenue of $7.8 million will be acquired by 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 14: Eliminate Workers' Compensation Information Sunset - Trailer Bill Language

Budget Issue. DHCS proposes trailer bill language to eliminate the sunset provision and indefinitely extend the Department of Industrial Relations (DIR) authority to supply work-related injury or claim data from the Workers' Compensation Information System (WCIS) to the DHCS.

Background. DHCS is responsible for enabling compliance with state and federal law related to the legal liability of third parties to pay for a Medi-Cal beneficiary's health care, so that the Medi-Cal program is the payer of last resort. DHCS contracts with outside vendors to process worker's compensation (WC) claims and to recover Medi-Cal costs from settlements arising from work-related injuries where a liable third party exists.

In 1981, Welfare and Institutions (W&I) Code Section 14124.81 et seq. directed the state to enter into two pilot project contracts for WC third party recoveries. Initial recoveries made under these contracts consisted entirely of reimbursements from contested cases; claims filed against an insurance carrier or employer who has not accepted liability for the injuries sustained. These cases are identified using data from the Workers' Compensation Appeals Board.

In 2010, DHCS learned that DIR also compiled data on non-contested WC cases (i.e., claims filed against an insurance carrier who has accepted liability for the injuries sustained) in the WCIS. AB 2780 (Solorio), Chapter 611, Statutes of 2010, sponsored by Health Management Systems (a WC contractor) amended Labor Code Section 138.7 to authorize DHCS to "obtain and use individually identifiable information, as defined for the purposes of seeking recovery of Medi-Cal costs incurred by the state for treatment provided to injured workers…" However, that bill included the sunset provision date of January 1, 2017 and revisions to LC 138.7 that would become operative on January 1, 2017 if the WCIS provisions sunset.

In May 2012, DHCS entered into an interagency agreement with DIR to secure a data transfer of the WCIS file in order to identify non-contested WC cases. In November 2014, this interagency agreement was extended through June 30, 2019, and allows DHCS's WC contractor to create liens and recover from settlement awards for non-contested cases, which they otherwise would not have been able to do. Removing the sunset date provision as proposed would allow DHCS to maintain compliance with state and federal law and sustain current recovery levels, benefitting the Medi-Cal population with minimal administrative costs to the General Fund.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 15: Supplemental Drug Rebates Cleanup Trailer Bill Language

Budget Issue. DHCS requests trailer bill language to make minor technical changes to Welfare and Institutions (W&I) Code §14105.436 and §14105.86 as amended by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014. These technical changes will correct non-sequential lettering errors and inconsistent and erroneously omitted language in order to accurately preserve the intent and purpose of SB 870, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

According to DHCS, if left uncorrected, the errors may lead to a misinterpretation of the intent of SB 870 and place the state at risk of losing supplemental drug rebate revenues.

Background. SB 870 extended the state's authority to collect state supplemental drug rebates based on drug utilization data from all Medi-Cal programs, including fee-for-service (FFS) and managed care plans (MCPs). SB 870 applies to certain prescription drugs, including, but not limited to, drugs used to treat hepatitis C, HIV/AIDS, cancer, and hemophilia.

Prior to SB 870, DHCS had the authority to collect state supplemental drug rebates based on drug utilization data from FFS and county organized health systems only. SB 870 provided new authority to DHCS to invoice manufacturers of contracted drugs and collect state rebates based on utilization data from all MCPs for prescription drugs subject to coverage policies and where DHCS reimburses MCPs through separate capitated rate payments or other supplemental payments.

SB 870 amended three sections of the California Welfare and Institutions Code, revising the description of utilization data to determine state rebates: §14105.33 (pertaining to state rebates and contracts with drug manufacturers), §14105.436 (pertaining to HIV/AIDS and cancer drug rebates), and §14105.86 (pertaining to blood factor rebates).

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.