SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mike Morrell

April 24, 2014

1:30 p.m.
Room 4202, State Capitol

Agenda
(Michelle Baass)

PLEASE NOTE:

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

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

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VOTE ONLY

0530 Secretary for Health and Human Services Agency

1. Office of Systems Integration - CalHEERS

Budget Issue. The Governor's budget requests a decrease in Office of Systems Integration (OSI) reimbursement authority in 2014-15, in the amount of $32,060,149 for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project. (Reimbursements are from the Health Benefit Exchange Board, the Department of Health Care Services, and the Managed Risk Medical Insurance Board.)

This decrease is in line with the project schedule and reflects the completion of development and implementation (D&I) and the beginning of operation and maintenance (O&M).

An increase of $5,746,167 is also required in 2013-14, which will be requested separately via a Section Letter. The increase in 2013-14 is a result of activities being shifted across fiscal years. The total project costs do not change over what was previously approved in the May 2013 *CalHEERS As-Needed Implementation Advance Planning Document Update*.

Background. OSI has been chosen by the California Health Benefit Exchange (Exchange) to provide project management services during the design, development and implementation and system stabilization of the CalHEERS solution to help meet the federally mandated timelines and requirements. In order to provide adequate project management for the CalHEERS Project, OSI requires reimbursement from the Exchange for the costs associated with these project management services in 2013-14.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding OSI's role in the CalHEERS project. It is recommended to approve this request to ensure continued development and management of the CalHEERS project.

4260 Department of Health Care Services (DHCS)

1. Every Woman Counts Contract Conversion

Budget Issue. DHCS requests four two-year limited-term positions to replace existing contract staff in the Every Woman Counts (EWC) Program in order to comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants. DHCS expects this proposal to result in savings of $143,000 federal funds.

DHCS proposes to acquire the following positions for this purpose:

- Associate Governmental Program Analysts (2.0)
- Associate Information Systems Analyst (1.0)
- Research Scientist Supervisor II (1.0)

To fill these positions, DHCS intends to hire the same individuals who currently are employed as the contracted staff to do this work, thereby ensuring the availability of qualified individuals to fill these positions.

Background. The EWC is funded through a combination of tobacco tax revenue, General Fund, and a federal Centers for Disease Control (CDC) grant. The CDC grant requires the program to monitor the quality of screening procedures, and therefore the program collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal. This recipient data is then reported to CDC biannually and assessed for outcomes to determine if outcomes meet performance indicators, such as the number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment.

The existing contract positions are responsible for performing core program performance activities associated with the federal grant deliverables and data analyses to support the development and completion of the annual report to the Legislature required under the Revenue and Tax Code Section 3046.6 (f). These positions provide semi-annual estimates, quarterly reports on caseload, program expenditures and program monitoring, as required by SB 853 (Committee on Budget & Fiscal Review), Chapter 717, Statutes of 2010. Currently, DHCS contracts with the University of California, Davis, to provide contract staff to perform these federally mandated data collection and reporting activities.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal.

ISSUES FOR DISCUSSION

4260 Department of Health Care Services (DHCS)

1. CalHEERS and Medi-Cal Enrollment

Budget Issue. DHCS requests the extension of 12 two-year limited-term positions which expire June 30, 2014, and $1,777,000 ($314,000 General Funds, $857,000 federal funds, and $606,000 Reimbursement from Covered California) in associated funding to support the ongoing planning, design, development, implementation, and ongoing maintenance of the Medi-Cal Eligibility Data Systems (MEDS) system changes and integration with the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) and county eligibility consortia systems. These positions are currently filled.

The Medi-Cal Eligibility Division requests to extend three positions to support the planning, development, implementation, and evaluation of Medicaid eligibility rules and enrollment simplification provisions as required by the ACA.

The Information Technology Services Division requests to extend nine positions to support the planning, design, development, implementation and ongoing maintenance of the MEDS changes and integration with CalHEERS and the county systems.

Background. The Affordable Care Act required the Health Benefit Exchange to be operational by January 1, 2014. Functions of the Exchange include eligibility determinations for Exchange products and insurance affordability programs including Medi-Cal and Children's Health Insurance Programs (CHIP). Federal regulations and state law require coordination between the Exchange, Medi-Cal, and CHIP programs to ensure a seamless, integrated process for individuals seeking health coverage. This integration requires interfaces with CalHEERS, the information technology (IT) computer system designed for the Exchange functions, the three county eligibility consortia that determine Medi-Cal eligibility and MEDS, the statewide database that includes eligibility information for Medi-Cal, CalWORKs, and CalFRESH.

The 2013 Budget Act provided 12.0 two-year limited-term 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. However, there have been significant scope and functionality delays; and, consequently, the Administration requests to extend these 12 positions for another two years. See table below for the proposed CalHEERS schedule.

Table: Proposed CalHEERS Release Schedule and Functionality

<table>
<tr><th colspan="2">March - May</th></tr>
<tr><td colspan="2">Theme: Medi-Cal and eHIT Improvements, Special Enrollment, Medi-Cal pre-ACA Renewals and Redeterminations</td></tr>
<tr><td>Completed Work:
Medi-Cal Effective Dating/Discontinuances/Notices
Medi-Cal Pre-ACA Conversion Renewals - Report A Change Reporting - Add a person to Pre-ACA Medi-Cal or Non-MAGI case
Federal Poverty Level – Table Update
eHIT Defect Resolution</td><td>Pending Work:
eHIT Defect Resolution (ongoing)
Changes to Special Enrollment
MAGI Medi-Cal Negative Action
MEDS Transactions Defect Resolution
Federal Poverty Level/COLA Processing
Remote Identity Proofing
Residency Verification (MEDS & Franchise Tax Board)
MAGI-Based Medi-Cal Aid Code Hierarchy (Former Foster Care)
Eliminate Deprivation
Changes for Processing Lump Sum Income</td></tr>
<tr><th colspan="2">June</th></tr>
<tr><td colspan="2">Theme: Medi-Cal and eHIT Improvements</td></tr>
<tr><td colspan="2">Include Unborn Child in Family Household for MAGI determinations
Additional Lump Sum Income updates
eHIT Schema Changes
Updates for Verify Lawful Presence
PRUCOL
Add Servicing County if different from county of residence
Continuous Eligibility for Children (CEC)
Continuous Eligibility for Pregnant Women
Enhancements for Reporting Changes for QHP enrollments
IRS Reporting for Advanced Premium Tax Credits (APTC) Consumers</td></tr>
<tr><th colspan="2">Summer</th></tr>
<tr><td colspan="2">Theme: Updates to Single Streamlined Application</td></tr>
<tr><td colspan="2">Updates for CMS Requirements
Updates to align paper and on-line application
Updates based on advocate feedback
Updates based on consumer / usability feedback
Medi-Cal Plan Selection</td></tr>
<tr><td colspan="2">Theme: MAGI Medi-Cal and Qualified Health Plan (QHP) Renewals</td></tr>
<tr><td colspan="2">Updates and changes required for first year renewals of MAGI and QHP Renewals</td></tr>
<tr><td colspan="2">Other Items</td></tr>
<tr><td colspan="2">Integrate AIM and CHIM Programs
Updates for Financial Management
Full implementation of Voter Registration Requirements</td></tr>
<tr><th colspan="2">Fall</th></tr>
<tr><td colspan="2">Theme: Second Year Open Enrollment for QHP</td></tr>
<tr><td colspan="2">Updates and changes required for second Exchange Open Enrollment</td></tr>
<tr><td colspan="2">Theme: Carrier and Enrollment Improvements</td></tr>
<tr><td colspan="2">On-line payments for QHP enrollments
Enhancements for Plan-based enrollers
Enhancements for Issuers on-line
Enrollment transaction enhancements</td></tr>
</table>

CalHEERS Delays and Inaccuracies Have Significant Impact on Medi-Cal Enrollment. Delays in implementation and inaccuracies in CalHEERS functionality have had a significant impact on Medi-Cal enrollment. Consequently, there is a backlog of almost 900,000 pending Medi-Cal applications. This includes individuals with applications submitted and likely MAGI (Modified Adjusted Gross Income) Medi-Cal eligible but need verification or need application information corrected or updated, or duplicate-case to be deleted:

- Submitted Oct 1 – Dec 31, 2013, and pending as of March 31: approximately 224,000
- Submitted Jan 1 – Mar 31, 2014, and pending as of March 31: approximately 673,000 (includes 390,000 submitted in March)

According to DHCS, most of the pending applications need residency verification, and approximately half of the pending applications need income verification. Since residency and income verification are the two requirements to make an applicant eligible (or conditionally eligible, if immigration status is pending), the policy of suspending the requirement for paper verification of residency means that potentially half of the pending applicants could be cleared by the temporary verification policy. However, DHCS notes that some of the older applications missing only residency verification may have other errors or outstanding issues to resolve before eligibility determination can be completed.

Approximately 34,000 consumers were determined eligible for MAGI Medi-Cal on an expedited basis because they have an immediate need for health care services, from January 1, 2014 through March 31, 2014.

Although the Administration has taken steps to address these issues by waiving certain requirements, such as suspending the requirement that Medi-Cal applicants provide paper documentation of residency until May 1, 2014, ensuring that key functionality is included in CalHEERS is critical to the Medi-Cal program. Consumer advocates and other stakeholders urge the continuation of the suspension of residency verification until the planned electronic verifications are implemented.

Additionally, since CalHEERS is a joint project between DHCS and Covered California, it is important to ensure that there is an equal focus on Medi-Cal when developing the public-messaging about health care reform and the CalHEERS website. For example, Medi-Cal does not have an open enrollment period as does Covered California's health coverage; however, when the open enrollment period for Covered California was ending, CalHEERS contained misleading information regarding a person's ability to enroll in Medi-Cal. DHCS and Covered California are working with stakeholders on this messaging; however, it is important for all future CalHEERS development and webpages to ensure that Medi-Cal's focus and rules are always considered.

Subcommittee Staff Comment and Recommendation—Hold Open. CalHEERS is a very complex IT system that was developed in an expedited timeframe to meet federal and state timelines. It is important to remember that this system impacts the ability of millions of Californian's to get the health coverage they need. It is recommended to hold this item open as discussions continue on steps that can be taken to suspend requirements or ease manual processing to ensure that individuals receive the coverage for which they are eligible.

Questions.

1. Please provide an overview of this proposal.

2. What is the backlog of pending Medi-Cal applications? How many of these applications would be addressed by the suspension of residency verification until May 1, 2014? How have these applications been processed? What is the timeline to clear the backlog? What other work-arounds have been implemented?

3. Please explain the income verification issues that are resulting in delays in processing eligibility and the corrective action steps that have been taken?

4. Please provide a high-level overview of the critical pieces of functionality that need to be implemented in CalHEERS.

5. Will all CalHEERS functionality be available to successfully process renewals? If not, what functionality will not be available?

6. How is DHCS seeking stakeholder feedback regarding changes to CalHEERS and the proposed CalHEERS release schedule?

7. Has DHCS considered suspending renewals, as permitted by the federal Centers for Medicare and Medicaid Services, and as has been done in other states in order to clear the backlog of pending cases?

8. Please explain what criteria DHCS and Covered California use to prioritize changes in CalHEERS?

9. What is the timeline for complying with the requirement to produce pre-populated forms?

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

11. According to the proposed schedule, integration of AIM into CalHEERS is not proposed until the summer. If AIM is transition to DHCS on July 1, 2014 as proposed in the budget, how does DHCS plan to process AIM applications? How is DHCS planning for this and communicating with stakeholders on this potential future process?

2. SB 28 - Medi-Cal ACA Implementation – New County Administration Methodology

Budget Issue. DHCS requests $1,485,000 ($742,000 General Fund) and seven three-year, limited-term, positions for the Medi-Cal Eligibility Division (MCED) and for the Audits and Investigations Division (A&I), as well as funds for contracted services (for monitoring and evaluation time studies). This request is based on language included in SB 28 (Hernandez), Chapter 442, Statues of 2013, which directs DHCS in consultation with the counties and County Welfare Director's Association (CWDA) to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act (ACA) on county administrative work and present that methodology to the Legislature no later than March 2015.

The positions requested for the MCED consist of one associate governmental program analyst (AGPA) and one staff services manager (SSM I) who will coordinate research and development of a new budgeting methodology for county administration of the Medi-Cal program.

The positions requested for A&I consist of four health program auditor IIIs, and one health program audit manager I to conduct a variety of on-site activities, including but not limited to, fiscal reviews to verify the accuracy of Medi-Cal administrative claimed costs in each of the 58 counties, to verify accuracy of reported time study information, and to verify the accuracy of data reported on county performance.

Background. The state's 58 counties perform eligibility determinations for applicants to the Medi-Cal program as well as case maintenance activities. Currently, counties are budgeted for their activities based on claimed expenditures from previous years, and there is no county share of cost for administrative activities in the Medi-Cal program. SB 28 requires the development of a new budgeting methodology for county administrative costs. This new budgeting methodology will be used to compensate counties for the work they will be performing under ACA while also providing DHCS with improved data on county operations and costs relative to Medi-Cal eligibility determinations and case maintenance activities for applicants and beneficiaries. The new budgeting methodology shall be implemented no sooner than 2015-16 and DHCS would be required to provide the new budgeting methodology to the legislative fiscal committees by March 2015.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. The Administration believes that most of this work should be done by A&I as they have the experience, expertise, and skills necessary to perform these activities. DHCS states that A&I lacks certain critical expertise in the area of monitoring and evaluation of time studies. Consequently, DHCS proposes to hire contract staff with specific knowledge to develop the new methodology, create an ongoing monitoring plan, and train A&I staff on monitoring and evaluation of time studies.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the classifications and divisions of the proposed staff. CWDA is concerned that most of the requested positions (five) would be in the A&I division, which does not have expertise in Medi-Cal eligibility or county administration.

Questions.

1. Please provide an overview of this proposal, including the implementation timeline.

2. The number of Medi-Cal applications in the county workload is higher than originally estimated. Does the Administration plan to make adjustments to this estimate as a result?

3. Please provide DHCS's rationale for why five of these positions would be in A&I. Could similar classifications be added to MCED?

3. Suspend Cost-of-Living Adjustment for County Eligibility Administration

Budget Issue. DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA). This would result in a $20.2 million ($10.1 million General Fund) savings in the budget year. See table below for summary of county administration funding.

Table: Summary of Proposed County Administration Funding

	2013-14		2014-15	
	Total Fund	**General Fund**	**Total Fund**	**General Fund**
Base County Administration	$1.3 billion	$651.3 million	$1.3 billion	$651.3 million
Affordable Care Act Implementation	$143.8 million	$71.9 million	$130 million	$65 million
Cost-of-Living Adjustment (COLA)	$30.8 million	$15.4 million	$20.2 million	$10.1 million
Elimination of COLA	N/A	N/A	-$20.2 million	-$10.1 million
Rollover of Prior Year Medi-Cal Eligibility Processing Costs	$37.6 million	$18.8 million	$35.9 million	$17.9 million
Other	$321.3 million	$57.9 million	$281 million	$127.9 million
Enhanced Federal Funding		-$124.2 million		-$248.4 million
Total	**$1.8 billion**	**$653.6 million**	**$1.7 billion**	**$506.5 million**

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

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

The 2013 Budget Act included supplemental funding for the counties reflecting the substantial increase in workload expected as a result of implementation of the Affordable Care Act. This supplemental funding included a COLA for 2013-14. Related, and as discussed in the prior issue on this agenda, SB 28 (Hernandez & Steinberg) Chapter 442, Statutes of 2013, requires DHCS, in consultation with stakeholders, to create a new methodology for budgeting and allocating funds for county administration for the Medi-Cal program, and for this new methodology to be implemented in 2015-16.

LAO Findings and Recommendation. The LAO recommends the Legislature reject the Administration's proposed trailer bill language that would express the Legislature's intent to suspend the COLA for Medi-Cal county administration on an ongoing basis. The LAO finds that the proposed trailer bill language is premature. Statutory language enacted in 2013 requires DHCS to work with counties to

develop a new budget methodology for Medi-Cal county administration no sooner than 2015-16. In the LAO's view, any discussion of the ongoing nature of COLAs should be part of the broader discussion of the new budget methodology that is being developed. Until the new budget methodology is developed and adopted, to the extent the Legislature choses to suspend the COLA for county administration, it can be suspended through the annual budget process—consistent with what has been done in recent years.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as updated estimates regarding county administration funding will be included in the May Revise.

Questions.

1. Please provide an overview of this item.

4. Medi-Cal Rates, Payment Reductions (AB 97), and Access Monitoring

Background. As a result of the state's fiscal crisis, AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, required the Department of Health Care Services (DHCS) to implement a 10 percent Medi-Cal provider payment reduction, starting June 1, 2011. This 10 percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access.

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

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider 10 percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

Budget Issue. The Governor's budget continues these payment reductions and recognizes $489 million ($244.5 million General Fund) in ongoing annual savings and $76.6 million ($38.3 million General Fund) in savings from the recoupment of certain retroactive reductions (that are not forgiven as discussed below) in 2014-15. The 2013 budget included $849.3 million ($424.6 million General Fund) in annual ongoing savings. The differences between the 2013 budget act and the Governor's proposal are described below.

Forgives Certain Retroactive Obligations. The Governor's budget forgives certain retroactive fee-for-service (FFS) provider payment reductions for physicians/clinics, specialty drugs, dental, intermediate care facilities for the developmentally disabled (ICF/DDs), and medical transportation.

This results in an $11.6 million ($5.8 million General Fund) increase in 2013-14 and a $72.6 million ($36.3 million General Fund) increase in 2014-15. The total cost of these recoupments is $434.2 million ($217.1 million General Fund), which will be forgiven over the next several years. The Administration finds that implementation of both the retrospective and prospective reduction for these provider types would have a negative impact on access to these services for Medi-Cal enrollees. See table below for a summary.

The Administration indicates that federal CMS has no concerns with the proposal to forgive retroactive obligations and has provided guidance on the ability to draw down federal funds to help pay (based on a 50:50 split) for this proposal. Previously, the Administration indicated the federal funds would not be available to address retroactive reductions and consequently would have been all General Fund.

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

Medi-Cal Provider Payment Reductions (AB 97) Summary						
Provider Type	Retroactive Savings Period	Total Retroactive Savings	Estimated Savings from AB 97 Reduction			
			2013-14		2014-15	
			On Going	Retro	On Going	Retro
Nursing Facilities - Level A	6/1/11-6/30/12	$245,754	$253,544	$122,877	$253,544	$20,480
ICF/DDs	8/1/12-10/31/13	forgiven	$11,603,317	$0	$17,404,975	$0
DP/NF-B	6/1/11-9/30/13	$83,437,273				$15,170,413
Phase 1 Providers (1)	6/1/11-12/20/11	$28,753,171	$55,208,892	$14,376,585	$56,136,663	$0
Physician 21 yrs+	6/1/11-1/9/14	forgiven	$24,873,072	$0	$49,746,144	$0
Medical Transportation	6/1/11-9/4/13	forgiven	$12,051,092	$0	$14,461,310	$0
Medical Supplies/DME	6/1/11-10/23/13	$39,427,840	$11,595,992	$1,251,677	$17,393,988	$7,510,065
Dental	6/1/11-9/4/13	forgiven	$35,451,470	$0	$64,733,864	$0
Clinics	6/1/11-1/9/14	forgiven	$9,255,850	$0	$18,511,701	$0
Pharmacy	6/1/11-2/6/14	$296,621,286	$47,382,359	$0	$113,717,663	$53,931,143
CHDP Providers (2)	6/1/11-10/31/13	forgiven	$1,609,367	$0	$2,414,050	$0
Managed Care			$100,675,930	$0	$134,234,574	$0
Grand Total (Federal&GF)		**$448,485,324**	**$309,960,885**	**$15,751,139**	**$489,008,476**	**$76,632,101**
General Fund		**$224,242,662**	**$154,980,443**	**$7,875,570**	**$244,504,238**	**$38,316,051**
Notes:						
(1) Phase I includes providers not specified above, generally ancillary services, such as laboratory and radiology.						
(2) Child Health and Disability Prevention Program (CHDP)						

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

Key Changes from 2013 Budget Act. In addition to the forgiveness of certain retroactive obligations, key changes to the implementation of the AB 97 reductions since the enactment of the 2013 budget include:

- Certain Prescription Drugs – The budget includes the implementation of the exemption of certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions. The 2013 budget included $271.9 million ($135.9 million General Fund) in ongoing annual savings from pharmacy, whereas, the proposed budget only includes $113.7 million ($56.8 million General Fund) in ongoing annual savings from the implementation of this reduction. On March 30, 2012, DHCS submitted a State Plan Amendment to the federal CMS for this change and it is still pending CMS approval.

- Distinct Part Nursing Facilities (DP/NFs) – On a prospective basis, DHCS exempted rural DP/NFs as of September 1, 2013 based on access and SB 239 (Hernandez and Steinberg), Chapter 657, Statues of 2013 exempted all DP/NFs from these reductions as of October 1, 2013. The 2013 budget included $38.2 million ($19.1 million General Fund) in ongoing annual savings from this reduction. The proposed budget does not include any ongoing savings from DP/NFs.

- Managed Care Rates – The 2013 budget included $267.5 million ($133.8 million General Fund) in ongoing annual savings from this rate reduction on managed care rates. The Governor's 2014-15 budget only includes $134.2 million ($67.1 million General Fund) in ongoing annual savings from implementation of this reduction on managed care plans. This is discussed in more detail below.

- Pediatric Dental Surgery Centers (for profit and nonprofit) – DHCS exempted most nonprofit dental pediatric surgery centers effective September 1, 2013; and most for-profit dental pediatric surgery centers effective December 1, 2013.

Issues to Consider. The following considerations are important when evaluating these Medi-Cal payment reductions:

- ***Shift to Managed Care and Actuarial Soundness of Rates.*** The 2013 budget act assumed that the ongoing savings on an annual basis from the imposition of this payment reduction on managed care plans would be $267.5 million ($133.8 million General Fund). However, as the chart above reflects, it is now estimated that the annual ongoing savings from this reduction on managed care would be $134.2 million ($67.1 million General Fund). There was no change in circumstance applied to managed care plans. This loss in savings is a result of the requirement that managed care plan rates be actuarially sound (and also reflected the application of AB 97 exemptions to certain FFS services). As such, managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, the 2013-14 managed care rates were reduced by less than one percent as a result of AB 97.

  Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards *and* a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services).

- ***How to Evaluate the Impact of Provider Payment Reductions on Access?*** As the Legislature evaluates the impact of these reductions on access to services, the following factors and examples may be considered:

  - **Does Payment Cover the Cost?** In March 2012, DHCS proposed exempting certain drugs because it found that the Medi-Cal payment for these drugs (with the 10 percent reduction) would not cover the costs of these drugs.

  - **Is Medi-Cal a Large Portion of the Line-of-Business?** The Governor's budget proposes to forgive the retroactive recoupment of payment reductions for medical transportation because DHCS found that non-emergency medical transportation providers serve mostly Medi-Cal clients and that these providers do not have the cash available (i.e., these providers cannot cost-shift) to sustain retroactive recoupments and the prospective payment reduction.

  - **What is the Geographic Capacity of a Service/Provider?** DHCS exempted Community-Based Adult Service (CBAS) centers in certain rural parts of the state from the provider payment reduction due to geographic access and utilization analyses.

- ***Federally-Required Access Monitoring.*** The federal CMS requires DHCS to continually monitor to ensure that access (based on geographic location) is not impacted. DHCS uses call-center information, real-time information provided by provider groups, and cost data, for example, to evaluate impact. Additionally, DHCS has established an ongoing access monitoring system that considers 23 access measures (e.g., primary care physician ratios). However, given that most of the

payment reductions have not been in effect due to court injunctions, the available access monitoring reports generally do not reflect the implementation of these payment reductions. As the provider payment reductions are put into effect, these access monitoring reports will be critical in assessing the impact on Medi-Cal enrollees.

LAO Findings and Recommendations. The LAO has reviewed DHCS's baseline access analyses and quarterly monitoring reports and has come away with numerous concerns about the quality of the data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on access. In the LAO's view, these concerns are sufficient to render the Administration's public reporting of very limited value for the purpose of understanding beneficiary access in the fee-for-service (FFS) system. The LAO also finds that much of the debate regarding the Medi-Cal provider payment reductions has focused mainly on FFS while access issues in managed care are gaining more importance (as a majority of Medi-Cal enrollees are in managed care). Since dental care will remain primarily a FFS benefit for the foreseeable future, the LAO recommends the Legislature create meaningful standards for monitoring Denti-Cal (FFS) access. In addition, the LAO recommends future oversight focus on monitoring the managed care system. The LAO indicates that it plans to produce a more detailed analysis on this topic in the future.

Stakeholder Concerns. Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations.

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

Subcommittee staff has requested technical assistance from DHCS to develop more specific metrics and methods to monitor Denti-Cal access.

Questions.

1. Please provide an overview of this issue and the January budget proposal.

2. Please explain what data sources and other information the department uses to evaluate access to providers and services.

3. Some of the provider types specified in the chart above encompasses a broad range of providers. For example, Medical Supplies/Durable Medical Equipment includes specialty providers such as custom rehabilitation technology (wheelchairs) and Pharmacy includes specialty long-term care pharmacy providers. These specialty provider types are different from the more general providers and may have special considerations. How does DHCS evaluate the impact of the AB 97 reductions to each specific provider type to ensure that access is not compromised? Has DHCS completed an access evaluation for custom rehabilitation technology or long-term care pharmacy providers?

4. Is there concern that the dental provider payment reduction will impede the partially restored adult dental benefit?

5. How does DHCS measure access for services and providers who do not have a choice to provide services, such as ambulatory and emergency room physician services?

5. Monitoring Medi-Cal Dental Services Utilization & Pediatric Dental Outreach Proposal

Oversight Issue. Over the last few years, concerns have been raised regarding access to and utilization of Medi-Cal dental services. As discussed in the prior agenda item, the state currently does not have tools to monitor Medi-Cal Denti-Cal fee-for-service (FFS) access or utilization in 56 counties. While there is the ability to monitor Medi-Cal dental services provided through dental managed care in Sacramento and Los Angeles counties, these monitoring reports indicate that plans have experienced difficulty in meeting performance benchmarks.

Budget Issue. DHCS proposes $17.5 million ($8 million Proposition 10 funds provided by the California Children and Families Commission [First 5] and $9.4 million federal funds) to increase dental care outreach activities for children ages zero to three years. This includes:

- $643,000 ($190,000 Proposition 10 funds) for outreach activities.
- $16.8 million ($7.9 million Proposition 10 funds) to be used for the expected increase in dental services utilization as a result of these outreach activities.

DHCS proposes to identify beneficiaries who are ages 0-3, during their birth months, that have not had a dental visit during the past 12 months, and mail parents/legal guardians a letter that: (1) encourages them to take their children to see a dental provider; and (2) provides educational information about the importance of early dental visits.

DHCS is in discussions with First 5 on the use of Proposition 10 funds for this purpose. This item is proposed to be discussed at the First 5 Commission's meeting on April 24, 2014.

Background. Medi-Cal provides dental services through two service models: FFS, also known as Denti-Cal, and dental managed care (DMC). Currently, only two counties—Sacramento and Los Angeles—offer DMC; while all other counties offer Denti-Cal. In Sacramento, beneficiaries are mandatorily enrolled in DMC whereas in Los Angeles, enrollment into DMC is voluntary, and if beneficiaries do not enroll in DMC, they are automatically enrolled in Denti-Cal. Currently, about 6.5 million beneficiaries are enrolled in Denti-Cal and about 500,000 beneficiaries are enrolled in DMC. The number of Medi-Cal beneficiaries with dental coverage is expected to grow as coverage for adult dental benefits is partially restored on May 1, 2014 and as Medi-Cal eligibility is expanded through the Affordable Care Act. As with the current population of children who receive dental coverage under Medi-Cal, the vast majority of these adult beneficiaries will be served by Denti-Cal.

Covered dental services under managed care are the same dental services provided under the fee-for-service Denti-Cal Program. These services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days).

Performance of Dental Managed Care. In response to a 2010 First 5 report on Sacramento's Geographic Managed Care, subsequent press coverage, legislative hearings, and stakeholder input, provisions to address the shortcomings of dental managed care were included in AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012. This bill required (among other things):

- ***Dental Plan Performance Measures.*** DHCS is to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

- ***Annual Reports.*** DHCS is to submit annual reports to the Legislature, beginning March 15, 2013, on dental managed care in Sacramento and Los Angeles, including changes and improvements implemented to increase Medi-Cal beneficiary access to dental care. The bill also required the DMHC to provide the Legislature, by January 1, 2013, its final report on surveys conducted and contractual requirements for the dental plans participating in Sacramento.

The March 15, 2014 report, required by AB 1467, has not yet been submitted to the Legislature and information from Los Angeles County has not yet been posted to the department's website. However, information from Sacramento County indicates that annual dental visits, use of preventative services, use of sealants, overall utilization of dental services, and use of dental treatment services declined across all plans and age groups, often by more than two percent. As a result, DHCS staff held a conference call with the plans to discuss these results, and have asked the plans to submit Corrective Action Plans (CAP) to tell DHCS how they will attempt to reverse this trend. The plans noted that some fourth quarter data encounters have not yet been reported, but DHCS does not believe these claims will materially affect the plan-reported results.

DHCS expects to receive the CAPs by April 10, 2014, consistent with All Plan Letter 13-004. In addition, the impacted plans will suffer financial penalties of up to 13 percent this year from amounts withheld from the plans' monthly capitation payment over the past year. DHCS may withhold up to 10 percent if a plan fails to meet their utilization goals, plus up to three percent for failing to submit timely and accurate deliverables.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic. Subcommittee staff has requested technical assistance from DHCS to develop more specific metrics and methods to monitor Denti-Cal access.

Finally, it should be noted that a State Auditor Report is expected to be released in October 2014 regarding the Denti-Cal program.

Questions.

1. Please provide an overview of the pediatric dental outreach proposal and explain why DHCS thinks that the proposed outreach letters will improve utilization. Why is DHCS targeting 0-3 year olds?

2. What is the status of the discussions with the First 5 Commission on the use of their funds for this proposal?

3. Please provide an overview of the recent dental managed care monitoring report. When does DHCS plan to post information on Los Angeles County?

4. Please discuss efforts to include local stakeholders in the monitoring and enforcement efforts for Sacramento Geographic Managed Care.

5. Has DHCS received the corrective action plans from the dental managed care plans?

6. How does DHCS envision working with the newly-proposed State Dental Director at the Department of Public Health?

7. How does DHCS monitor FFS dental utilization and access?

6. Coordinated Care Initiative (CCI) Update and Position Request

Budget Issue. The Governor's January budget includes a net General Fund savings of $159.4 million in 2014-15 (DHCS budget only) as a result of the CCI, including the General Fund savings from the sales tax on managed care organizations (MCO). Without the MCO tax revenue, CCI would have a General Fund cost of $172.9 million in 2014-15.

On February 28, 2014, the Department of Finance (DOF) provided the following statutorily required update on overall General Fund savings across all departments: The CCI is expected to result in a net General Fund savings of $84.1 million in 2013-14 and $65.4 million in 2014-15. DOF also states that this will be updated again at May Revise.

DHCS also requests four three-year limited-term positions and $760,000 ($380,000 General Fund, $380,000 federal fund) of which $300,000 is to be added to the existing Mercer Health and Benefits LLC contract for actuarial services, to implement provision of SB 94 (Committee on Budget & Fiscal Review), Chapter 37, Statutes of 2013, related to the use of "risk corridors."

Background. The 2012 budget authorized the Coordinated Care Initiative[1] (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). CCI is composed of three major parts:

- **Long-Term Supports and Services (LTSS) as a Medi-Cal Managed Care Benefit**: CCI includes the addition of LTSS into Medi-Cal managed care. LTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

- **Cal MediConnect Program**: A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).

- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded Seniors and Persons with Disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health and social care for Medi-Cal consumers, to pilot a coordinated delivery system for dual eligibles, and to create fiscal incentives for

1 Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care).

For a complete discussion on CCI, please see page 99 of the Senate Budget and Fiscal Review Committee's Overview of the 2014-15 budget, published February 3, 2014:
http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/Overview2014_15BudgetBillSB851.pdf

CCI Updates and Milestones. Since the February 6th Joint Senate Budget and Fiscal Review Committee and Senate Health Committee hearing on CCI, the following changes and updates have occurred:

- **Aligning Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS) Enrollment.** Moving forward, beneficiaries who are in Medi-Cal FFS will not transition to MLTSS ahead of their Cal MediConnect passive enrollment date. This will reduce the number of plan choices a beneficiary will need to make, and reduce confusion.

- **MLTSS Transition for FFS Population to Start in August.** To ensure that the MLTSS 90-day notices have had appropriate quality reviews, DHCS will not start MLTSS enrollment for Medi-Cal FFS populations (non-duals or duals excluded from Cal MediConnect) until August 2014. The previous enrollment schedule was to have the enrollment of this population begin in July.

- **Changes in timeline in Alameda and Orange Counties.** Enrollment in Alameda and Orange Counties is being delayed until no sooner than January 2015 (due to fiscal and program deficiencies) to allow more time to achieve plan readiness.

- **Cal MediConnect Implemented on April 1, 2014.** On April 1, 2014, 3,200 dual eligibles were passively enrolled in Cal MediConnect in San Mateo County and 300 dual eligibles voluntarily enrolled in Cal MediConnect in Los Angeles, Riverside, San Bernardino, and San Diego Counties.

- **Cal MediConnect Ombudsman Program Started on April 1, 2014.** The Cal MediConnect Ombudsman Program (overseen by the Department of Managed Health Care) became operational on April 1, 2014.

- **90-Day Notifications Sent to Eligible Beneficiaries in Los Angeles.** On March 28, 2014, approximately 45,000 eligible beneficiaries in Los Angeles County received a 90-day notice informing them that they are eligible for Cal MediConnect and will be enrolled. On April 3, 2014, DHCS began sending voluntary notices notifying eligible beneficiaries about Cal MediConnect. This voluntary notice went to approximately 20,000 eligible beneficiaries in Los Angeles County.

- **Federal Approval for Cal MediConnect Received.** On March 19, 2014, the federal CMS approved the state's waiver amendment to implement Cal MediConnect.

- **Duals Plan Letter—Complaint and Resolution Tracking.** On April 10, 2014, DHCS issued a letter to all Medi-Cal managed care plans participating in Cal MediConnect. This letter specified requirements on plans to report monthly on the number of complaints, the number of these

complaints that were fully or partially resolved or not resolved, and information about the type of complaint.

- **Next Implementation Date for Cal MediConnect.** The next major milestone is May 1, when passive enrollment into Cal MediConnect begins in Riverside, San Bernardino, and San Diego Counties. Individuals in these counties have already received a 90-day, 60-day, and 30-day notification about this implementation.

Concerns with Choice Form. Following the 60-day notification about the Coordinated Care Initiative, Medi-Cal enrollees will receive a Choice Form. Generally, on this form, enrollees may select their Medicare and/or Medi-Cal health plans. Stakeholders have raised concerns that this form does not present a clear choice or option to opt-out of Cal MediConnect. DHCS indicates that it has received a lot of feedback on this form and understands the concerns. As a result, DHCS is working with CMS to develop new forms that will undergo beneficiary testing in Los Angeles (at the end of April/early May) and that this feedback would be used to develop new notifications. The new materials would be ready for stakeholder review in June with the goal of having these materials ready for production in August/September.

Revised Medicare Advantage and D-SNP Proposal Still Unknown. As part of the Governor's January budget proposal, the Administration indicated that it would be proposing trailer bill language to no longer exempt dual eligible enrollees of Medicare Advantage and D-SNP plans from Cal MediConnect enrollment, effective January 2015. (Medicare Advantage is a Medicare managed care plan and includes D-SNPs which are special types of Medicare Advantage plans offered to dual-eligible individuals.) However, soon after the budget was released, DHCS indicated that it is still evaluating its proposal regarding Medicare Advantage and D-SNP plans. Under current law, these individuals are exempt from passive enrollment in Cal MediConnect in 2014 and as a result, would have to move to a new health plan with Cal MediConnect. The Administration still has not released its proposed policy regarding these Medicare plans. The federal government reauthorized the D-SNP program until 2016.

Continued Concerns with Los Angeles County Readiness. One of the health plans planning to participate in Cal MediConnect (LA Care) is ineligible to receive passive enrollment until it improves its Centers for Medicare and Medicaid Services star rating. In an attempt to offer choices to Los Angeles beneficiaries, DHCS announced in February that it is offering three other plans , CareMore, Care 1st, and Molina (which were already Cal MediConnect subcontractor plans), in addition to the existing plan option (Health Net) as options for passive enrollment starting no sooner than July 1, 2014.

CMS is recommending, and DHCS concurs, that these three plans be allowed to market in Los Angeles County beginning May 1, 2014. CMS also recommends that DHCS do additional monitoring of the nursing facility network for Care1st in the form of a network compliance plan, that would be jointly developed by the contract management team and the plan.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised regarding the requested extension of the limited-term CCI positions. However, it is recommended to hold this item open as discussions continue on issues related to CCI.

Questions.

1. Please provide an update on the Coordinated Care Initiative.

2. Please describe what steps DHCS is taking to revise the Choice Form.

3. When will the Administration have its proposal regarding Medicare Advantage and D-SNP plans?

4. Please provide an update on the status of the CMS and DHCS Cal MediConnect health plan readiness assessment of CareMore, Care 1st, and Molina in Los Angeles County.

7. Medi-Cal Managed Care Ombudsman Program

Oversight Issue. Concerns have been raised that the Medi-Cal Managed Care Ombudsman Program is not responsive to consumer calls and inquiries. Until recently, consumers could reach a busy-signal and were not able to speak to a representative or leave a message. Additionally, since 2011 and through the budget year, close to three million new individuals enrolled into Medi-Cal managed care (either by transitioning from fee-for-service or as a part of the Medi-Cal expansion under the Affordable Care Act), and yet, no new resources or staff have been added to the Medi-Cal Managed Care Ombudsman Program.

Recently, DHCS redirected nine positions and hired two students to support the existing Medi-Cal Managed Care Ombudsman program to help with the increased workload related to all the transitions/enrollment occurring. (Prior to this redirection, this ombudsman program had eight staff.) These were actual filled positions from other areas in DHCS: Eligibility/Benefits/Third Party Liability and others. However, DHCS views this as a temporary redirection since it will impact the work in the areas from which these staff were redirected

Background. The Medi-Cal Managed Care Office of the Ombudsman helps solve problems from a neutral standpoint to ensure that Medi-Cal members receive all medically necessary covered services for which plans are contractually responsible. The ombudsman will not automatically take sides in a complaint. This office:

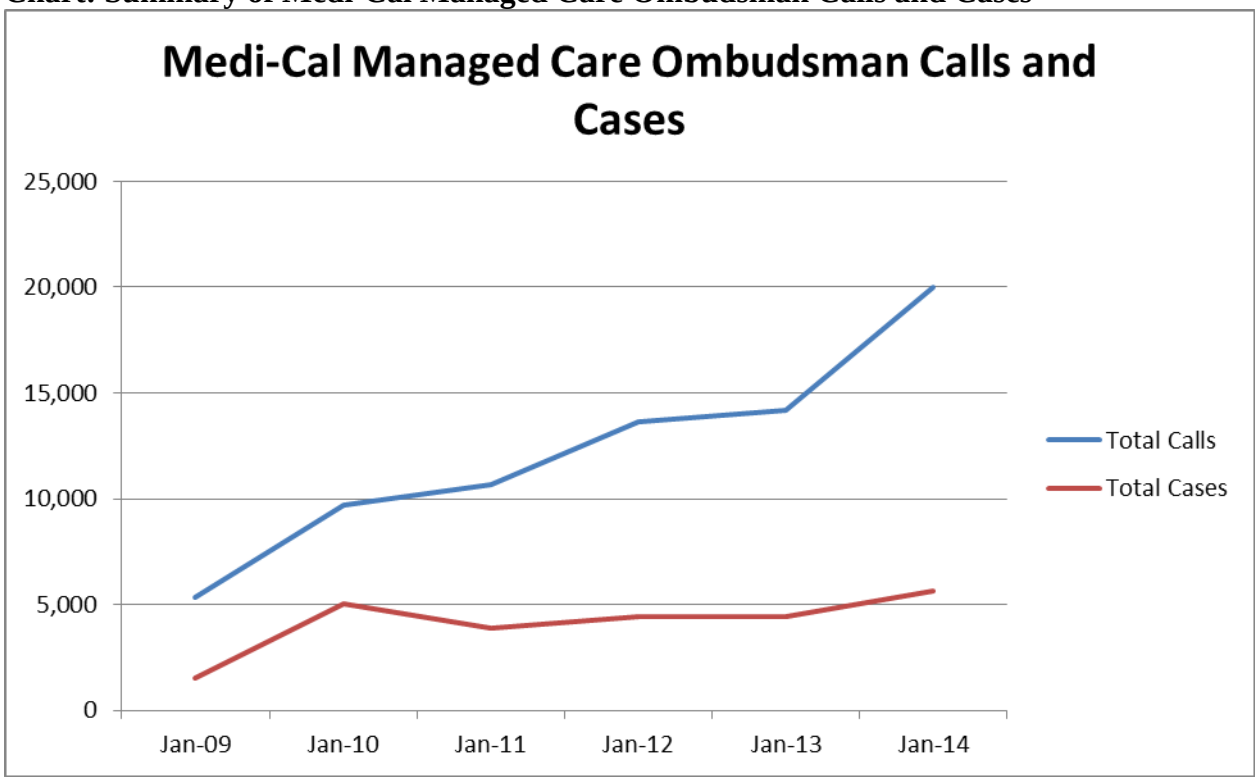
- Serves as an objective resource to resolve issues between Medi-Cal managed care members and managed care health plans.
- Conducts impartial investigations of member complaints about managed care health plans.
- Helps members with urgent enrollment and disenrollment problems.
- Offers information and referrals.
- Identifies ways to improve the effectiveness of the Medi-Cal managed care program.
- Educates members on how to effectively navigate through the Medi-Cal managed care system.

Increased Call Volume. As shown in the table below, the call and case volumes for the ombudsman program has increased in the last five years. Please note it is unclear how many calls were unable to get through due to busy signals or hang-ups due to long waits. With the implementation of the Affordable Care Act (ACA), the monthly call volumes have increased dramatically, but the volume increase began when DHCS began enrolling more and more beneficiaries into managed care. This includes the addition and transitions of Seniors and Persons with Disabilities, Healthy Families, Low Income Health Program, Rural Expansion, Express Lane, and ACA into Medi-Cal managed care. These are permanent additions to the managed care rolls.

Table: Medi-Cal Managed Care Ombudsman Program Calls and Cases

Date	Total Calls to Ombudsman	Total Cases by Ombudsman	Date	Total Calls to Ombudsman	Total Cases by Ombudsman
Jan-09	5,334	1,507	Jan-12	13,638	4,407
Feb-09	5,581	1,440	Feb-12	12,507	3,749
Mar-09	9,147	2,355	Mar-12	14,632	5,125
Apr-09	7,650	1,854	Apr-12	13,930	4,704
May-09	8,856	2,360	May-12	14,386	5,104
Jun-09	10,117	3,778	Jun-12	12,063	3,947
Jul-09	8,153	4,371	Jul-12	13,470	4,756
Aug-09	14,724	7,262	Aug-12	14,536	5,030
Sep-09	7,868	3,799	Sep-12	10,800	3,282
Oct-09	9,195	4,586	Oct-12	13,168	4,253
Nov-09	9,129	4,655	Nov-12	10,129	3,944
Dec-09	8,542	4,365	Dec-12	9,631	2,844
Jan-10	9,709	5,041	Jan-13	14,189	4,405
Feb-10	9,549	5,193	Feb-13	12,160	3,961
Mar-10	9,667	4,914	Mar-13	14,816	4,737
Apr-10	8,113	4,076	Apr-13	15,932	5,225
May-10	8,952	4,935	May-13	13,635	4,440
Jun-10	10,202	5,452	Jun-13	13,506	4,790
Jul-10	10,570	5,913	Jul-13	14,695	4,688
Aug-10	12,815	7,368	Aug-13	15,100	4,896
Sep-10	14,523	8,700	Sep-13	14,544	4,863
Oct-10	14,323	8,700	Oct-13	15,622	4,958
Nov-10	15,648	9,828	Nov-13	12,460	3,831
Dec-10	12,660	7,499	Dec-13	14,140	4,019
Jan-11	10,693	3,858	Jan-14	20,000	5,649
Feb-11	9,260	3,459	Feb-14	18,226	5,130
Mar-11	13,866	5,813	Mar-14	20,611	5,842
Apr-11	12,123	4,992			
May-11	9,641	3,113			
Jun-11	10,199	2,863			
Jul-11	9,757	2,835			
Aug-11	12,654	3,756			
Sep-11	12,424	3,699			
Oct-11	12,466	3,723			
Nov-11	12,822	3,898			
Dec-11	11,649	3,651			

Chart: Summary of Medi-Cal Managed Care Ombudsman Calls and Cases



Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open to continue discussions on the appropriate level of permanent staff needed at the Medi-Cal Managed Care Ombudsman Program. Given that millions of individuals now receive Medi-Cal through managed care, it is appropriate to ensure that resources are available to assist consumers and help them understand their managed care benefits and help resolve any questions or issues.

Questions.

1. Please provide a summary of the role of the Medi-Cal Managed Care Ombudsman Program.

2. Please describe how and why the call and case volumes have increased in the last five years.

3. Please describe phone-line capacity and call wait times.

4. Please describe performance standards for responding to calls.

5. How long does DHCS plan to keep the nine redirected staff at the ombudsman program? What is DHCS's long-term plan for staffing this program?

6. Does the ombudsman program staff have other responsibilities related to referrals and fair hearings?

7. Does DHCS plan to include information about Medi-Cal Managed Care Ombudsman Program calls and cases on its dashboard?

8. Why is there such a discrepancy between the number of calls and the number of cases? Is there a backlog of calls that have not been followed-up on?

8. Add Applied Behavioral Analysis (ABA) Services to Medi-Cal Managed Care

Issue. Last year's Senate version of the 2013-14 budget, which was not ultimately adopted, added applied behavioral analysis (ABA) services to Medi-Cal managed care for children ineligible for regional center services. This proposal continues to be a priority of the Senate.

According to the Administration, the annual costs to add ABA to Medi-Cal managed care for children ineligible for regional center services is $270 million ($125 million General Fund). According to DHCS, given the multitude and variability of data points, DHCS performed several calculations that varied from as low as $75 million annual total fund costs to nearly ten times that amount, or $750 million in annual total fund costs. DHCS also considered that for the most severe/costly cases the likelihood is that those children would meet the necessary qualifications to receive services at the regional centers and, therefore, the responsibility of the health plans would be *only* for those children ineligible for regional center services. Given these estimates and assumptions, DHCS determined that using an estimated per member per month cost in the mid-range ($4.50) would be the most appropriate way to develop an estimate.

Background. In the fall of 2012 during the planning for the Healthy Families Program (HFP) transition to Medi-Cal, questions about the provision of ABA services in Medi-Cal for children with autism were raised. Stakeholders requested specific information regarding the differences in services provided by HFP and Medi-Cal in order to identify issues prior to any transition and plan for their remedy. Senator Steinberg sent a letter to the California Health and Human Services Agency on November 29, 2012 requesting this specific information. However, the Administration did not respond to Senator Steinberg and did not provide stakeholders a clear representation for how the eligibility for this service differed between HFP and Medi-Cal.

On April 1, 2013 as HFP children in some counties were transitioned to Medi-Cal, families were given very short notice that their children would no longer be able to access ABA services once enrolled into a Medi-Cal managed care plan. This was in spite of months of awareness of this concern and clear feedback from consumer advocates that there was still confusion about this issue.

Pursuant to AB 88 (Thomson), Chapter 534, Statutes of 1999 and SB 946 (Steinberg) Chapter 650, Statutes of 2011, commercial insurance plans including HFP were required to pay for behavioral services (e.g., ABA) while health plans contracted with Medi-Cal were exempt from these provisions. Consequently, Medi-Cal does not currently have a set of services designated as "ABA." Currently, Medi-Cal pays for behavioral services for children under the Department of Developmental Services' Home- and Community-Based waiver provided through the regional centers. Not all HFP children receiving behavioral services qualify for these services in the regional centers because of eligibility and medical necessity criteria.

ABA is an intensive behavioral intervention therapy which is designed to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Recent Court Decisions and Settlements. The federal CMS has not issued guidance on whether or not ABA is a required benefit under Medicaid's Early Periodic Screening, Diagnosis, and Treatment

(EPSDT); however, recent court decisions[2] and settlements appear persuasive in specifying that ABA is a benefit under EPSDT. It is unclear how these court decisions and settlements may impact the Medi-Cal program in California.

Subcommittee Staff Comment and Recommendation—Hold Open. This issue continues to be a priority of the Senate. It is recommended to hold this item open as discussions continue on this topic.

Questions.

1. Please provide an overview of this proposal.

2. What rate of ABA utilization is assumed in this estimate?

3. What is DHCS's assessment of the case law on this topic?

2 *K.G. ex rel. Garrido v. Dudek (Fla. 2013) WL 5930764 and Parents' League for Effective Autism Services v. Jones-Kelley (6th Cir. 2009) 339 Fed.Appx. 542*

9. CBAS Program and Continued Transition of SPDs to Medi-Cal Managed Care

Budget Issue. DHCS requests the extension of three limited-term positions in the Long-Term Care Division (LTCD), expiring on August 31, 2014, for an additional year, and the extension of current limited-term positions, set to expire on June 30, 2014, another two years in the Medi-Cal Managed Care Division (MMCD) with $540,000 ($241,000 General Fund and $299,000 Federal Fund) to fund these positions in order to complete required workload pursuant to the Community-Based Adult Services (CBAS) Settlement Agreement and federal 1115 Waiver.

According to DHCS, these positions will assist in the processes and policies that will be reflected in the 1115 Waiver amendment, which is currently under development. In addition, the MMCD conversion of these limited-term positions for an additional two years is vital for ongoing health plan monitoring and member assistance to ensure compliance with the Waiver and the Coordinated Care Initiative (CCI). CBAS is maturing into a functional part of the CCI, with CBAS benefits being offered through managed care plans, allowing participants with various medical level-of-care needs to access CBAS without being institutionalized at a much greater cost. Additionally, extending the LTCD's positions and the MMCD's positions allows for continued program integrity, monitoring and oversight, completing required litigated, legislative, and federal reporting.

Background. The CBAS program developed out of the December 2011 *Darling et al. v. Douglas et al.*, Settlement Agreement (Case No. C-09-03798-SBA) and the April 2012 approval to the 1115 Medi-Cal Bridge to Reform (BTR) Waiver Amendment, following the elimination of Adult Day Health Care (ADHC) as a State Plan benefit via AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. State operations authority was granted to operate the CBAS program through the end of the Settlement Agreement on August 30, 2014.

SB 1008 (Committee on Budget and Fiscal Review), Chapter 22, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review) Chapter 45, Statutes of 2012 (regarding implementation of the CCI) provide that CBAS is a managed care plan benefit, thus, requiring CBAS benefits to continue past the August 2014 end date by amending the 1115 Waiver and the establishing positions needed to support this ongoing managed care effort.

The CBAS program developed from the elimination of ADHC as a Medi-Cal benefit, when the Governor signed AB 97 on March 24, 2011. The Center for Medicare and Medicaid Services (CMS) approved DHCS' State Plan Amendment to eliminate the ADHC benefit effective September 1, 2011. However, in June 2011, ADHC participants filed a motion in federal court to enjoin the elimination of ADHC "unless and until adequate replacement services were in place," asserting that the elimination of the benefit would place beneficiaries at risk of unnecessary institutionalization. The parties reached a settlement before further court action (Settlement Agreement). The Settlement Agreement allowed the elimination of the ADHC program as an optional Medicaid benefit on February 29, 2012, and required establishment of the CBAS program on March 1, 2012 (subsequently moved to April 1, 2012) to provide similar services in outpatient facilities (CBAS Centers) to seniors and adults with disabilities who met the eligibility criteria defined in the Settlement Agreement and Waiver.

DHCS previously requested and received five limited-term positions effective in January 1, 2013, through June 30, 2014: three positions in LTCD, and two positions in MMCD for establishing, structuring, and assisting in rolling CBAS benefits into managed care plans, as well as the rollout in rural counties.

The CBAS program was implemented through the BTR Waiver Amendment, and work is in progress to extend the CBAS program beyond August 2014 through a Waiver Amendment. Work will continue to be necessary for a small number of fee-for-services beneficiaries with the majority of beneficiaries enrolled in managed care plans throughout the state.

Requested Positions. According to DHCS, the extension of three limited-term positions in the LTCD is necessary to complete all reporting requirements necessary under the Settlement Agreement and the CBAS amendment to the Bridge to Reform Waiver. Additionally, with extending the Waiver for ongoing CBAS, positions are necessary to transition the program to an ongoing managed care benefit. Extending the LT positions allows for completing and transitioning the program where it can be a permanent part of LTSS. Furthermore, these three positions will facilitate the CBAS conversion to managed care during the managed care expansion into the 28 remaining fee-for-service counties. These positions are necessary for monitoring and oversight of current and future CBAS within managed care.

The extension of two limited-term positions for an additional two years is necessary to continue oversight of health plan compliance in administering CBAS in all counties when CCI takes place. These positions oversee the ongoing contractual requirements and reporting specific to CBAS and assisting members receiving CBAS in order to ensure continued compliance with the Waiver amendment. Additionally, these positions work to provide health plan guidance in delivering member benefits, assist health plans in coordinating care with CBAS facilities, and resolve inquiries specific to CBAS from health plans, beneficiaries and stakeholders. Extending the staffing an additional two years is requested since managed care plans will continue to provide CBAS benefits to eligible beneficiaries after the Settlement Agreement and current Waiver expire in August 2014.

CBAS Stakeholder Process to Develop Waiver Amendment. DHCS and the California Department of Aging (CDA) convened a series of stakeholder meetings regarding CBAS beginning in October 2013 and concluding in April 2014. The purpose of these meetings is to provide interested parties an opportunity to provide input regarding the future direction of CBAS and recommendations for amending the CBAS provisions in the BTR Waiver, see below for a summary of the workgroup recommendations. DHCS and CDA propose to use the feedback from these meetings to develop the waiver amendment. Stakeholders have commented that these meetings have been comprehensive, transparent, and well-organized.

Summary of Stakeholder/Workgroup Recommendations:

- Delete obsolete provisions related to ADHC to CBAS transition.
- Continue access monitoring and streamline reporting requirements to CMS.
- Create new State Terms and Conditions/Standard Operating Procedures section clarifying plan/provider relationships.
- Retain language for fee-for-service grievances and appeals.
- Allow plan discretion regarding conducting of face-to-face eligibility determinations for individuals clinically appropriate.

- Allow authorization for up to 12 months as determined by plan to be clinically appropriate.
- Redesign the individual plan of care (IPC) form and revise references in waiver to reflect plan/provider collaboration on participant IPC development.
- Include references in waiver to care coordination.
- Correct waiver language regarding CBAS benefits.
- Allow planned growth of new CBAS centers.
- Retain unbundled services.
- Revise waiver quality assurance requirements.
- Address rate issues:
    - Allow plans to pay CBAS providers based on acuity
    - Restore rate
    - Establish new rate methodology
- Add statutory references to SOPs.
- Delete non-profit provider provisions.
- Give CDA authority to grant program flexibility.
- Allow payment for days of service less than four hours under defined circumstances.
- Revise SOP language regarding staffing and ADA.

In addition, as a result of this process, the following future workgroups were identified:

- Redesign the IPC.
- Explore issues with data capture and utilization.
- Develop a quality strategy.
- Address issues with the CBAS rate.
- Reform ADHC statutes and regulations.
- Address access and develop a plan/process for growth of new CBAS centers.
- Develop strategies for enhancing plan/provider relationships.

DHCS and CDA plan to submit the draft waiver amendment to the federal CMS in May and seek CMS approval prior to August 31, 2014.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal.

Questions.

1. Please provide an overview of this proposal.

2. Please provide an update on the CBAS waiver amendment development and the stakeholder process.

3. Does the Administration plan to codify the new CBAS waiver amendment? Please explain.

10. Family Health Estimate - CCS, GHPP, CHDP, EWC

Budget Issue. The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Children's Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts (EWC).

The costs of these programs specific to Medi-Cal enrollees are captured in the Medi-Cal estimate. As described below, the Administration is not proposing any substantial policy or fiscal changes to these four programs.

The overall Family Health Estimate shows a projected 3.7 percent decrease in funding in the proposed budget year, compared to the estimate for the current year. This decrease results from a decrease in costs in the CCS program, which reflects the transition of children from Healthy Families to Medi-Cal.

Table: Family Health Estimate Summary

Program	Budget Act 2013-14	Projected 2013-14	Proposed 2014-15	CY to BY $ Change	CY to BY % Change
CCS	$118,910,000	$131,966,000	$93,874,000	($38,092,000)	(29%)
CHDP	1,795,000	1,767,000	1,811,000	44,000	2.5%
GHPP	110,741,000	101,497,000	122,333,000	20,836,000	20.5%
EWC	52,619,000	52,696,000	59,142,000	6,446,000	12.2%
TOTAL	**$284,065,000**	**$287,926,000**	**$277,160,000**	**($10,766,000)**	**(3.7%)**

Background--California Children's Services (CCS). CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

Historically, CCS has served children who fit into three categories: 1) children in Medi-Cal; 2) children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal Estimate. Therefore, a reduction in costs associated with the decreasing number of children in the Healthy Families Program can be seen as an equivalent increase in CCS costs within the Medi-Cal budget.

CCS is administered as a partnership between county health departments and the DHCS. Historically, approximately 70 percent of CCS-eligible children were Medi-Cal eligible; their care is paid for with state-federal matching Medicaid funds. The cost of care for the other 30 percent of children had been split equally between "CCS Only" and "CCS Healthy Families." The cost of care for CCS-only is funded equally between the state and counties. The cost of care for CCS Healthy Families was, and continues to

be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

CCS Budget. Excluding Medi-Cal costs, the proposed 2014-15 CCS budget is $93.9 million ($17 million General Fund), as compared to the 2013-14 estimate of $132 million ($12.4 million General Fund). This $38 million reduction primarily reflects the transition of approximately 760,000 children from Healthy Families to Medi-Cal. This is not a savings for the state, but rather a cost shift from the CCS Healthy Families program to CCS Medi-Cal. Therefore, the Medi-Cal estimate includes an equivalent increase in cost (as the state continues to receive 65 percent FFP and 17.5 percent county funding for this population).

Table: CCS Budget Summary

	2013-14	**2014-15**
Non-Medi-Cal CCS		
CCS-Only	$90,022,000	$92,916,000
CCS Healthy Families	$41,944,000	$958,000
Total	**$131,966,000**	**$93,874,000**
Federal Funds	$119,594,000	$76,860,400
General Fund	$12,371,000	$17,013,600
Non-Medi-Cal Caseload	20,271	19,754
Medi-Cal Caseload	161,895	166,207

Background--Children's Health & Disability Program (CHDP). CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. CHDP oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, CHDP began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

CHDP Budget. The proposed CHDP budget includes $1.811 million ($1.8 million General Fund and $11,000 Childhood Lead Poisoning Prevention Fund), as compared to the current year estimate of $1.76 million ($1.75 million General Fund and $11,000 Childhood Lead Poisoning Prevention Fund).

Background--Genetically Handicapped Person's Program (GHPP). GHPP provides medical care for adults with specific genetically handicapping conditions. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added other medical conditions including

Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP Budget. The proposed 2014-15 GHPP budget includes total funds of $122.3 million ($63.6 million General Fund), compared to the 2013-14 estimate of $101.5 million ($17.3 million General Fund). This increase largely is a result of an expected increase in base costs and a decrease in the amount of the Special Rebate Fund that can be used in the budget year.

Table: GHPP Caseload

	2013-14	**2014-15**
GHPP State Only	967	987
GHPP Medi-Cal	723	755
Total	**1,690**	**1,742**

Background—Every Woman Counts (EWC). The EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage. The EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC Budget. The proposed 2014-15 budget includes $59.1 million ($21.4 million General Fund) for EWC, a $6.4 million (12 percent) increase over the 2013-14 estimate of $52.7 million ($18 million General Fund), which primarily reflects a full year of digital Mammography costs, as compared to only a half year in 2013-14.

CCS Carve Out. For many years, the CCS program has operated as a managed care "carve-out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve-out was approved through AB 301 (Pan), Chapter 460, Statutes of 2011, which extended the sunset on the carve-out until January 1, 2016. DHCS indicates that although the Administration did not include a specific proposal in this year's budget, they believe that the program would greatly benefit from various reforms. DHCS states that these reforms would not necessarily transition the program to managed care; however, the program would be operated within the framework of an "organized delivery system." DHCS states that a great deal of confusion results from the current program organization, given that children must leave their managed care networks in order to receive CCS services, and it becomes somewhat unclear if the state or the managed care organization holds fiscal responsibility for these services.

Update on CCS Pilots. One component of the 1115 Bridge to Reform Medi-Cal Waiver is to better coordinate care for children in CCS through four different pilot programs: Existing Managed Care Plans (MCO), Enhanced Primary Care Case Management (EPCCM), Specialty Health Care Plan (SHCP), and Provider-Based Accountable Care Organization (ACO). The pilots are aimed at improving health outcomes, improving cost-effectiveness, creating clearer accountability, improving satisfaction with care, and promoting timely access to care and family-centered care. All pilots eliminate the current Medi-Cal managed care carve-out for CCS children. Five counties were awarded grants to carry out the four pilots on October 12, 2011. Below is an update on these pilots:

- The Health Plan of San Mateo was implemented as an existing Managed Care Organization and began operations on April 1, 2013. There are approximately 1,500 enrolled CCS-eligible children who receive comprehensive health care under the umbrella of one organization. There is no longer a "carve-out" of CCS services through this demonstration.

- Rady Children's Hospital of San Diego (RCHSD) is working closely with the Department of Health Services (DHCS) to implement an Accountable Care Organization model CCS demonstration. Under this model, RCHSD will enroll children diagnosed with Hemophilia, Cystic Fibrosis, or Sickle Cell Disease. DHCS and Rady have continued to collaboratively identify and resolve operational challenges; progress has permitted DHCS to update the existing draft contract which will be reissued to Rady in the near future. While a projected date for operations to begin has not yet been determined, it is hoped that enrollments can begin during the fall of 2014.

- The remaining three demonstration locations have been in various stages of development but have lagged behind the Health Plan of San Mateo and RCHSD for a number of reasons. This situation has prompted DHCS to consider engaging stakeholders in discussions about alternative health care delivery models and improving quality of care for the CCS population. No decision has been made on a particular service delivery model, including managed care and will not be made until meaningful discussions with stakeholders' takes place. To this end, the DHCS is currently developing a stakeholder process.

According to DHCS, it has considered the challenges associated with the concept of testing various organized health care delivery models on a limited geographical basis and now believes that a statewide approach is advisable. There have been a number of statewide initiatives that have been developed and implemented by DHCS including the Coordinated Care Initiative, the Seniors and Persons with Disabilities to managed care population, the transition of the Healthy Families Program to Medi-Cal and the rural expansion of Medi-Cal managed care. According to DHCS, these initiatives involved complex sensitive issues from which it has gained much valuable experience. Consequently, DHCS indicates that it is in a unique situation to now pursue discussions about improving the CCS Program.

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

Questions.

1. Please provide an overview of the Family Health Estimate and each of its programs.

2. Please describe the department's plans for changing the CCS delivery model. Why does DHCS feel that it is necessary to change the CCS carve-out? How does DHCS plan to involve stakeholders in the discussions about changes to the CCS delivery model? Does DHCS have a timeline for this process?

3. Please provide an update on the CCS pilots. Given that only one pilot is operational, how does DHCS think that the experience in San Mateo can guide a statewide change in service delivery? Why would it be less challenging to transition all CCS children in the state to a coordinated delivery system than to implement pilot projects?

4. How can the Legislature assess what is the best model for these very fragile children with special health care needs without the benefit from pilot projects as was originally planned?

11. CA-MMIS Change Order Contract Exemption

Budget Issue. DHCS requests trailer bill language to establish an expedited contract process to exempt any California Medicaid Management Information System (CA-MMIS) Fiscal Intermediary (FI) contract amendments, modifications, and change orders from Public Contract Code requirements.

DHCS contends that this proposal would eliminate delays for DHCS seeking approval prior to implementing changes or requirements introduced by state legislation or federal laws and mandates while still remaining under the general programmatic and fiscal oversight of the California Department of Technology, the Bureau of State Audits, the federal Centers for Medicare and Medicaid (CMS), and the Department of Finance. This proposal does not exempt the department from the competitive bid process for awarding new FI contracts pursuant to Welfare and Institutions Code Section 14104.3.

Background. Approximately 8.3 million Medi-Cal beneficiaries receive health care services via the Medi-Cal program administered by DHCS. The CA-MMIS processes and pays approximately $17 billion a year in Medi-Cal fee-for-service health care claims to providers for medical care services provided to Medi-Cal beneficiaries, as well as the claims for other DHCS health care programs. In addition, it provides oversight and ensures the quality management process of Medi-Cal managed care payments. The FI, currently Xerox, operates and maintains the system as a contractor of DHCS. Each week, CA-MMIS, through Xerox, processes over four million claims and disburses on average $330 million to health care providers statewide.

DHCS is responsible for the overall administration, management, oversight, and monitoring of the FI contract with Xerox and all services provided under the contract. Other FI services include: the operation of a telephone service center and provider relations functions (publications, outreach, and training), system operations, updates and enhancements, processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. The FI is also responsible for planning, developing, designing, testing, and implementing a new replacement system to replace the current thirty year-old legacy system that will put into effect current technology and support a service-oriented architecture, consistent with the new federally mandated Medicaid Information Technology Architecture (MITA).

Under the existing Public Contract Code, contracts entered into pursuant to Welfare & Institutions (W&I) Code section 14104.3 must adhere to a contract process that is subject to Department of General Services (DGS) review and approval, State Administrative Manual & State Contracting Manual guidelines, and DGS purchasing laws and policies, including those for information technology. According to DHCS, the current administrative process puts DHCS at risk of delays in meeting federal requirements that could result in a loss of enhanced federal funding. Without the continued receipt of enhanced federal funding there may be a significant impact to the General Fund. The estimated 2014-15 cost of the FI contract is $250,541,000 ($60,828,000 General Fund).

DGS has acknowledged that the current FI change orders and contract amendments process do not fit within the standard DGS contract review parameters. Accordingly, DGS has expressed support for DHCS to pursue statutory changes necessary to allow for such contract exemptions, including an

exemption from DGS review. DGS has also reviewed DHCS's proposed language and is in agreement that it accomplishes the desired goal.

California State Auditor Letter on CA-MMIS. On February 25, 2014, the State Auditor sent a letter to the Governor and Legislature regarding its concerns with CA-MMIS. See table below for key concerns discussed in the letter and steps DHCS has taken to address these concerns.

Table: Summary of State Auditor Concerns and DHCS Action Steps

State Auditor Concerns	DHCS Action Steps
• Implementation of key functionality has been delayed. • Xerox's implementation of similar systems in other states has also been delayed.	• System replacement project switched from "waterfall" approach to "agile" approach to more quickly and frequently deliver and test enhancements and changes. • Modified project timeline to reflect new approach.
• Xerox has continued to experience significant staff turnover.	• Requested a corrective action plan to address staffing concerns. • Established a staffing dashboard to monitor staffing over time and at a more granular level.
• DHCS has not paid Xerox for any of its system replacement work.	• Phase I and Phase II requirements proposed to be submitted late April. If these are submitted, DHCS will make a payment.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to adopt the placeholder trailer bill language. No concerns have been raised regarding this proposal.

Questions.

1. Please provide an overview of this proposal.

2. Please provide a brief summary of the State Auditor's letter and DHCS's actions steps.

12. Non-Payment and Reporting of Provider-Preventable Conditions

Budget Issue. DHCS requests statutory authority to comply with federal rules that require states to report Provider Preventable Conditions (PPCs) and prohibit Medicaid (Medi-Cal) payment for costs of services related to PPCs. Specifically, proposed language would authorize DHCS to exclude from Medi-Cal coverage certain increases in charges billed to the Medi-Cal program that are directly related to the treatment of PPCs, and to recoup any payments made for those excluded charges. Proposed language would also require providers to report PPCs to the department as specified by the department.

Background. The Deficit Reduction Act of 2005 authorized the U.S. Department of Health and Human Services (HHS) to develop quality measures for the Medicare Program. HHS adopted national coverage determination policies (non-payment policies) for hospitals participating in Medicare for secondary diagnoses associated with a "hospital acquired condition" that was not present on admission. Previously, Medicare's national coverage determination policies prohibited payment for certain adverse events.

In March 2010, Section 2702 of the Affordable Care Act required HHS to prepare similar non-payment practices for Medicaid. The Centers for Medicare and Medicaid Services (CMS), issued its Final Rule, CFR, Title 42, Parts 434, 438, and 447, in June 2011, requiring states to institute non-payment practices and reporting for PPCs, which include "Other Provider-Preventable Conditions" and "Health Care-Acquired Conditions" as referenced below.

Other Provider-Preventable Conditions (to be applied in <u>all</u> health care settings):

- Wrong surgical or other invasive procedure performed on a patient,
- Surgical or other invasive procedure performed on the wrong body part, or
- Surgical or other invasive procedure performed on the wrong patient.

Health Care-Acquired Conditions (to be applied in inpatient hospital settings at a minimum):

- Foreign Object Retained After Surgery
- *Iatrogenic pneumothorax with venous catheterization*[3]
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma including Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns and Electric Shock
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection

[3] *Reflects new reporting requirement mandated by CMS effective July 1, 2012.*

- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
  - Coronary Artery Bypass Graft - Mediastinitis
  - Bariatric Surgery including Laparoscopic Gastric Bypass, Gastroenterostomy, and Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures of spine, neck, shoulder and elbow
  - *Cardiac implantable electronic device (CIED) procedures*[4]
- For non-pediatric/obstetric population, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) resulting from
  - Total Knee Replacement
  - Hip Replacement

As noted above, the exclusion from reimbursement of Other Provider-Preventable Conditions applies to all health care settings. To date, the exclusion from reimbursement of Health Care-Acquired Conditions is limited to services provided by inpatient hospitals, which reflects the minimum federal standard. This proposal would authorize DHCS to extend these non-payment provisions for Health Care-Acquired Conditions to additional care settings, as permitted under the federal rule, following notification and consultation with appropriate stakeholders.

Under existing state law, there is no specific authority that requires providers to report PPCs to the state, nor is there specific authority for DHCS to reduce or recoup Medi-Cal reimbursement for costs associated with PPCs. Without statutory authority, the state is at financial risk for both General Fund and federal funds claimed inappropriately for unreported PPCs.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to adopt the proposed placeholder trailer bill language with the clarification that prohibits the Medi-Cal enrollee from being billed for these procedures.

Questions.

1. Please provide an overview of this proposal.

[4] *Reflects new reporting requirement mandated by CMS effective July 1, 2012.*

4265 Department of Public Health (DPH)

1. California Reducing Disparities Contract Exemption

Budget Issue. DPH requests a statutory exemption from the Public Contract Code for the California Reducing Disparities Project (CRDP) that would allow DPH to complete the Strategic Plan (Phase I) and commence Phase II, a $60 million (Mental Health Services Act Funds) endeavor to implement and evaluate community-defined mental health practices.

Background. In 2009, the former Department of Mental Health (DMH) initiated seven CRDP contracts. Those published reports have culminated in a draft statewide Strategic Plan. The focus of the strategic plan is on improving the delivery of prevention and early intervention services for California's unserved, underserved, and inappropriately served communities. Once finalized, the plan will be the blue print for the DPH's design of Phase II Request for Proposals (RFPs) to commence the Mental Health Services Act (MHSA) funded, $60 million, four-year project to reduce mental health disparities.

The Legislature eliminated DMH (June 30, 2012) and moved functions and contracts to many state entities pursuant to AB 109 (Committee on Budget) Chapter 29, Statutes of 2011. DMH historically was granted authority under Welfare and Institutions Code 5897(e) for exemptions to the Public Contracting Code for MHSA funds. However, when DMH was eliminated and the CRDP contracts were transferred to the DPH in 2012, a technical oversight within trailer bill AB 1467 (Committee on Budget) Chapter 23, Statutes of 2012, resulted in the exemptions not transferring to DPH.

According to DPH, this statutory change would correct a technical oversight from the transfer of the CRDP from DMH to DPH. Because the CRDP is the first of its kind, the flexibility is needed to complete and implement the recommendations developed by diverse communities throughout the state. If this exemption is not provided, there will be delays to the phases of CRDP, and MHSA funds designated for local service providers would be delayed, ultimately impacting individuals from vulnerable communities in need of mental health services. In addition, the data regarding community-defined evidence and the robust evaluation component of CRDP Phase II will be delayed.

Table: CRDP MHSA Fund Projections for Phase I and Phase II (in thousands)

	2012-13	2013-14	2014-15	2015-16
	Phase I			
Carryover	-	-	-	-
Appropriated	$2,349	$2,201	$3,537	$3,537
Expenditures	2,280	1,510	3,537	3,537
Balance	$69	$691	-	-
	Phase II			
Carryover	-	$15,000	$30,000	$30,000
Appropriated	$15,000	15,000	15,000	15,000
Expenditures	-	-	15,000	15,000
Balance	$15,000	$30,000	$30,000	$30,000

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to adopt this placeholder trailer bill language. No concerns have been raised with this proposal.

Questions.

1. Please provide a brief overview of this proposal.

2. Health in All Policies Task Force

Budget Issue. The DPH requests $458,000 and four full-time permanent positions to staff the Health in All Policies Task Force (HiAP Task Force) in order to meet both statutory and Executive Order mandates. The source of this proposed funding includes: (1) $270,000 federal funds, (2) $120,000 Licensing and Certification Fund, (3) $27,000 Genetic Disease Testing Fund, and (4) $24,000 Radiation Control Fund.

Background. Executive Order SO-04-10 established the HiAP Task Force under the auspices of the Strategic Growth Council (SGC). The SGC coordinates state agencies to assist and support the planning and development of sustainable communities which strengthen the economy, ensure social equity and enhance environmental stewardship. The order directed the Task Force be facilitated and staffed by DPH.

DPH first collaborated with the University of California, San Francisco, and then with the Public Health Institute (PHI), to provide initial staffing with financial support from The California Endowment. In subsequent years, additional funding to support PHI staff came from the Kaiser Foundation and the American Public Health Association. DPH contributed in-kind support for office space and supplies, as well as a Public Health Medical Officer II in the Center for Chronic Disease Prevention and Health Promotion.

In March 2010, the SGC convened the HiAP Task Force, designating 19 California state agencies, departments, and offices to participate. Each designated agency, department, and office was asked to identify a representative who was familiar with the breadth of their agency's activities, connected to staff with in-depth expertise, empowered to speak on their agency's behalf, and able to engage agency leadership in discussions and decisions about the Task Force's work. By December 2010, the HiAP Task Force held public workshops which resulted in 11 priority recommendations to improve community health that were addressed in eight implementation plans. Implementation plans were commenced as they were approved by the SGC with two plans near completion and the last plan approved in the spring of 2012. The Task Force has employed myriad strategies to aggregate the evidence for action, coordinate administrative resources, educate the public and the state workforce involved with HiAP, develop guidance and provide oversight, management, and accountability for the project.

In July 2012, Health and Safety Code Section 131019.4 was added to provide statutory authority for the new Office of Health Equity in CDPH. Pursuant to statute, the Office of Health Equity is to work collaboratively with the HiAP Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health. The statutes further describe a variety of ways that the office is to build and inform the HiAP Task Force including:

- Develop intervention programs with targeted approaches to address health and mental health inequities and disparities.
- Prioritize building cross-sector partnerships within and across departments and agencies to change policies and practices to advance health equity.

- Work with the advisory committee and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, multi-sectoral strategies.

Many of the policies and programs that affect health and the social determinants of health originate outside the health sector (e.g., housing, education, community safety). Public health government agencies; therefore, need to address population health using a strategy that fosters intersectoral action.

In 2012-13, The California Endowment communicated that their funding priorities for the HiAP approach was shifting from state support to more local support, so it was likely that funding for PHI staff for the California HiAP Task Force would end after 2013-14.

Subcommittee Staff Comment and Recommendation—Hold Open. No concerns have been raised regarding support for the HiAP Task Force; however, the nexus between the proposed funding sources and the purpose of this task force is not clear. According to the authorizing statute the charge to OHE includes prioritizing the building of cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity. Additionally, this task force supports the work of 19 other state agencies, yet this proposal does not include any reimbursements from these other state agencies to support this work. It is recommended that the Administration provide additional sources of potential funding, by the May Revise, such as housing, education, workforce-related, and environmental sources in order to assure alignment of the funding and the purpose of this task force.

Questions.

1. Please provide an overview of this proposal.

2. Has DPH requested reimbursements from other state agencies to support this task force? If not, why not?

3. Suspension of Tuberculosis Control Mandate

Budget Issue. The Governor proposes to suspend the tuberculosis control (TB) mandate in 2014-15. The Commission on State Mandates Cost Estimate, adopted on September 27, 2013, put the average annual cost (three year period from 2008-09 through 2011-12) at $28,356 and the total cost to date (claims from 2002-03 to 2011-12) at $132,855. These amounts are based on claims submitted by three counties (Orange, San Bernardino, and San Francisco). The Administration does not have an estimate of the total potential statewide cost if retroactive claims were submitted, but the statewide annual cost would likely be less than $1 million.

The Administration contends that the procedures required under the TB control mandate are best practices and locals would continue to follow these procedures, even if they are not specifically reimbursed for them.

Background. TB is a contagious bacterial disease that is spread through airborne particles. DPH is the lead state agency for TB control and prevention activities. However, the primary responsibility for TB control resides with local health officers (LHOs). The LHOs have broad statutory responsibility to protect the public from the spread of TB.

The DPH provides about $6.7 million General Fund and about $4 million in federal funds to LHOs for TB control through a formula that is based on the number of TB cases in each jurisdiction.

On October 27, 2011, the Commission on State Mandates determined that the following TB control laws constitute state-reimbursable mandates:

1. **For LHOs.** Reviewing treatment plans submitted by health facilities within 24 hours of receipt and notifying the medical officer of a state parole region when there are reasonable grounds to believe that a parolee with TB has ceased TB treatment. (Health and Safety Code Section 121361(a)(2))
2. **For Local Detention Facilities.** Notifying and submitting a written treatment plan to LHOs when an inmate with TB is discharged and notifying the LHO and medical officer of the local detention facility when a person with TB is transferred to a facility in another jurisdiction. (Health and Safety Code Section 121361(e)(1))
3. **For Counties and Cities with Designated LHOs.** Providing counsel to non-indigent TB patients, who are subject to a civil detention order, for purposes of representing the TB patients in court hearings reviewing civil detention orders. (Health and Safety Code Section 121366)

Subcommittee Staff Comment and Recommendation—Hold Open. The LAO, Administration, and local health offers are in discussions about potential alternatives to suspending this mandate. It is recommended to hold this item open to continue these discussions to ensure that this important public health activity continues.

Questions.

1. Please provide an overview of this proposal and any updates on alternatives to this proposed mandate suspension.

4. Authority to Apply for Federal Grants

Issue. Concerns have been raised public health advocates that DPH has been reluctant to apply and/or reapply for federal grants because it finds that it does not have sufficient statutory authority to do so. In particular, concerns have been raised regarding the Wisewoman (a federal grant to address heart disease in women) and colorectal cancer federal grants.

DPH contends that it has sufficient statutory authority to apply for federal grants and cites:
Health and Safety Code Section 131085 (a), which reads: The department may perform any of the following activities relating to the protection, preservation, and advancement of public health:

(1) Studies.
(2) Demonstrations of innovative methods.
(3) Evaluations of existing projects.
(4) Provision of training programs.
(5) Dissemination of information.

(b) In performing an activity specified in subdivision (a), the department may do any of the following:

(1) Perform the activity directly.
(2) Enter into contracts, cooperative agreements, or other agreements for the performance of the activity.
(3) Apply for and receive grants for the performance of the activity.
(4) Award grants for the performance of the activity.

DPH acknowledges the concerns that have been raised and indicates that it does not foresee this problem in the future, but it has not provided any rationale or explanation as to why these concerns occurred in the first place.

DPH Technical Assistance. Given the concerns that have been raised, subcommittee staff requested technical assistance on trailer bill language that would provide clear authority for DPH to apply for federal grants within the purview of public health. DPH provided the following draft language as technical assistance:

Add Health and Safety Code 131058 as follows:

131058. The State Department of Public Health may investigate, apply for, and enter into agreements to secure, federal or non-governmental funding opportunities for the purposes of advancing public health, subject to the provisions of Section 13326 of the Government Code or applicable administrative review and approval of non-governmental funding opportunities.

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

Questions.

1. Please provide an explanation as to why DPH was at first reluctant to reapply for the Wisewoman and colorectal cancer federal grants.

2. Does DPH find that it has sufficient authority to apply for any new or existing federal grants that are related to public health?

5. State Dental Director - April Finance Letter

Budget Issue. A DPH April Finance Letter requests $474,000 ($250,000 General Fund and $224,000 in reimbursements, federal funds from the Department of Health Care Services) to establish a State Dental Director, add an epidemiologist, and provide related consulting services to re-establish a statewide dental health program.

The State Dental Director would guide the development of a statewide dental health plan and establish partnerships and coalitions to advance dental health throughout California. The epidemiologist would support this work.

The proposed consulting services include:

1. External Contracts: (a) California State University Sacramento College of Continuing Education for conference and training services for $26,000 and (b) California Epidemiologic Investigation Service Fellow - $43,000 to fund an epidemiologist-in-training to work under staff at DPH to assist with the proposed activities.
2. A Memorandum of Understanding with the Behavioral Risk Factor Surveillance System administrator (California State University) to add four dental questions regarding dental health for children, adolescents, and adults for $30,000.

Background. Current law (Health and Safety Code Sections 104750-104765) establishes authority for DPH to maintain a dental program that includes: (1) development of comprehensive dental plans, (2) consultation necessary to coordinate national, state, and local agency programs related to dental health, (3) program evaluation related to preventative services, (4) consultation and program information to health professions, health professional educational institutions, and volunteer activities, (5) establishment of a Dental Director, and (6) authority to receive funds to establish a State Dental Program.

However, DPH has limited funding dedicated to the purposes described above and currently only provides $213,000 (through a federal grant) to promote drinking water fluoridation. DPH also serves as a fiscal intermediary for a federal oral health workforce development grant to the University of the Pacific that ends September 2014.

Tooth decay is the most common chronic condition in children. In 2006, 54 percent of kindergarten children and 71 percent of third graders in the state had tooth decay. In addition, low-income and minority children suffer disproportionately from dental tooth decay.

With these resources, DPH proposes to develop a Dental Burden of Disease (Burden) report which would help identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden. The Burden report would be the foundation for the development of the State Dental Plan (Plan). The Plan would serve as the roadmap for California's short-term, intermediate, and long-term priorities, goals, and objectives to address dental disease burden and prevention.

DPH proposes the following implementation timeline:

- By October 2014, establish DPH's Dental Team (State Dental Director, epidemiologist, and develop and execute consulting contracts)
- By December 2014, establish an Advisory Committee and Coalition
- By December 2014, establish the Dental Program Website
- By March 2015, publish the Dental Burden of Disease Report
- By June 2015, publish the State Dental Plan

DPH indicates that it has been working to identify appropriate classifications, prepare duty statements, and consider the need for exams in order to be prepared to start the recruiting process upon approval of the state budget. In addition to the standard job posting, DPH will conduct an aggressive recruiting campaign. DPH will work with public health programs and the state dental association to assist with recruiting efforts. Job announcements will also be posted on the Association for State and Territorial Dental Directors national list serve, California Dental Association job listings, and other job postings for dental public health programs such as the American Association for Public Health Dentistry.

Rationale for Dental Director at DPH. According to DPH, state public health departments are uniquely qualified with epidemiological expertise to define and monitor the oral disease burden throughout the state and to provide the statewide oral health professional leadership to plan and develop statewide strategies to reduce the burden of disease. DPH is positioned to collect statewide oral health surveillance data through unique data sources, leverage and integrate with health department components, such as other chronic disease programs, develop and implement statewide policy and programmatic strategies that cut across multiple chronic conditions, and to share support of complementary activities.

DPH would provide leadership for oral health initiatives, and would have access to statewide partnerships such as the state dental association, public health organizations, etc. Specific public health focus areas include statewide surveillance of oral disease, reporting the burden of disease, facilitating the development and implementation of a statewide oral health coalition and state oral health plan, coordination with other chronic disease and maternal and child health programs, development of statewide dental sealant programs, and community water fluoridation coordination, as well as management of program capacity and infrastructure to sustain a state oral health program within DPH.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as no issues have been raised. This proposal is an important step in addressing oral health in the state.

Questions.

1. Please provide an overview of this proposal.

2. What public health outcomes would DPH expect as a result of this proposal? How does DPH plan to measure whether or not these outcomes have been achieved?

3. How will the Dental Director coordinate and work with the Department of Health Care Services to improve Medi-Cal dental services utilization and quality?

0530 Secretary for Health and Human Services Agency

1. Overview and State Only Health Programs

Background. The primary mission of the Health and Human Services Agency (HHSA) is to provide policy leadership and direction to the departments, boards, and programs it oversees, to reduce duplication and fragmentation among HHSA departments in policy development and implementation, to improve coordination among departments on common programs, to ensure programmatic integrity, and to advance the Governor's priorities on health and human services issues.

The HHSA accomplishes its mission through the administration and coordination of state and federal programs for public health, health care services, social services, public assistance, health planning and licensing, and rehabilitation. These programs touch the lives of millions of California's most needy and vulnerable residents. The HHSA states that it is committed to striking a balance between the twin imperatives of maintaining access to essential health and human services for California's most disadvantaged and at-risk residents, while constantly pursuing ways to better manage and control costs.

The following departments and entities fall under the purview of the HHSA:

- Department of Aging
- Department of Child Support Services
- Department of Community Services and Development
- Department of Developmental Services
- Emergency Medical Services Authority
- Department of Health Care Services
- Department of Public Health
- Department of Rehabilitation
- Department of Social Services
- Department of State Hospitals
- Office of Statewide Health Planning and Development
- Managed Risk Medical Insurance Board

Table: California Health and Human Services Agency Secretary Budget Summary (dollars in thousands)					
Fund Source	**2012-13 Actual**	**2013-14 Projected**	**2014-15 Proposed**	**BY to CY Change**	**% Change**
General Fund	$2,568	$3,142	$3,115	(27)	(0.9%)
Federal Trust Fund	1,685	4,333	3,643	(690)	(15.9)
Reimbursements	2,919	3,642	3,282	(360)	(9.9)
Internal Health Information Integrity Quality Improvement Account	-	25	25	-	-
California Health Information Technology and Exchange Fund	7,119	21,000	9,798	11,202	53.3
Office of Patient Advocate Trust Fund	2,110	2,731	2,741	(10)	(0.4)
Office of Systems Integration Fund	262,391	-	-	-	-
Central Service Cost Recovery Fund	839	819	849	30	3.7
California Health and Human Services Automation Fund	-	318,118	246,655	(71,463)	(22.5)
Total Expenditures	**$279,631**	**$353,810**	**$270,108**	**$83,702**	**23.7%**
Positions	210.2	250.7	257.7	7.0	2.8%

Transition of State Health Programs with Implementation of Federal Health Care Reform. The Administration does not have a proposal or plan to consider how to enroll eligible individuals in state health programs into comprehensive coverage through Covered California or Medi-Cal. HHSA indicates that it is focusing on getting health care reform stabilized before it develops mechanisms to easily enroll individuals in state health programs into comprehensive coverage.

LAO Comments and Findings. The LAO has no concerns regarding HHSA's budget. However, the LAO finds that the budget does not assume caseload decreases in some smaller state health programs such as the Breast and Cervical Cancer Treatment Program (BCCTP)—or funded primarily with state funds (also known as state-only programs), such as the Genetically Handicapped Person Program, which have traditionally provided coverage to individuals who may not qualify for full-scope Medi-Cal and who may not have private health insurance. Under the Affordable Care Act (ACA), some of the individuals who would have otherwise enrolled in these programs will likely obtain coverage through the optional Medi-Cal expansion or Covered California—thereby likely decreasing caseload in these programs. In some programs, such as the AIDS Drug Assistance Program, the budget adjusts for savings associated with reduced caseload under the ACA. In other programs, the budget does not adjust for likely caseload declines. See following table for a list of these programs.

Consequently, the LAO recommends the Legislature direct the Administration to report in budget hearings on the following: (1) the existing state health programs that are likely to experience caseload declines under the ACA; (2) factors that would limit any potential decline in caseload and costs in these programs, such as a substantial portion of enrollees who continue to be ineligible for Medi-Cal or

subsidized coverage through Covered California; and (3) the Administration's timeline for making adjustments to the budgets of these programs.

Table: LAO Summary Chart of State-Only Health Programs

Figure 6

State Health Programs Affected or Potentially Affected by the ACA[a]

Program	Major Eligibility Criteria[b]	Description of Services
Prostate Cancer Treatment Program	• Age 18 or older. • Income up to 200 percent FPL. • No other health coverage.	Prostate cancer treatment, patient education, and case management/patient navigation.
Every Woman Counts	• Female. • Income up to 200 percent FPL. • Services not covered by health coverage or coverage has high deductible/copayment.	Comprehensive breast and cervical cancer screening and diagnostic services, clinical follow-up, and tailored health eduction.
Breast and Cervical Cancer Treatment Program	• In need of treatment for breast or cervical cancer. • Income up to 200 percent FPL. • No other health insurance. • State-only program for individuals: (1) without satisfactory immigration status, (2) with high cost health insurance, and (3) females 65 years or older.	Full-scope coverage for individuals who meet federal eligibility criteria; cancer treatment and cancer-related services for individuals in state-only portion of the program.
Genetically Handicapped Persons Program	• Generally over age of 21. • Diagnosis of an eligible genetic condition. • No income limit. • State-only program for Medi-Cal-ineligible persons.	Medically necessary services, including case management services, regardless of whether services are related to qualifying medical condition.
Major Risk Medical Insurance Program	• Persons unable to obtain private health insurance because of a pre-existing medical condition.	Health coverage, including preventative care, hospital care, physician visits, and drugs.
Access for Infants and Mothers Program	• Pregnant women. • Income 200 percent to 300 percent FPL. • No health coverage or coverage has maternity-only deductible or copay greater than $500.	Comprehensive benefits, including pregnancy and non-pregnancy related services.
AIDS Drug Assistance Program	• HIV-infected. • Over age 18. • Income up to $50,000. • Lack health coverage that covers the medications.	HIV/AIDS medications.
Medi-Cal 200 Percent FPL Pregnant Women	• Pregnant women. • Income at or below 208 percent FPL.	Pregnancy related and 60-day post partum services.[e]
Medi-Cal Medically Needy Share-of-Cost Families	• Pregnant women, parent/caretaker relatives, and children. • No income limit, but income determines share-of-cost amount. • Asset test.	Full-scope Medi-Cal once share-of-cost has been met.
Family Planning, Access, Care, and Treatment	• Income up to 200 percent FPL. • No other source of health care coverage for family planning, or meet other specified criteria.	Family planning and reproductive health services.
California Children's Services (CCS)[c]	• Under age 21. • Diagnosed with CCS-eligible medical condition. • State-only program for children ineligible for Medi-Cal with family income less than $40,000 per year or estimated annual cost of care that exceeds 20 percent of family income.	Pediatric specialty and subspecialty health care, case management, and care coordination; school-based therapy services available regardless of family income.
Qualified aliens inside the five-year bar[d]	• Qualified aliens who otherwise meet Medi-Cal eligibility requirements, but who have been legally residing for less than five years and, thus, do not qualify for federal matching funds.	Full-scope Medi-Cal .

[a] Includes programs that provide services to individuals who became newly eligible for Medi-Cal or federally subsidized coverage on Covered California beginning January 1, 2014.
[b] Citizenship and immigration status requirements may also differ between programs, but are generally not included in this Figure.
[c] Reflects spending for state-only portion of the program.
[d] Qualified aliens inside the five-year bar from 0 percent to 400 percent FPL are eligible for federally subsidized coverage on Covered California.
[e] Certain qualified aliens inside the five-year bar qualify for federal matching funds. This spending number reflects costs for qualified aliens inside the five year bar who do qualify for the match and those who do not.

TF=total funds; GF=General Fund; and FPL=Federal Poverty Level.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the state health programs.

Questions.

1. Please provide an overview of HHSA's departments and budget.

2. What is the Administration's plan for moving eligible individuals in state health programs into comprehensive coverage through Covered California, at open enrollment, and Medi-Cal?

2. Office of Patient Advocate

Oversight Issue. HHSA has not fully implemented AB 922 (Monning), Chapter 522, Statutes of 2011, regarding the Office of Patient Advocate (OPA).

The intent of AB 922 was to develop a robust response system to address consumer questions and grievances about the health care system and to provide for much needed, clear and understandable consumer information and assistance by expanding and strengthening current programs operating at the local level. OPA has not used the authority provided in AB 922 to develop this robust system.

For example, in the fall of 2013, OPA released its planned activities for 2014. This plan did not include key components of AB 922 such as providing direct consumer assistance and subcontracting with community-based organizations to provide individualized assistance.

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

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

1. Publicly report and analyze aggregate data on consumer complaints regarding health coverage.

2. Render assistance to consumers regarding problems with their health care coverage or services, including assistance with procedures, rights, and responsibilities related to the filing of complaints, grievances, and appeals.

3. Develop protocols and procedures for assisting in the resolution of consumer complaints, including the referral of complaints to the appropriate regulator or health coverage program.

4. Develop, in consultation with specified health coverage programs, education and informational guides to be made available to the public online and through public outreach and education programs.

5. Provide outreach and education about health care coverage options and coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform.

6. Operate a toll-free telephone number that can route callers to the proper regulating body or public program, their health plan, or local consumer assistance program.

7. Operate an Internet website, social media, and up-to-date communication systems to provide information regarding consumer assistance programs.

Complaint Data Reporting. The 2013-14 budget included an augmentation of $184,000 (Office of Patient Advocate Trust Fund) and one two-year limited-term position to develop a Complaint Data Reporting System, as required by AB 922. This included $67,000 for ongoing technical/statistical support from the National Committee for Quality Assurance and $12,000 to cover expenses associated with the design, translation, printing, promotion, and dissemination of the annual complaint reports and annual stakeholder preview sessions. It is anticipated that by the summer of 2014, submission of complaint data by the Department of Managed Health Care (DMHC), Department of Insurance (CDI), Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), and the California Health Benefit Exchange (Exchange) will commence and that the first complaint report will be issued in the summer of 2015.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. Senate legislative staff and HHSA have been working on placeholder trailer bill language to ensure a consumer assistance program. It is recommended to adopt this placeholder trailer bill language that:

1. Revises the responsibilities of the OPA to clarify that it is not the primary source of direct assistance to consumers

2. Clarifies OPA's responsibilities to track, analyze, and produce reports with data collected from calls, on problems and complaints by, and questions from, consumers about health care coverage received by health consumer call centers and helplines operated by other departments, regulators or governmental entities.

3. Requires OPA to make recommendations for the standardization of reporting on complaints, grievances, questions and requests for assistance.

4. Requires the OPA to develop model protocols, in consultation with each call center, consumer advocates and other stakeholders that may be used by call centers for responding to and referring calls that are outside the jurisdiction of the call center or regulator.

5. Shifts funding to the Department of Managed Health Care to supplement contracts with community-based organizations to provide direct consumer assistance.

Questions.

1. Please provide an update on AB 922 implementation activities.

2. Please provide an overview of the proposed placeholder trailer bill language.

3. CalOHII – HIPAA Compliance - April Finance Letter

Budget Issue. The California Office of Health Information Integrity (CalOHII) requests $750,000 ($375,000 General Fund and $375,000 reimbursements) for consulting services on a two-year limited-term basis. CalOHII indicates that this request would help ensure that state departments would meet data interoperability and expanded Health Insurance Portability and Accountability Act (HIPAA) requirements. (The reimbursements are federal Medicaid funds.)

Background. Division 110 of the Health and Safety Code, known as the Health Insurance Portability and Accountability Act of 2001 specifies CalOHII's responsibilities and authority including:

- Statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation by impacted state departments;
- Full authority to establish policy and provide direction to state entities, monitor progress, and report on HIPAA implementation efforts; and
- Responsibility for determining which provisions of state law concerning personal health information are preempted by HIPAA for state agencies.

The federal government continues to issue new updates to existing HIPAA regulations and there are five compliance deadlines that must be met in the next two years. The federal government utilizes HIPAA to govern the standards, including security requirements, associated with efforts to enable electronic movement of health data. It is expected that with implementation of the Affordable Care Act the federal government will be issuing and modifying HIPAA rules. Some of these include HIPAA Certification Part 2 which will take effect December 2015, Operating rules in January 2016, and the Health Plan Identifier rule with compliance date in 2016.

Below is a chart of HIPAA impacted or HIPAA covered entities. "HIPAA impacted" means they are not considered covered entities but they have business/program functions that require they comply with HIPAA requirements in order to conduct business with other HIPAA covered entities.

Table: CalOHII's Existing HIPAA Oversight Responsibilities

CURRENT COVERED & IMPACTED ENTITIES	COVERED ENTITIES				IMPACTED ENTITIES		
	Health Care Provider	Health Care Plan	Health Care Clearinghouse	Hybrid Entity	Business Associate	Trading Partner	Impacted by Data Content
Aging, Department of		X		X	X	X	X
Controller, California State					X	X	X
Corrections and Rehabilitation, Department of (PIA Optical only)	X					X	X
Corrections and Rehabilitation, Department of (all except PIA Optical)						X	X
Developmental Services, Department of	X		X	X	X	X	X
Emergency Medical Services Authority						X	X
Employment Development Department							X
Forestry and Fire Protection, Department of	X			X	X		X
Health Planning and Development, Office of Statewide							X
Health Services, Department of	X	X			X	X	X
Industrial Relations, Department of						X	X
Insurance, Department of					X	X	X
Managed Health Care, Department of							X
Managed Risk Medical Insurance Board		X				X	X
Human Resources, Department of		X			X	X	X
Public Employees' Retirement System		X		X		X	
Public Health, Department of	X	X				X	
Social Services, Department of					X		
State Hospitals, Department of	X	X			X	X	X
Veterans Affairs, Department of	X	X				X	X
TOTAL IMPACTED ENTITIES	**7**	**8**	**1**	**4**	**10**	**15**	**18**

On April 1, 2014, CalOHII issued a reassessment document to all state departments within the Executive Branch to determine which additional departments are impacted or covered by HIPAA. Those results will be collected and a report will be prepared in May 2014. With the expansion of HIPAA in the Omnibus Rule, CalOHII projects the HIPAA impacted departments to increase.

The table below is a *projection* of the expansion of CalOHII's oversight responsibilities that will be confirmed with the pending reassessments.

Table: Projected Expansion of CalOHII's HIPAA Oversight Responsibilities

PROJECTED COVERED & IMPACTED ENTITIES	COVERED ENTITIES				IMPACTED ENTITIES		
	Health Care Provider	*Health Care Plan*	Health Care Clearinghouse	Hybrid Entity	Business Associate	Trading Partner	Impacted by Data Content
Correctional Health Care Services, California	X						
CDCR, PIA Optical and Dental				X			
Inspector General for Veteran Affairs, Office of					X		
Managed Health Care, Department of							X
Victims Compensation & Government Claims Board							X
Youth Authority, Department of							X
TOTAL IMPACTED ENTITIES	**1**			**1**	**1**		**3**

HIPPA Compliance Review. CalOHII conducts the following steps for its HIPAA compliance reviews of state departments:

- On-site compliance reviews with a Subject Matter Expert auditor for each HIPAA rule.
- Field visits to institutions, satellite offices or other department facilities as necessary including statewide travel.
- Large departments and complex programs will require multiple visits or audits.
- A dashboard report based on defined performance measures is provided.
- Final reports identify deficiencies and best practices and do the following:
    - Identify compliance level for all requirements
    - Identify deficiencies and best practices
    - Make recommendations on corrective action plan (CAP)/prevention
    - Identified deficiencies are shared with Executive Management and Agency.
- Assistance to develop corrective action plans and monitor progress is provided through on-going technical assistance to bring departments into compliance.
- Conduct follow-up reviews of departments with a CAP to validate deficiencies are eliminated and full compliance is achieved.

Purpose of Request. This proposal would fund three contracts. Each of these contracts would cost $250,000.

1. **Compliance Audits Infrastructure –** This contract includes:
   - Development of an audit tool for compliance reviews.
   - Development of performance measures and dashboard for compliance with applicable state and expanded federal health information privacy and security, transactions and code sets, unique identifiers, and patient rights laws.

   This contract will address all HIPAA rules and compliance deadlines. State entities are required to comply with federal and state laws and regulations regarding patient privacy, information security, patient access rights, unique identifiers, and standardizing electronic transactions and codes. This contract will define the infrastructure to conduct compliance audit / reviews of each department's implementation of the rules.

2. **Compliance Audits –** This contract includes:
   - Compliance audits (approximately 5-7 departments).
   - Draft final reports to identify deficiencies and best practices.
   - Development of corrective action plans and monitor progress. Provide compliance technical assistance to departments.

   CalOHII is mandated by Health and Safety Code sections 130300 *et seq*. to create state policy that ensures compliance with these laws, determine which or if both federal and state laws apply. CalOHII also has jurisdiction over all HIPAA affected state entities and has responsibility for statewide leadership, coordination, direction and oversight for HIPAA implementation and compliance. In order to fully achieve compliance with CalOHII's mandated scope one uniform statewide policy manual for all impacted state entities is in development. This contract will produce tools to be included in the policy manual for assisting departments in self-monitoring the achieving of compliance.

3. **Statewide Health Information Policy Manual –** This contract includes:
   - Finalization of the Statewide Health Information Policy Manual.
   - HIPAA Subject Matter Expertise.

   The compliance audit / reviews for impacted state departments will be based on the new State Health Information Policy Manual for state agencies. The policies outlined in this manual are based on all applicable requirements outlined in both state and federal health information laws and regulations. This methodology will allow for consistent standard interpretation and application of federal and state laws and regulations across all state agencies.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this request.

Questions.

1. Please provide an overview of this proposal and CalOHII's role in regard to HIPAA compliance.