California State Assembly

Second Extraordinary Session
PUBLIC HEALTH AND
DEVELOPMENTAL SERVICES COMMITTEE

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BACKGROUND

Thursday, July 9, 2015
Upon adjournment of Floor Session -- State Capitol, Room 4202

Informational Hearing:

Supporting and Enhancing California's Medi-Cal and Developmental Services Programs

Introduction.

In the wake of the enactment of fiscal year (FY) 2015-16 State Budget, Governor Jerry Brown issued a proclamation that called for two Extraordinary Sessions, often referred to as a special session, of the Legislature. The second special session is devoted to matters pertaining to Medi-Cal and services for people with developmental disabilities.

Section 3 of Article 4 of The California Constitution vests the Governor with the power, in extraordinary occasions, to call the Legislature into special session. The special session can only legislate on those topics in the Governor's proclamation. A copy of the Governor's proclamation is contained in Appendix A. The proclamation calls the Legislature to assemble for the following purposes:

- To consider and act upon legislation necessary to enact permanent and sustainable funding from a new managed care organization tax and /or alternative fund sources to provide:
    - At least $1 billion annually to stabilize the General Fund's costs for Medi-Cal;
    - Sufficient funding to continue the 7% restoration of In-Home Supportive Services hours beyond 2015-16; and,
    - Sufficient funding to provide additional rate increases for providers of Medi-Cal and developmental disability services.
- To consider and act upon legislation necessary to:
    - Establish mechanisms so that any additional rate increases expand access to services; and,

- Increase oversight and effective management of services provided to consumers with developmental disabilities through the regional center system; and, Improve the efficiency and efficacy of the health care system, reduce the cost of providing health care services, and improve the health of Californians.

In response, the Assembly created three special session committees. This Committee, the Public Health and Developmental Services Committee, will be the policy committee for the special session. The Committee has an ambitious schedule of hearings. After this first hearing, the Committee will have two informational hearings during the week of August 17th. One will focus on the Medi-Cal program and the other on developmental services, in particular the issues that are the subject of the special session. These hearings will have stakeholder witnesses and ample time for public comment. After the informational hearings, the Committee will be ready to hold bill hearings to consider special session legislation.

As the one policy committee for the breadth of special session issues, the jurisdiction of the committee will be broad. It is not a reconstituted regular session committee. Given the committee's breadth, many members and staff will be less familiar with the issues the committee it slated to address. As a result, this hearing is being set up as an introductory and educational session. There will not be any public comment or testimony taken at this first hearing. The purpose of the hearing is intended to provide the Members of the Committee with the background information necessary to consider and act upon the issues of the special session. As noted above, the Committee is seeking public comment at its subsequent hearings.

The Lanterman Act.

The Lanterman Developmental Disabilities Services Act, which was enacted in 1977, guides the provision of services and supports for Californians with developmental disabilities. Each individual under the Act (typically referred to as a "consumer") is legally entitled to treatment and habilitation services and supports in the least restrictive environment possible. Lanterman Act services are designed to enable all consumers to live more independent and productive lives in the community.

The term "developmental disability" is defined in statute as a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. It includes intellectual disabilities, cerebral palsy, epilepsy, and autism spectrum disorders. It also includes disabling conditions that are closely related to intellectual disabilities or require treatment, care, and management similar to what is required for individuals with an intellectual disability. Included conditions must occur before age 18, result in a substantial handicap, be likely to continue indefinitely, and involve brain damage or dysfunction (conditions that are solely psychiatric or physical in nature are excluded).

Passage of the Lanterman Act marked the beginning of California's shift from a model of care that relied on institutional placement to one that focused on providing services and supports at home or in other community-based settings, and it was followed by a number of federal and state legal decisions, as well as administrative and legislative initiatives, which reinforced the new entitlement to services. Of particular note was the 1994 settlement agreement reached in the William Coffelt et. al. v. the California Department of Developmental Services (DDS), et. al. class-action lawsuit to develop additional community placement options and reduce the population of individuals in institutions by 2,000 within five years. Five years later, the U.S. Supreme Court ruled in Olmstead vs LC (527 U.S. 581 (1999)) that a lack of community supports was not legal grounds for denying people with disabilities a move from an institution into a community setting if they could benefit from community placement. The court ruled that such a denial constituted a violation of individual civil rights, as well as discrimination under the Americans with Disabilities Act. In California, 10 years after the Olmstead decision, Capitol People First et al. v DDS, et al. resulted in a settlement in which DDS and the regional centers agreed to develop additional community living options and establish new practices to ensure the Lanterman Act's promise of services in the least-restrictive environment would be maintained.

Regional Centers.

Direct responsibility for implementation of the Lanterman Act service system is shared by DDS and 21 regional centers. Regional centers are private nonprofit entities established pursuant to the Lanterman Act that contract with DDS to carry out many of the state's responsibilities under the Act. The primary duties of regional centers include intake and assessment, individualized program plan development, case management, and securing services through generic agencies (e.g., school districts, In-Home Supportive Services) or purchasing services provided by vendors. Regional centers also share responsibility with local education agencies for the provision of early intervention services under the California Early Intervention Services Act (e.g., Early Start Program). In 2015-16, funding for DDS is $5.9 billion (General Fund/federals fund).

Regional centers contract with a network of local providers that are authorized to receive state and federal funding by becoming vendors of the local regional center. Prior to being approved to receive funding from a regional center for providing services to a consumer, a service provider must become vendored by the regional center that oversees the catchment area in which the provider is located. This "vendorization" process includes verifying that the provider is qualified to provide the planned services and meets all other regulatory standards and requirements. It is important to note that vendorization makes a provider eligible to provide services paid for by the regional center, but does not guarantee the regional center will refer consumers. Furthermore, there is nothing precluding a vendor from being vendorized by more than one regional center. There are over 45,000 vendors that provide services paid for by regional centers in California.

Services provided to people with developmental disabilities are determined through an individual planning process, which is coordinate by regional center case managers. Within this process,

planning teams—which include, among others, the consumer, his or her parent(s) or other legally authorized representative, and one or more regional center representatives—jointly prepare an Individual Program Plan (IPP) based on the consumer's needs and choices. The Lanterman Act requires that the IPP promote community integration and maximize opportunities for each consumer to develop relationships, be part of community life, increase control over his or her life, and acquire increasingly positive roles in the community. The IPP must give the highest preference to those services and supports that allow minors to live with their families and adults to live as independently as possible in the community.

The regional center caseload includes over 280,000 individuals who receive services such as respite care, transportation, day treatment programs, residential placements, behavioral therapies, independent and supported living, supported employment, and numerous other social and therapeutic activities and services. Another 10,000 individuals are within the "diagnosis and evaluation" phase of their respective regional centers, half of which are children under three years of age.

According to DDS data, 60% of the regional center population is between 18 and 61 years of age; about two-thirds of all consumers have an intellectual disability, just over 30% are diagnosed with autism or a related disorder; and nearly 18% are identified as having severe behaviors. As of April 2015, around 77% of consumers live in their own home with a parent or guardian, and nearly 25,000 (8.9%) receive independent living or supported living services. As of July 1, 2015, there are 1,077 regional center consumers who reside at one of California's three developmental centers (Porterville, Sonoma, and Fairview) and one state-operated, specialized community facility (Canyon Springs). These facilities provide 24-hour habilitation and medical and social treatment services. While some residents in these facilities were voluntarily placed by relatives and conservators due to acute medical needs and other special needs that made it unsafe for them to live in the community at the time of placement, other residents have experienced involuntary placements due to court orders (e.g., forensic placements at Porterville Developmental Center within the secured treatment unit).

The state's regional centers vary considerably in size and organization, from Redwood Coast Regional Center, which serves the smallest caseload at almost 3,500 consumers all the way to Inland Regional Center, with a caseload of 30,000. Additionally, while some regional center catchment areas are geographically expansive, others provide services alongside many other regional centers, often due to higher, more concentrated populations. For example, Inland Regional Center, with the highest caseload for a single regional center, covers San Bernardino and Riverside Counties, whereas neighboring Los Angeles County includes seven regional center catchment areas, which together serve over 87,500 consumers.

Regional Center Rates.

Current statute and regulations set forth rate requirements for regional centers to adhere to when contracting with vendors to provide services to consumers. There are different types of rates for

services provided in different settings, many of which are negotiated between regional centers and vendors and are subject to a cap as a result of the state's cost-containment efforts over the past several years. July 1, 2008 marked the original implementation date for statewide and regional center median rates, with a requirement that regional centers do not negotiate rates higher than the lower of the two median rates for services. Each regional center is required to annually certify to DDS its median rate for each negotiated rate service, which DDS verifies during its biennial fiscal audit of the regional center. Despite the median rate cap, a regional center can obtain a rate increase from DDS under a "health and safety exemption" for a particular consumer if the regional center can demonstrate the exemption is necessary to maintain his or her health and safety. Most recently, FYs 2014-15 and 2015-16 Budget trailer bill provisions allowed for provider rate increases to address new state minimum wage requirements and sick leave benefits. A brief overview prepared by the Legislative Analyst's Office (LAO) for this hearing will provide additional information related to regional center rate methodologies and a recent history of provider rate cuts.

Medi-Cal—California's Largest Health Program.

The Medi-Cal program provides health care services to 12 million low-income Californians. Medi-Cal is administered by the Department of Health Care Services (DHCS), and the federal Centers for Medicare and Medicaid Services (CMS) oversees the program to ensure compliance with federal law. Medi-Cal has seen marked changes in recent years. The number of individuals enrolled in California's Medi-Cal program has almost doubled in a very short period, increasing from 6.6 million in 2007–08 to 11.9 million in FY 2014-15.

Medi-Cal provides health care services to aged, disabled, and low-income Californians through two different delivery systems—fee-for-service (FFS) and managed care. Under the FFS system, beneficiaries can receive medical services from any health care provider who participates in Medi-Cal—the provider is reimbursed for the services delivered. Under managed care, the beneficiary receives medical services through a single provider selected from within the proper Medi-Cal Managed Care Health Plan's network of primary care physicians. Both DHCS and the Department of Managed Health Care (DMHC) assess each health plan's ability to serve enrollees.

Of the 12.2 million people expected to be enrolled in Medi-Cal in FY 2015-16, 73% will be in Medi-Cal managed care plans (8.9 million people) and 27% (3.2 million people) will be in Medi-Cal FFS. Although California was a pioneer in enrolling beneficiaries in managed care and within the last 10 years the proportion in managed care has grown very rapidly.

Medicaid (Medi-Cal in California) is a cooperative federal-state program, and in order to qualify for federal funds, states must submit their Medicaid plan and any amendments to CMS. CMS looks at the states' plans to determine, in part, if there are enough providers to ensure that care and services are available under their plan, at least to the extent that such care and services are available to the general population in the geographic area.

The LAO 2014-15 analysis of the State Health Budget reviewed DHCS' baseline analysis and quarterly monitoring reports. The LAO came away with numerous concerns about the quality of the DHCS data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on FFS 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 FFS system. The LAO specifically cited inflated estimates of available FFS physicians, and a flawed construction and interpretation of enrollee-to-physician ratios that failed to take into account physicians accepting new patients.

Medi-Cal Managed Care.

Medi-Cal managed care rates are also set under state and federal requirements. Managed care is the predominant form for delivering Medi-Cal services. Almost 80% of Medi-Cal beneficiaries are enrolled in Medi-Cal managed care. State law requires DHCS to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods. Medi-Cal managed care plans must provide DHCS with financial and utilization data to establish rates. Capitation rates are a lump sum amount paid to the managed care plan to provide health care services to those that are enrolled. Capitation generally transfers financial risk for the care from DHCS to the managed care plan and is generally thought to provide an incentive for effective treatment and, in particular, an incentive against unnecessary treatment. Federal regulations for Medicaid managed care plans require all payments under risk contracts (such as to Medi-Cal managed care plans) and all risk-sharing mechanisms in contracts to be actuarially sound.

For enrollees of Medi-Cal managed care plans, DHCS has requirements for network adequacy in existing law, regulation, contracts with health plans, and through All Plan Letters issued by DHCS. For example, DHCS contractually requires Medi-Cal managed care plans to abide by the time and distance standards in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). The Knox-Keene Act is the body of law regulating health plans.

In addition, the Knox-Keene Act requires Medi-Cal managed care plans to make all services readily available at reasonable times to each enrollee, consistent with good professional practice. Regulations implementing the Knox-Keene Act require timely access to care by requiring urgent and non-urgent appointments to be provided within specified timeframe. The current exception are the County Organized Health Systems, which are locally created public plans and are the only managed care plan in the counties they serve.

In its 2014-15 Health Budget write-up, the LAO noted that it is increasingly important to exercise oversight over access to services in Medi-Cal managed care, given the state's growing reliance on managed care to cover more complex groups of beneficiaries and services as the majority of Medi-Cal beneficiaries are mandatorily enrolled in managed care. The LAO stated, in concept, that shifting beneficiaries and services from FFS to managed care should also improve the state's monitoring of access to care in the Medi-Cal program as there are no state

statutory guidelines for interpreting adequate access in FFS Medi-Cal, other than compliance with the broad equal access provision of federal Medicaid law.

Do Medi-Cal Rates Ensure Access to Care?

Despite the state requirement for an annual review of physician and dental rates, the federal requirement for actuarially sound capitation rates, and the federal requirement that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population, multiple studies have found Medi-Cal rates are below those paid by other payors, and access to care for Medi-Cal beneficiaries is not the same as for individuals with employer-sponsored insurance (ESI). Surveys of Californians conducted before coverage expansions enacted under the federal Patient Protection and Affordable Care Act (ACA) consistently show a wide gap between Medi-Cal enrollees and other insured populations with respect to access to care.

- A 2011 survey funded by the California HealthCare Foundation of over 1,500 Medi-Cal beneficiaries identified difficulties in finding health care providers who accept their coverage, 34% of Medi-Cal beneficiaries said it was difficult to find health care providers who accept their insurance, compared to 13% for people with other coverage.

- The 2012 California Health Interview Survey asked how access to care in Medi-Cal compares to ESI for adults with similar health care needs. Medi-Cal had worse gaps in potential access to care, with 21.5% reported difficulties in finding health care providers. This included Medi-Cal beneficiaries being less likely to have a usual source of care other than the emergency room as compared to individuals with ESI at 8.1%.

- DHCS' Medi-Cal Managed Care 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) provides the results of a member satisfaction survey conducted of adult and child members of Medi-Cal managed care plans during the first half of 2013. In assessing the Medi-Cal managed care plans' strengths and weaknesses across the CAHPS global ratings and composite measures, 28 out of 44 Medi-Cal managed care plans demonstrated poor performance for "Rating of Health Plan", and 32 of the 44 plans demonstrated poor performance for the "Getting Care Quickly" measure.

In addition to surveys of beneficiaries, surveys of physicians and dentists have found lower participation in Medi-Cal and lower reimbursement rates as compared to Medicare and private insurance.

- A survey of physicians by the Medical Board of California found the percentage of California physicians accepting new Medi-Cal patients in 2013 was 62%, compared to 79% for private insurance and 75% for Medicare.

- A December 2012 publication by the Kaiser Commission on Medicaid and the Uninsured stated that in California, Medi-Cal fees for all services were 51% of Medicare and Medi-Cal primary care physician fees were 43% of Medicare.

Denti-Cal Audit

In December 2014 the Bureau of State Audits (BSA) issued an audit of the Denti-Cal program that found that while the number of active providers statewide appears sufficient to deliver dental services to children, some counties may not have enough providers to meet the dental needs of child beneficiaries. BSA reported five counties may lack active providers, an additional 11 counties had no providers willing to accept new Medi-Cal patients, and 16 other counties appear to have an insufficient number of providers. BSA also found the utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. BSA's analysis of federal data from federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the data, only 43.9% of California's child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6%.

The BSA stated a primary reason for low dental provider participation rates is low reimbursement rates compared to national and regional averages and to the reimbursement rates of the other states BSA examined. For example, California's rates for the 10 dental procedures most frequently authorized for payment within the Medi-Cal program's FFS delivery system in 2012 averaged $21.60.

Managed Care Audit

A recent audit by BSA looked at elements of the state's managed care program.

Key Audit Findings:

- DHCS did not verify health plan data: therefore, it cannot ensure that health plans had adequate provider networks to serve Medi-Cal beneficiaries.
- DHCS does not verify the accuracy of the provider network data it receives from the health plans. Then DHCS provides the unverified data to DMHC, which uses the data to perform quarterly assessments of network adequacy.
- DHCS' process to evaluate the accuracy of the directories is inadequate and methods for determining which providers to contact for verification are inconsistent. The Auditor found inaccuracies in the provider directories, but DHCS didn't find them for the same directories.

- DHCS' Medi-Cal Managed Care Office of the Ombudsman, which investigates and resolves complaints by or on behalf of beneficiaries about the health plans, has a telephone system that cannot handle the volume of calls it receives nor can its staff answer all of the calls the system does accept.

- DHCS has not consistently monitored health plans to ensure that they meet beneficiaries' medical needs—it did not perform annual medical audits before 2012 and performed medical audits on less than half of the health plans in FY 2013-14.

- DHCS did not ensure that DMHC performed the quarterly assessments of provider networks for existing health plans as per their agreement. In fact, DMHC has not performed assessments for health plans that serve 28 counties as of the first quarter of 2014.

- Although permitted by law, neither DMHC nor DHCS rely on the work performed by the other to meet their overlapping responsibilities—DMHC could rely on DHCS' review since DHCS is required to review the 22 Medi-Cal health plans more frequently.

Legislation to Address Medi-Cal Rates and Access to Care.

There have been a variety of legislative efforts in the area of Medi-Cal rates. To provide the briefest summary, the state's fiscal crisis in 2008 led to the adoption of many bills as part of the State Budget which either decreased rates or addressed specific issues related to decreasing rates. Conversely, there has been significant legislation introduced to try and reverse rate decreases, and those have been only partially successful. Last year, AB 1805 (Skinner) would have eliminated budget reductions adopted as part of a previous budget. Specifically, the bill targeted a 10% Medi-Cal rate reduction, commonly known as the AB 97 cuts. In addition, AB 1759 (Pan and Skinner) would have made permanent the temporary reimbursement rate increase required by the ACA for specified Medi-Cal primary care providers. Beginning January 1, 2015, the ACA required states to increase Medicaid primary care physician service rates to 100% of Medicare rates for services provided from January 1, 2013 through December 31, 2014). Neither bill became law.

This year, SB 243 (Ed Hernandez) and AB 366 (Bonta) are identical companion bills that have been introduced to increase Medi-Cal rates up to Medicare payment levels. SB 243 was held on the Senate Appropriations Committee suspense file and AB 366 has been amended to require DHCS to conduct an ongoing study of the rates paid in the Medi-Cal program.

Managed Care Organization Tax.

The California Constitution imposes a 2.35% tax on insurers doing business in California. Commonly referred to as the "gross premiums tax", the annual insurance tax is based on insurers' gross premiums, less return premiums. The State Constitution specifies that the 2.35%

tax is in lieu of all other taxes and licenses, with specified exceptions. Any person that meets this constitutional provision's "insurer" definition must register with the Department of Insurance and remit the annual gross premiums tax.

As defined in the Constitution, "insurer" does not expressly include a health care service plan, such as a Medi-Cal managed care plan. The Knox-Keene Act covers these providers. Therefore, these plans are not generally prohibited from other taxation. Until July 1, 2013, existing law imposed a tax rate of about 2.3% annually on every Medi-Cal managed care organization (MCO) doing business in this state. The tax was changed and, effective July 1, 2013, an MCO tax of almost 4% is imposed upon the seller of Medi-Cal health care services at retail, measured by the gross receipts from the sale of those services.

The importance of this tax to the state cannot be overstated. The state collects the funds, approximately $1 billion and uses these funds as a match to draw down additional federal funds to support the Medi-Cal program. Given its importance, the recent CMS opinion on the MCO tax was far from welcome news. A July 25, 2014 letter from CMS officials said California's existing MCO tax is inconsistent with federal Medicaid regulations — "thereby putting over $1 billion in federal funding to the state at risk in future years if the tax is extended in its current form." The federal guidance indicated that the current MCO tax is likely impermissible under federal Medicaid regulations after its expiration on June 30, 2016, because it only applies narrowly to Medi-Cal managed care plans. The applicable federal requirement is that a tax paid by providers should be broadly based, meaning it cannot just apply exclusively to a select group of providers, in particular those enrolled in Medi-Cal. The federal government is trying to discourage states from supporting their programs with taxes on Medi-Cal providers that are in turn reimbursed with higher rates with what is usually a majority of federal funds.

The Governor's budget proposes to replace the existing MCO tax on Medi-Cal managed care plans with a broad-based MCO tax that would satisfy the requirements of recently issued federal guidance. This proposed version of the MCO tax would have applied broadly across managed care plans regulated by DMHC and/or DHCS. The proposed tax was to be a tiered amount based on various plan enrollment levels and would have been sufficient to raise the same amount of General Fund savings as the current MCO tax, as well as the funding needed to restore the 7% reduction in In-Home Supportive Services hours. According to the LAO, that revision should meet federal standards, but it raised concerns about the precedent the revised tax would set.

"We find the governor's proposed MCO tax would likely meet federal requirements, but note that in doing so, the proposal would in part resemble an actual tax on commercial health coverage (in addition to being a typical Medi-Cal financing scheme to leverage federal funding), with broader economic and social implications," the LAO report states.

The Legislature did not adopt the Governor's proposal, hence a replacement for the current MCO tax is necessary or the state will face a $1 billion ongoing deficit in the Medi-Cal program. The Legislature was very concerned with the tiered approach which had significant differential impacts on plans and threatened to significantly distort the overall health insurance market.