

JOINT OVERSIGHT HEARING

AGENDA

**ASSEMBLY SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES
ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR**

**ASSEMBLY HEALTH COMMITTEE
ASSEMBLYMEMBER RICHARD PAN, CHAIR**

**THURSDAY, FEBRUARY 28, 2013
UPON ADJOURNMENT OF SESSION - STATE CAPITOL ROOM 4202**

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ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: HEARING AID REIMBURSEMENT POLICY

On January 15, 2013, the Department of Health Care Services (DHCS) administratively implemented a change in the Medi-Cal reimbursement policy for hearing aids. The new policy requires the state to reduce the reimbursement by the amount of discounts or rebates, provided by manufacturers to hearing aid providers, when reimbursing for the cost of the hearing aids, thus ending the long-standing practice of reimbursing for the full amount paid prior to discounts or rebates. This new policy results in a substantial reduction in reimbursement to Medi-Cal and California Children's Services (CCS) hearing aid providers.

The Governor's proposed 2013-14 budget assumes General Fund savings from this policy change of \$392,280 for 2012-13 and \$1,099,480 for 2013-14.

PANELISTS

Panel 1: Stakeholders

- Amnon Shalev, Co-Owner
Supertone Hearing Aid Center
- Jody Winzelberg, AuD, PASC, Chief, Audiology, Director
*Rehabilitation Services and The Children's Hearing Center
Lucile Packard Children's Hospital at Stanford*
- Rupa Balachandran, PhD, CCC-A, Director of Clinical Services,
Hearing and Speech Center of Northern California

Panel 2: Administration

- Department of Health Care Services

Public Comment

BACKGROUND

Current Law & Regulations

The Medi-Cal reimbursement policy for hearing aids is established in statute. Welfare and Institutions Code Section 14105.49 states (in bold):

(b) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:

(1) The maximum allowable amount established by the department.

DHCS established the maximum allowable amount in regulations (Title 22, Section 51517) at:

1. Monaural (single hearing aid) - \$883.80
2. Binaural (pair of hearing aids) - \$1,480.32

(2) The one-unit wholesale cost, plus a markup determined by the department.

According to DHCS, the lesser of the four options is almost always this one. The policy change instituted by DHCS on January 15, 2013 made a change to the definition of "one-unit wholesale cost," a definition that DHCS develops and implements within the Medi-Cal Provider Manual or bulletin, per authority provided to them to do so within this same section of law (WIC Section 14105.49). The definition was and is as follows:

- Prior to January 15, 2013: The "unit price" or the "single unit price" as identified in the manufacturer's wholesale catalog not including rebates, discounts, taxes, or any other factors.
- Post January 15, 2013: The "unit price" or the "single unit price" as identified in the manufacturer's wholesale catalog, *less rebates, discounts, or other reductions in price and not including taxes.*

DHCS states that the markup is intended to cover the costs of an average of 6 visits with each patient. DHCS has established the markup at:

1. Monaural - \$256.37
2. Binaural - \$326.08

Therefore, the one-unit wholesale cost, plus markup, is approximately:

1. Monaural - \$811.62
2. Binaural - \$1,363.79

(3) The billed amount.

DHCS states that the billed amount is never the lowest of the four options. Relevant to this option, regulations (Title 22, Section 51517) state the following:

"(a) Reimbursement for hearing aids, accessories, and related services shall be the usual charges made to the general public not to exceed the maximum reimbursement rates listed in this section."

As described below, the "usual charges made to the general public" far exceed Medi-Cal reimbursements; however, DHCS states that "the billed amount" is the equivalent to "usual charges made to the general public" which is never the lowest amount (of the four options), and therefore is not taken into consideration. However, DHCS also stated in an April 2012 letter to Assemblymember Blumenfield that: "The

Department does not have a method to obtain the usual charges for hearing aids that providers charge the general public."

(4) The rate established by the department's contracting program.

DHCS does not have contracts with hearing aid providers, and therefore this does not figure into the reimbursement rate.

Cost of Hearing AIDS

As stated above, the usual reimbursement for a pair of hearing aids in the Medi-Cal program is approximately \$1,363.79. This is considerably lower than the private market and the "usual charges made to the general public," as evidenced by the following:

- According to a National Institutes of Health 2010 fact sheet, "The average price of a digital hearing aid is about \$1,500, with top-of-the-line devices costing \$3,000-\$5,000."
- The Better Hearing Institute stated that in 2008, the average out-of-pocket costs for a pair of hearing aids was \$3,350.
- In 2009, Consumer Reports noted that their survey of hearing aid consumers showed a median price of \$3,352 per pair.
- AARP reported in 2011 that the approximate price of a pair of hearing aids is \$3,600.

State Savings

As stated above, the Governor's proposed budget assumes General Fund savings from this policy change of \$392,280 for 2012-13 and \$1,099,480 for 2013-14. This estimate seems questionable given the following:

1. DHCS has stated that its goal in instituting this new policy is to ensure that the state only pays the actual costs of hearing aids, rather than also covering the costs of rebates and discounts that manufacturers give to providers after they pay the full cost. However, manufacturers may not continue to offer these rebates to providers knowing that the state is effectively taking the rebates. If manufacturers stop offering rebates, the state will realize no savings from this policy change. Only manufacturers would experience savings by no longer paying the rebates.
2. In January, DHCS stated that only approximately half of all hearing aid providers would be affected by the new policy, as only approximately half of the hearing aid claims involve a rebate. However, subsequently, DHCS acknowledged that the claims data that was the basis for this assertion was faulty given that not all of the claims reflect the rebates even when they have been part of the transaction. Hearing aid providers collected data and provided it to DHCS that showed that nearly 100 percent of the hearing aid purchases involve rebates, and therefore virtually all providers and all claims would be affected.

Providers & Stakeholders

Hearing aid providers have expressed strong and sustained objection to this new policy, explaining that many providers will not continue to participate as Medi-Cal providers due to the substantial reduction that will occur as a result of this new policy. In general, providers explain that the rebates and discounts that they receive from manufacturers make up for inadequate reimbursements from the state. According to Supertone Hearing Aid Center, the new policy will reduce the reimbursement from \$1,363 to approximately \$699. Supertone states that there are many unreimbursed costs associated with providing hearing aids to Medi-Cal patients and therefore the lower rate will result in a \$14 loss on each hearing aid. Supertone reports the following under-reimbursements:

- Hearing tests – no reimbursement
- Custom ear-molds – reimbursement is less than the acquisition cost
- Repairs (out of warranty) – reimbursement is equal to acquisition costs

Hearing Solutions and Hearing HealthCare Providers also state that this new policy will result in an approximately 50 percent reduction to the hearing aid reimbursement.

Access to Hearing Aids

The new hearing aid policy has the potential to result in a significant loss of access to hearing aids for Medi-Cal beneficiaries, should many providers choose to leave the Medi-Cal program based on this new reimbursement policy. DHCS has stated that they will be monitoring access and can take swift action should they become aware of a significant reduction in access. Several concerns have been raised:

CCS Children

According to CCS hearing aid providers, there has been a significant access problem in the CCS program for many years, which has remained unaddressed by DHCS. In 2008, Assemblymember (now State Insurance Commissioner) Dave Jones organized a meeting with DHCS, the CCS program, the California Academy of Audiology, and Packard Children's Hospital to discuss the myriad of billing problems that audiologists and hearing aid providers face, making participation in the program nearly intolerable for many of them. In fact, in July 2008, the Redding Hearing Institute sent a letter to Assemblymember Jones stating that they would no longer be accepting CCS/Medi-Cal patients. Their letter states: "Issues that have led us to this decision include slow reimbursement, improperly adjusted claims, repeated "take backs" or "recoveries," and repeated 10 percent reimbursement cuts." CCS providers are not aware of any substantial changes or improvements to the billing process as a result of this 2008 meeting.

DHCS Monitoring

DHCS intends to monitor access by monitoring claims, provider participation, and beneficiary calls. Nevertheless, already there is evidence of a growing number of providers leaving Medi-Cal in response to this new policy. For example:

- The California Academy of Audiology conducted their own informal survey (SurveyMonkey) of Medi-Cal and CCS providers on their reactions to the new reimbursement policy. Approximately 250 providers responded to the survey, and 61.3 percent of the respondents stated that they intend to stop serving CCS/Medi-Cal kids altogether or will only serve existing patients but no new patients.
- HearWell Hearing Aid Center provides hearing aids to Medi-Cal beneficiaries in skilled nursing facilities (SNFs) and is the only provider to 60 SNFs in San Diego County. HearWell sent a letter to the Governor stating that they will no longer serve Medi-Cal should this new policy be implemented.
- Hearing Solutions sent a letter to DHCS Director Toby Douglas stating that this new policy will result in a 50 percent rate cut which is unsustainable for them, and therefore that not only will they no longer serve as Medi-Cal providers but that they will be closing their doors altogether. Hearing Solutions states that there is only one other audiologists who serves Medi-Cal in San Jose who also plans to close.
- The California Speech-Language-Hearing Association states that "this policy change will make it financially impossible for many audiologists and hearing aid dispensers to treat Medi-Cal beneficiaries because the cost of providing the treatment will exceed the reimbursement the provider receives.
- DHCS hosted a meeting of stakeholders on February 13, 2013 to discuss the new hearing aid policy, at which several other providers announced their intent to leave Medi-Cal and/or close their businesses entirely. Providers also indicated that there will be a lag time of three months in claims and other paperwork; therefore, by the time the reduction in access is detectable, many providers will have left the program, and state that they will not return.

Alternative Reimbursement Policies

The California Academy of Audiology has suggested the following three alternative reimbursement policies:

1. Reimburse with a 60 percent markup on the single unit wholesale cost of a hearing aid;
2. Reimburse with the wholesale cost of a hearing aid, plus a professional fee of \$500 for one hearing aid, and \$800 for two hearing aids; or,
3. Utilize the Medi-Cal regulations on reimbursements for durable medical equipment, which is net invoicing plus 100 percent markup.

STAFF COMMENTS/QUESTIONS

DHCS adopted this same policy in 2004, and shortly thereafter restored the traditional policy in reaction to providers leaving the program. In 2008, stakeholders came together to discuss major bureaucratic challenges for providers related to extremely onerous billing practices and the resulting access problems for CCS children, yet no substantial changes were made to the program. In the current scenario, the administration's goal is to create more transparency and fairness in the reimbursement policy, by discontinuing the practice of reimbursing providers the amounts they receive in manufacturer rebates. Nevertheless, they have adopted a policy that cuts the reimbursements in half, and may not result in any savings for the state. Providers have urged the department to reconsider, and to revert to the old policy until an alternative can be developed to which all stakeholders can agree.

The Committees have asked DHCS to answer the following questions:

1. What is/are the goal(s) of the new reimbursement policy?
2. If the goal of the new policy is to ensure that, the state pays only the actual cost of hearing aids, what alternative reimbursement policies have you considered that could ensure this without resulting in a substantial cut to hearing aid providers?
3. How do you measure and monitor access to hearing aids? How would you know if access diminishes significantly?
4. How many hearing aids were purchased, through Medi-Cal and CCS, per month in 2012, and in January and February 2013?
5. Were you aware of CCS providers having difficulty accessing hearing aids for their patients, prior to this new policy?
6. Please describe the purpose and genesis of a meeting on hearing aids that DHCS had in 2008 with the CCS program, Packard Children's Hospital, and then-Assemblymember Dave Jones.
7. How much savings do you anticipate as a result of this policy change?

Staff Recommendation: No actions are recommended for this hearing

ISSUE 2: COMMUNITY-BASED ADULT SERVICES IMPLEMENTATION

The 2011 Budget Act prohibited the continuation of Adult Day Health Care (ADHC) as a Medi-Cal benefit, one of the federal Medicaid program's optional benefits for states. Many legislators supported the elimination of ADHC based on the understanding that a smaller, less costly, yet very similar program would replace ADHC; legislative intent language adopted in the budget trailer bill expresses this understanding and expectation. Although the Governor vetoed subsequent legislation to create a smaller program, advocates sued the state resulting in a settlement that created a smaller program, called Community-Based Adult Services (CBAS), which the administration has been implementing over the past year.

PANELISTS

Panel 1: Stakeholders

- Nina Nolcox, Administrator
Graceful Senescence Adult Day Health Care, South Los Angeles
- Elissa Gershon, Senior Attorney
Disability Rights California

Panel 2: Administration

- Department of Health Care Services

Public Comment

BACKGROUND***Adult Day Health Care (ADHC)***

For many years, California's Medi-Cal program included ADHC, a federal Medicaid benefit that is optional for states to offer in their Medicaid programs. ADHC beneficiaries received an integrated service that treated the health and supportive needs of older adults with multiple, chronic conditions in a medically supervised day setting. According to the California Association of Adult Day Services (CAADS), the average profile of an ADHC client was an impoverished female, 78 years old, with three or more chronic diagnoses, and dependent upon others for a range of supports. ADHC also provided specialized care to individuals who have Alzheimer's disease or other dementia, stroke-related conditions, chronic disorders such as cardiovascular disease, diabetes, neurological disorders, head or spinal cord injuries, developmental disabilities and mental illnesses. The goal of ADHC was to manage the conditions in order to prevent or delay placement into nursing homes or other costlier settings while improving and preserving each individual's physical and mental health, as well as their overall quality of life. Medi-Cal paid approximately \$76 for a typical day in an ADHC program.

Community-Based Adult Services (CBAS)

CBAS was created by a settlement between the State of California and ADHC consumers who sued to block implementation of AB 97 (Budget Committee), Chapter 3, Statutes of 2011, a budget trailer bill that repealed the ADHC program and was signed by Governor Brown on March 24, 2011. On June 27th of that year, ADHC clients concerned about the loss of benefits for which there were no identifiable replacement services, filed for an injunction against the elimination of ADHC. The federal Centers for Medicare and Medicaid Services (CMS) approved of the elimination of ADHC on July 1, 2011, and DHCS scheduled elimination for September 1, 2011. By July 12th, the U.S. Department of Justice issued their observation that elimination of ADHC may deprive recipients of important rights related to receiving care in the least restrictive setting possible. Subsequently, DHCS requested permission to delay elimination of the ADHC optional benefit until December 1, 2011. On November 17, 2011, both the state and the ADHC clients facing the loss of benefits agreed to a settlement creating CBAS as an alternative to ADHC.

Effective April 1, 2012, DHCS established the CBAS program under California's "Bridge to Reform" 1115 Medicaid waiver. CBAS is nearly identical to ADHC. Like ADHC, CBAS is an outpatient, facility-based program that delivers skilled nursing care, skilled social services, skilled therapies, personal care, meals, transportation and caregiver training and support. The majority of CBAS beneficiaries are dually eligible for Medi-Cal and Medicare. Under the terms of the settlement, all beneficiaries, with limited exceptions such as living in a county that has no managed care, must enroll into a Medi-Cal managed care plan in order to receive the CBAS benefit. CBAS provides services roughly equivalent to those offered at ADHC centers, and is funded at the same rate for patients who qualify. Eligibility is based on medical need for those who are at risk for institutionalization.

Managed Care Requirement

Given that the settlement stipulated that the CBAS benefit would be available only to beneficiaries in managed care, DHCS has worked to educate beneficiaries about how to enroll in a Medi-Cal managed care plan to keep their CBAS benefit. Despite these efforts, a large number of beneficiaries opted to remain in Medi-Cal fee-for-service, which means they are no longer eligible for CBAS benefits. Both DHCS and stakeholders reported that some portion of these individuals had made this choice based on misinformation given to them by their primary care physicians (PCPs). Moreover, many of these people simply do not want to have to change PCPs, and therefore have chosen to stay in fee-for-service, thereby losing the CBAS benefit.

STAFF COMMENTS/QUESTIONS

A significant portion of former ADHC beneficiaries have not become CBAS beneficiaries either because they were deemed ineligible for CBAS, or because they chose not to transition into managed care. It would be quite valuable and instructive, in terms of both fiscal and health policy, to know what has happened to this population. Has their health deteriorated faster than when they were ADHC beneficiaries? Have they entered nursing homes at a faster rate than the ADHC population? It is also essential to identify lessons learned from this transition, as the state is on the cusp of a much larger and more complex transition with a nearly identical population of “dual-eligibles” moving into managed care.

The committees have asked DHCS to answer the following questions:

Managed Care Plan Reporting:

1. What data is reported to you by managed care plans so that it may be determined whether and to what extent this reporting will satisfy your reporting obligations under the Darling settlement?
2. What information will you receive from managed care plans with respect to quality assurance monitoring and random samples?

New CBAS Assessment Tool:

1. Please describe the status and development process of the new assessment tool.
2. What training and monitoring will be used specific to the use of the tool?
3. How much time do you expect there to be between when an individual receives a CBAS referral and when that person receives actual CBAS services?
4. What is the reason for the prohibition on use of information from CBAS providers in the assessment process? Won't this impede managed care plans' ability to conduct accurate and timely assessments?

Please provide the following CBAS data:

- *Eligibility Hearings:* To date: number of hearings requested, number conducted, and outcome (i.e., eligible or ineligible).
- *Level of Service Hearings:* Monthly to date: number of hearings requested regarding number of days authorized, broken down by geographic areas (county) and/or managed care plan.

- *Eligibility*: Monthly to date: number "determined" eligible through Sept. 30, batched similarly to prior report to Legislature.
- *Enrollment*: Monthly to date: number enrolled in CBAS, batched similarly to prior report to Legislature.
- *Managed Care Enrollment*: Monthly to date:
 1. Number enrolled in managed care by county and plan;
 2. Number of Class Members passively enrolled in managed care by September 30, 2012;
 3. Number who opted into managed care up to November 1, 2012;
 4. Number who re-enrolled through Easy Way Back;
 5. Number who opted out of managed care;
 6. Number who applied for Medical Exemption Request;
 7. Number granted MERs; and,
 8. Number of Class Members enrolled in DSNP Medicare plans.

Staff Recommendation: No actions are recommended for this hearing

ISSUE 3: HEALTHY FAMILIES PROGRAM TRANSITION

The Budget Act of 2012, and accompanying budget trailer bill, approved of the transition of all children enrolled in the Healthy Families Program to the Medi-Cal program, beginning no sooner than January 1, 2013. The federal CMS approved of this transition of approximately 860,000 children from one program to another on December 31, 2012 and the administration began transitioning children on January 1, 2013.

PANELISTS

Panel 1: Stakeholders

- Victor H. Perez, MD, MPH, General Pediatrician, Leadership Representative
American Academy of Pediatrics-California
- Melina Yang, Staff Member
Lao Family Community Empowerment, Stockton
- Kelly Hardy, Director, Health Policy
Children Now, 100% Campaign
- Cathy Senderling-McDonald, Deputy Executive Director
County Welfare Directors Association

Panel 2: Administration

- Department of Health Care Services

Public Comment

BACKGROUND

The federal Children's Health Insurance Program (CHIP) provides health coverage to children in families that are low-income, but with incomes too high to qualify for Medicaid. Until January 1, 2013, California's CHIP was the Healthy Families Program (HFP) administered by the Managed Risk Medical Insurance Board (MRMIB) and provided health insurance for about 863,000 children, up to age 19, in families with incomes above the thresholds needed to qualify for Medi-Cal but below 250 percent of the federal poverty level (FPL). (The FPL for 2013 is \$23,550 in annual income for a family of four). Under the CHIP program, states have the option to create a stand-alone program such as HFP or expand its Medicaid program to include these children in families with higher income. In both options, states receive a two-dollar federal match for every state dollar. As originally implemented in California, Medi-Cal covered infants under age one in families with income under 200 percent of FPL, children aged one to five in families with income up to 133 percent FPL, and children age six to 18 in families with income up to 100 percent FPL. A child in a family with income over the threshold but up to 250 percent FPL was covered by HFP.

MRMIB provided coverage by contracting with plans that provide health, dental, and vision benefits to HFP enrollees. Under state law, the benefits that HFP provided to enrollees was required to be equivalent to benefits provided to state employees through the California Public Employees' Retirement System, with certain exceptions for mental health benefits. HFP had a tiered premium structure that specified lower premiums for families below 150 percent of the FPL, and higher premiums for higher-income families. The premiums varied from between \$4 to \$24 per child per month depending on family income, with a maximum monthly family premium of \$72. Families had copays that varied from \$5 to \$15 depending on the services rendered, with a maximum annual family copayment amount of \$250.

As part of the eligibility simplification, the federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (ACA), effective calendar year 2014, replaces many of the complex categorical groupings and limitations in the Medicaid program (Medi-Cal in California). The ACA requires, by January 1, 2014, the state's Medicaid program to cover all children in families with income up to 133 percent FPL, thereby eliminating discontinuity based on the age of the child. In effect, this requires California to transition children in families with income between 100 percent FPL and 133 percent FPL between age six and 19 to Medi-Cal from HFP by 2014. The ACA also gives the states authority to integrate CHIP into the exchanges or retain as a stand-alone program. The maintenance of effort (MOE) provision requires states to maintain eligibility standards, methods, and procedures that are not more restrictive than those in effect at the time of the enactment of the ACA.

Governor's 2012 Budget Proposal. In the 2012 Budget, the Brown Administration proposed to begin the transfer of children in families up to 133 percent FPL in 2012 and to shift the remainder of the children (with incomes up to 250 percent FPL) to Medi-Cal, rather than integrate CHIP into the Exchange or retain as a stand-alone program. The Governor proposed to shift children in the HFP to Medi-Cal over a nine-month period beginning in October 2012.

AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012. The Legislature adopted a modified version of this proposed transition. AB 1494 provides for the transition of approximately 860,000 HFP subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. Children in HFP will transition into Medi-Cal's new optional Targeted Low Income Children's Program (TLICP) covering children with income up to and including 250 percent FPL. At the time AB 1494 was enacted, it was projected that this transition would result in \$13.1 million General Fund savings in 2012-13, \$58.4 million General Fund savings in 2013-14, and \$72.9 million General Fund savings annually thereafter.

The transition, as modified by the Legislature in AB 1494, breaks up the transfer to Medi-Cal into four phases. Phase 1 was to begin no earlier than January 1, 2013 and included about 415,000 children who are in an HFP plan that is also a Medi-Cal Managed Care (MCMC) plan. Phase 2 is to begin no earlier than April 1, 2013 and includes about 249,000 children enrolled in an HFP plan that subcontracts with a MCMC plan and requires, to the extent possible, the child to be enrolled in the MCMC plan that sub-contracts with the same plan. Phase 3 is to begin no earlier than

August 1, 2013 and consists of about 173,000 children enrolled in an HFP plan that is not a Medi-Cal plan and does not contract with a Medi-Cal plan in that county. Plan enrollment for these children is to include consideration of whether the child's primary care provider is available through the new plan. Phase 4 is to begin no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in counties with no MCMC into Medi-Cal fee-for-service (FFS). However, once Phase 1 is approved, all newly eligible children, regardless of county are being enrolled into Medi-Cal.

HFP also provided a choice of dental care plans and a stand -alone vision plan. Dental services in HFP were provided through two different models—Open Network and Primary Care plans. In Primary Care plans, each enrollee has a primary care dentist who authorizes dental care provided by specialists. In Open Network plans, enrollees are not assigned a primary care dentist. In both models, MRMIB paid a per-member, per-month negotiated rate to the dental plan.

The HFP shift included a change in dental and vision benefits. In most counties, Medi-Cal has a FFS dental program entitled Denti-Cal. In Los Angeles, there is voluntary dental managed care and in Sacramento, mandatory dental managed care. For Sacramento and Los Angeles counties, dental coverage for individuals transitioning would continue to be provided by their current dental managed care plan if the HFP dental plan is also a Medi-Cal dental managed care plan. For Sacramento County, if their plan is not a Medi-Cal dental managed care plan, the individual will be assigned to a plan, with preference to a plan with which their current provider is a contracted provider. For Los Angeles County, if their plan is not a Medi-Cal dental managed care plan, the individual may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal FFS for dental coverage. For all other counties, dental coverage for these children transitions to Medi-Cal FFS dental coverage. Additionally, children will be moved out of their HFP vision plan and will receive vision services through the MCMC health plan.

AB 1494 also required:

- The California Health and Human Services Agency (CHHSA), working with MRMIB, DHCS, and the Department of Managed Health Care (DMHC) to develop a strategic plan for this transition of children from HFP to Medi-Cal no later than October 1, 2012.
- DHCS to submit an implementation plan for each phase prior to transitioning children to Medi-Cal to ensure continuity of care with the goal of ensuring there is no interruption in services and there is continued access to coverage for transitioning individuals.
- At least 60 days prior to the transition of children, findings from a managed care health plan network adequacy determination must be submitted to the Legislature.

- Monthly status reports on the transition submitted to the Legislature. These reports must include information on health plan grievances related to access to care, continuity of care, requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment).
- Managed care plan performance measures be integrated and coordinated with the HFP performance standards, including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. This must occur prior to the implementation of Phase 1.
- Individuals must be informed of the change at least 60 days prior to the transition. This notification must include, at a minimum, information on how an individual's systems of care may change, when the change may occur, and whom to contact for assistance.

Implementation Phases. AB 1494 envisioned that Phase I would include approximately 400,000, children enrolled in 18 HFP plans that were also Medi-Cal managed care plans and who would be assigned to the same plan for Medi-Cal as they were in HFP. As required by AB 1494, the Department of Managed Health Care (DMHC) and DHCS collaborated in assessing the adequacy of the Medi-Cal managed care plans networks for Phase 1. The Network Adequacy Assessment Report was submitted on November 1, 2012. Generally, a high degree of overlap between providers contracted in the HFP and Medi-Cal networks in each county in which the health plans operate these lines of business was found. The report found that, although the departments had minor or moderate concerns with some health plan networks in Phase 1, the only health plans that the departments believed were not ready to transition on January 1, 2013 were Health Net of California, CalViva, and Anthem Blue Cross in Tulare County. Based on these findings the departments requested additional network information from these plans and submitted a First Addendum on January 1, 2013 summarizing the results of these inquiries.

Based on the findings of this report, stakeholder input and to ensure an orderly transition, DHCS sub-divided revised Phase 1 into in three sub-phases. The factors considered in placing counties in Parts A, B or C were:

1. A desire to have representation of each Medi-Cal managed care plan model— Two-Plan, County Organized Health System, and Geographic Managed Care in each phase;
2. Findings from the network adequacy assessment demonstrating the degree of overlap in providers for health plans; and,
3. The desire to work with a smaller group of counties in each sub-phase to be able to appropriately identify and address any unanticipated issues that may arise to further ensure a smooth transition for children who are in Part B and C .

The updated phase breakdown is as follows:

Phase 1 Part A, January 1, 2013. Children in the following counties will transition: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego (except for Health Net managed care health plan).

Phase 1 Part B, A March 1, 2013. Children in Medi-Cal managed care health plans except for Health Net in the following counties will transition: Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Tulare, Sacramento, Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo.

Phase 1 Part C, An April 1, 2013. Children in the Health Net managed care health plan in the following counties: Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin, and Stanislaus will transition.

The two most significant changes from the original Phase 1 plan resulted from the findings of the network adequacy assessments related to Health Net and CalViva. With regard to Health Net, the original assessment raised enough concerns to warrant requests for additional information and required a reassessment before the departments could make a determination of adequacy for transition. For instance, the overlap between HFP providers and Medi-Cal providers was very low and at that time, the plan was unable to secure assurances that the HFP-only providers would continue to see the children after transition. Conversely, the plan was unable to secure assurances that its Medi-Cal providers who also treated HFP enrollees would continue to treat the children after transition. As a result, Health Net was moved to Phase C. In the case of CalViva, the local initiative health plan that serves Fresno, Kings and Madera counties, CalViva did not have an HFP line of business and contracted with Health Net. CalViva was unable to secure assurances that the HFP-only providers would continue to treat the children in Medi-Cal post-transition. The departments expressed significant concerns about the adequacy of the CalViva network and found that key pieces of data were unavailable. Consequently, DHCS decided to move the transition of HFP members in CalViva to Phase 2.

Federal Approval. In order to implement the transition, federal approval from the Centers for Medicare and Medicaid Services (CMS) was required. Approval for the transition is to be obtained as an amendment to the existing Section 1115 Bridge to Reform Waiver. CMS granted a time-limited approval on December 31, 2012 for the transition beginning January 1, 2013. Separate written approval from CMS is required prior to the implementation of each phase. Prior to receiving CMS approval to implement Phase 1B and each subsequent phase thereafter, the state must demonstrate the successful provision of coverage to children in previous phases, as well as provider network adequacy, to serve the children in subsequent phases, including measures of time and distance standards, and appropriate plans for maintaining continuity of care for all services. To the extent that an unanticipated problem is identified by CMS or the state during the implementation process, CMS may request additional information prior to approval of any subsequent phase. In the

absence of sufficient evidence from the state demonstrating that an identified problem with a previous or pending phase has been resolved, CMS may delay implementation of any phase. As of this writing, CMS has not approved 1B, scheduled to begin on March 1, 2013.

Once the transition period is complete, the children enrolled in this demonstration Medicaid expansion population will be made eligible under the Medicaid state plan, and the demonstration authority will expire on December 31, 2013. California must submit a Medicaid state plan amendment that will expand coverage to optional targeted low-income children with family incomes up to and including 250 percent of the FPL 90 days prior to implementation of the last phase (Phase 4). The SPA must be approved by CMS prior to implementation of Phase 4 in order for Federal reimbursement to be available.

Behavioral Health Services. Prior to the transition, the HFP plans provided "basic" mental health services through the child's primary care provider or another mental health specialist that was part of the provider network. Children who are thought to be seriously emotionally disturbed (SED) are referred to the county mental health plan. Under Medi-Cal, children who are SED continue to be served by the county mental health plan. However, Medi-Cal managed care plans cover only the mental health services that can be provided by the child's PCP within the PCP's scope of practice. If the child's need exceeds this level the plan is supposed to refer them to a Medi-Cal fee for service (FFS) provider outside of the plan's network or to the county mental health plan if the health plan believes the child meets the medical necessity criteria to obtain specialty mental health services. During recent Behavioral Health Workgroup and Stakeholder meetings, participants representing plans and enrollees have suggested that obtaining mental health services for the children that are supposed to be referred to a FFS mental health provider has been a problem. The plans do not have a list of these providers in the county and DHCS has not provided any assistance. There have also been reports of significant shortages and wait times for appointments in some counties. A similar issue has been raised with regard to children with eating disorders and autism spectrum disorder (ASD). HFP plans were required to provide ABA services to children with ASD. In the transition to Medi-Cal, children are referred to the Regional Center. If a child is not eligible for the Regional Center, there is some uncertainty about the continuity of ABA services.

Stakeholder and Provider Outreach. DHCS has conducted a robust stakeholder process and provider outreach, particularly to the dental provider community and to local community groups who assist families with applications. There have been monthly Webinar Presentations with time for questions and comments. Several smaller work groups have been convened to address specific issues such as behavioral health and dental services. Stakeholders have been provided with opportunities to review notices to families prior to mailing, albeit with very short turnout times. DHCS has established a website and has posted information regularly, including a lengthy list of Frequently Asked Questions at the suggestion of stakeholders.

The dental transition has received additional attention. With the exception of Sacramento, children are transitioning from a dental plan of their choice to Denti-Cal, which is the Medi-Cal FFS dental program. In Sacramento, children are transitioning to mandatory Medi-Cal managed care dental plans and in Los Angeles, there is a choice of FFS or a managed care plan. In order to provide adequate access to dentists in Denti-Cal, DHCS undertook a number of efforts in consultation with the California Dental Association and other stakeholders. These efforts include:

- Provider Survey – to determine provider capacity, ability to accept new clients, and identify barriers to enrollment.
- Call Campaign – Denti-Cal will place calls to follow up with providers, who have not responded to surveys or have stated that they will not enroll in Medi-Cal. This will be another attempt to encourage the providers to enroll to ensure network adequacy and access to care.
- Streamlined Enrollment – HFP provider applications to enroll in Denti-Cal will have high priority for processing. If additional information is needed to process the applications, Denti-Cal staff will contact the provider by phone to retrieve information and expedite the processing of the application.
- Webinars – Denti-Cal will hold a series of webinars to educate providers on how to enroll in Denti-Cal, how to bill for services, and other frequently asked questions.
- Provider Bulletins – Bulletins will be published monthly to educate providers on program changes and/or reminders on events (i.e. trainings).
- Beneficiary Surveys – Surveys will be sent to determine reasons for utilization of dental services, how to educate beneficiaries on accessing dental services, and what common issues or barriers beneficiaries may face.

STAFF COMMENTS/QUESTIONS

The committees have asked DHCS to answer the following questions:

Lessons Learned

1. What lessons have you learned in Phase 1A?
2. What changes have you or will you incorporate into future transition phases?
3. What issues did advocates and stakeholders raise during the conference call with CMS?
4. What is the reason that the transition was started prior to electronic transfer being in place?
5. Have you had other IT-related problems or issues that you have had to resolve?

Children Who Lost Their PCPs

1. What follow-up has been conducted to track how well the 1,847 children, who were not able to remain with their primary care provider (PCP) when they were transitioned in Phase 1A, have been able to see new PCPs and access care?
2. Since it is a *relatively* small number, have there been attempts to contact the families to ensure they have a new PCP?
3. The Network Assessment for Cal Optima noted that 12 PCPs would have more than 2,000 enrollees and that if enrollees assigned to over-capacity providers have difficulty accessing care they would have to choose a new PCP. What did you do to prepare for this?

Communication Coordination

1. Please describe your activities around, and lines of communication with, MRMIB, the CAA network, and health care providers.
2. Have there been outreach and education efforts for pediatricians similar to what was done for dentists? Did it include the American Academy of Pediatrics? Is there a contact at DHCS for physicians to get assistance?

Continuity of Care

1. What types of information are being analyzed by DHCS to identify continuity of care issues?
2. How are you tracking outcomes for these children?
3. Please provide an update on what is being done for children with ASD (Autism Spectrum Disorder) who are having problems accessing ABA (Applied Behavioral Analysis) treatments.
4. Has a policy or protocol been developed for continuity for children receiving ABA who transition to a Medi-Cal plan if they don't qualify for a Regional Center?
5. What is the policy or procedure for children who were receiving mental health services through a HFP plan, but do not qualify for the specialty mental health services or do not have serious emotional disturbances?
6. What is the policy or procedure for children with eating disorders? Is there a list of FFS providers for the Medi-Cal plans to refer the enrollee as is being done for dental?

Beneficiary Surveys

1. What progress has been made in conducting beneficiary surveys?
2. What populations will be surveyed in the initial report, and how many people will be included to provide a statistically significant sample as agreed upon in the Special Terms and Conditions of CMS?
3. Have beneficiary survey questions been generated, and when will they be shared with stakeholders?

Dental Care

1. What are the impacts of the initiatives DHCS has undertaken to enroll providers in Denti-Cal, including the prioritization of Healthy Families providers and the Preferred Provisional Provider process?

Calls, Complaints and Grievances

1. Does the monitoring report data include calls to MRMIB and the plans?
2. If so what are the nature of those calls?
3. Are there identifiable patterns to the calls?

Staff Recommendation: No actions are recommended for this hearing
