Health and Human Services Policy Committee

Wednesday, November 4 ▪ 10:00 – 11:00 a.m.
Via Conference Call
Dial In: (800) 867-2581 ▪ Passcode: 7500559#

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

10:00 a.m.	**I.**	**Welcome and Introductions** *Supervisor Ken Yeager, Santa Clara County* *Supervisor Hub Walsh, Merced County*
10:05 – 10:20 **ACTION ITEM**	**II.**	**November 2016 Ballot Initiative 13-0022: State Fees on Hospitals. Federal Medi-Cal Matching Funds. Initiative Statutory and Constitutional Amendment** *Proponent: Anne McLeod, Senior Vice President, Health Policy & Innovation, California Hospital Association*
10:25 – 10:40	**III.**	**Federal Medi-Cal 2020 Waiver Update** *Kelly Brooks Lindsey, Partner, Hurst Brooks Espinosa, LLP*
10:40 –10:55	**IV.**	**Federal Labor Standards Act – In Home Supportive Services Overtime** *Farrah McDaid Ting, Legislative Representative*
10:55 – 11:00	**V.**	**Medi-Cal Inmate Claiming Program** *Michelle Gibbons, Legislative Representative*
INFORMATION ONLY	**VI.**	**California Children's Services Redesign Update**
11:00 a.m.	**VII.**	**Adjournment**

For those who wish to attend this meeting in person, it will be held in CSAC's Peterson Conference Room (1st floor, 1100 K Street, Sacramento).
The conference call number is noted above for those who wish to call in.

Conference Call Etiquette

1. Place your line on **mute** at all times until you wish to participate in the conversation.
2. **DO NOT PLACE THE LINE ON HOLD.**
3. Please identify yourself when speaking.

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November 2, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **State Fees on Hospitals. Federal Medi-Cal Matching Funds. Initiative Statutory and Constitutional Amendment. – ACTION ITEM**

Staff Recommendation: CSAC staff recommends that the CSAC Health and Human Services Policy Committee adopt a **SUPPORT** position on initiative number 13-0022 - 'State Fees on Hospitals. Federal Medi-Cal Matching Funds. Initiative Statutory and Constitutional Amendment.' – which has qualified for the November 2016 ballot.

Background: The Quality Assurance Fee, hereby referred to as 'the fee,' was first established from in 2009 during the Great Recession, when California was seeking to maximize federal funding for health care services.

The fee is a payment made by private hospitals to the state. The state then uses those funds to leverage or "pull down" federal funding for health care services. The funding from the federal government is then used to make supplemental payments, grant payments, and enhanced capitation payments to the hospitals for services to Medi-Cal patients, as well as offsetting some state General Fund obligations for low-income children's coverage.

Since it was first enacted, the fee has become a critical part of the state's health care funding picture. It was first enacted on April 1, 2009 through December 31, 2010 by AB 1383 (Chapter 627, Statutes of 2009). Several successor bills were passed to allow the fee to continue:

- SB 90 (Chapter 19, Statutes of 2011) – January 1, 2011 through June 30, 2011
- SB 335 (Chapter 286, Statutes of 2011) – July 1, 2011 through December 31, 2013
- SB 239 (Chapter 657, Statutes of 2013) – January 1, 2014 – December 31, 2016

The fee allows the state to leverage critical federal funding and support children's health care services. By all measures, the fee has worked well for hospitals and the state. However, each legislative vehicle has included a sunset provision for the fee.

Therefore, the California Hospital Association has drafted a statewide statutory and constitutional amendment to enact the fee in perpetuity. The initiative qualified for the

November 2016 ballot in 2013, but has not yet been assigned a ballot number designation by the Secretary of State.

Summary: This initiative would repeal the sunset date for the hospital Quality Assurance Fee and would instead extend it indefinitely. Further, the initiative seeks to ensure that the State uses the funds for the intended purpose of supporting hospital care to Medi-Cal patients and to help pay for health care for low-income children.

Fiscal Impacts: The most recent analysis by the Legislative Analysts' Office (LAO) – which was provided in November 2013 - estimates the State could save roughly $500 million in FY 2016-17 $1 billion annually by 2019-20 and 5 to 10 percent annually for the following years. Additionally, the LAO estimates $90 million for hospitals beginning in 2016-17 and up to $250 by 2019-20, also possibly growing 5 to 10 percent each year after. See below for their projections from FY 13-14 through FY 16-17.

Please note that the LAO will likely provide a more current analysis once the initiative is assigned a ballot proposition number.

Figure 2

Projected Fiscal Effects of Hospital Quality Assurance Fee Under the Act[a]

(In Millions)

	2013-14 (Half-Year Impact)	2014-15	2015-16	2016-17 (Half-Year Impact)
Total fees collected	$1,797	$4,103	$4,714	$2,553
Uses of Fee Revenues				
Direct grants to public hospitals	27	56	67	38
General Fund offset for children's coverage	310	745	863	460
Fee revenues used to draw down FFP	1,460	3,302	3,784	2,054
Payment Increases and Federal Match				
Medi-Cal payment increases to hospitals[b]	3,144	7,149	8,245	4,433
FFP[c]	1,685	3,847	4,461	2,379
Net benefit to hospitals[d]	1,374	3,102	3,598	1,918

[a] Medi-Cal Hospital Reimbursement Improvement Act of 2013.
[b] Sum of fee-related supplemental payments and capitation payment increases.
[c] Includes: (1) FFP leveraged by fee revenue, and (2) 100 percent federal funds for payment increases associated with the expansion population. During calendar years 2014, 2015, and 2016, the FMAP for the expansion population will be 100 percent.
[d] Sum of Medi-Cal payment increases to hospitals and direct grants to public hospitals less total fees collected.
FFP = federal financial participation; FMAP = federal medical assistance percentage.

Staff Comments: California's expenses for Medi-Cal services are rising and the state budget is facing significant pressure next year. In the health care area, there is the potential for a $1.1 billion dollar deficit due to the inability to revise the Managed Care

Organization (MCO) tax during the just-ended Legislative Session. The fee is another source of significant low-income health care services revenue for California and it is a priority to preserve the Quality Assurance Fee and the services it helps fund.

Please note that CSAC did not take a position on any of the enacting legislation for the quality assurance fee mentioned above. Further, hospitals benefit from the fee, but the assistance with state Medi-Cal and children's costs help ease the state's overall budget picture.

Process. Should the HHS policy committee adopt a 'SUPPORT' position, the initiative will be forwarded to the full CSAC Board of Directors for action before the November 2016 statewide election.

The California statewide General Election will be held on Tuesday, November 8, 2016.

Staff Contacts:

Farrah McDaid Ting can be reached at (916) 327-7500 Ext. 559 or fmcdaid@counties.org.
Michelle Gibbons can be reached at (916) 327-7500 Ext. 524 or mgibbons@counties.org.

Invited Speaker:

Sponsor: Anne McLeod, Senior Vice President, Health Policy & Innovation, California Hospital Association

Attachments:

Initiative Text

Initiative Fact Sheet

Initiative Supporter Coalition List

Legislative Analyst's Office Fiscal Analysis (2013, expected to be updated in 2016)

13-0022

BELL, McANDREWS & HILTACHK, LLP
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SACRAMENTO, CALIFORNIA 95814

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October 9, 2013

Initiative Coordinator
Office of the Attorney General
State of California
PO Box 994255
Sacramento, CA 94244-25550

Re: Request for Title and Summary for Proposed Initiative

Dear Ms. McFarland:

Pursuant to Article II, Section 10(d) of the California Constitution, I am submitting the attached proposed statewide ballot measure to your office and request that you prepare a circulating title and summary of the measure as provided by law. I have also included with this letter the required signed statement pursuant to California Elections Code sections 9001 and 9608, and a check in the amount of $200. My address as registered to vote is shown on Attachment 'A' to this letter.

Thank you for your time and attention to this important matter. Should you have any questions or require additional information, please contact me.

Sincerely,

Thomas W. Hiltachk

TWH/cfd
Enclosures as stated.

SECTION 1. STATEMENT OF FINDINGS 13-0022

A. The federal government established the Medicaid program to help pay for health care services provided to low-income patients, including the elderly, persons with disabilities, and children. In California this program is called Medi-Cal. In order for any state to receive federal Medicaid funds, the State has to contribute a matching amount of its own money.

B. In 2009, a new program was created whereby California hospitals began paying a fee to help the State obtain available federal Medicaid funds, at no cost to California taxpayers. This program has helped pay for health care for low-income children and resulted in California hospitals receiving approximately $2 billion per year in additional federal money to help hospitals to meet the needs of Medi-Cal patients.

SECTION 2. STATEMENT OF PURPOSE

To ensure that the fee paid by hospitals to the State for the purpose of maximizing the available federal matching funds is used for the intended purpose, the People hereby amend the Constitution to:

A. Require voter approval of changes to the hospital fee program to ensure that the State uses these funds for the intended purpose of supporting hospital care to Medi-Cal patients and to help pay for health care for low-income children.

SECTION 3. AMENDMENT TO THE CONSTITUTION

Section 3.5 of Article XVI of the California Constitution is added to read:

Sec. 3.5(a) No statute amending or adding to the provisions of the Medi-Cal Hospital Reimbursement Improvement Act of 2013 shall become effective unless approved by the electors in the same manner as statutes amending initiative statutes pursuant to section 10(c) of Article II, except that the Legislature may, by statute passed in each house by roll call vote entered into the journal, two-thirds of the membership concurring, amend or add provisions that further the purposes of the Act.

(b) For purposes of this section:

(1) "Act" means the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (enacted by Senate Bill 239 of the 2013-14 Regular Session of the Legislature, and any non-substantive amendments to the Act enacted by a later bill in the same Session of the Legislature).

(2) "Non-substantive amendments" shall only mean minor, technical, grammatical, or clarifying amendments.

(3) "Provisions that further the purposes of the Act" shall only mean:

(i) amendments or additions necessary to obtain or maintain federal approval of the implementation of the Act, including the fee imposed and related quality assurance payments to hospitals made pursuant to the Act;

(ii) amendments or additions to the methodology used for the development of the fee and quality assurance payments to hospitals made pursuant to the Act.

(c) Nothing in this section shall prohibit the Legislature from repealing the Act in its entirety by statute passed in each house by roll call vote entered into the journal, two-thirds of the membership concurring, except that the Legislature shall not be permitted to repeal the Act and replace it with a similar statute imposing a tax, fee, or assessment unless that similar statute is either: (i) a provision that furthers the purposes of the Act as defined herein; or (ii) is approved by the electors in the same manner as statutes amending initiative statutes pursuant to section 10(c) of Article II.

(d) The proceeds of the fee imposed by the Act and all interest earned on such proceeds shall not be considered revenues, General Fund revenues, General Fund proceeds of taxes, or allocated local proceeds of taxes, for purposes of Sections 8 and 8.5 of this Article or for the purposes of article XIIIB. The appropriation of the proceeds in the Trust Fund referred to in the Act for hospital services to Medi-Cal beneficiaries or other beneficiaries in any other similar federal program shall not be subject to the prohibitions or restrictions in Sections 3 or 5 of this Article.

SECTION 4. Amendments to Medi-Cal Hospital Reimbursement Improvement Act of 2013

(language added is designated in underlined type and language deleted is designated in ~~strikeout~~ type)

Section 14169.72 of Article 5.230 of the Welfare and Institutions Code is amended to read:

§14169.72. This article shall become inoperative if any of the following occurs:

(a) The effective date of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article, or Section 14169.54 or 14169.55, cannot be implemented. This subdivision shall not apply to any final judicial determination made by any court of appellate jurisdiction in a case brought by hospitals located outside the state.

(b) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve on or before the last day of a program period, the implementation of Section 14169.52, 14169.53, 14169.54, and 14169.55, and the department fails to modify Section 14169.52, 14169.53, 14169.54, and 14169.55 pursuant to subdivision (d) of Section 14169.53 in order to meet the requirements of federal law or to obtain federal approval.

(c) The Legislature fails to appropriate moneys in the Hospital Quality Assurance Revenue Fund in the annual Budget Act, or fails to appropriate such moneys in a separate bill enacted within thirty (30) days following enactment of the annual Budget Act. ~~A final judicial determination by the California Supreme Court or any California Court of Appeal that the revenues collected pursuant to this article that are deposited in the Hospital Quality Assurance Revenue Fund are either of the following:~~

~~(1) "General Fund proceeds of taxes appropriated pursuant to Article XIII B of the California Constitution," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.~~

~~(2) "Allocated local proceeds of taxes," as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.~~

(d) The department has sought but has not received federal financial participation for the supplemental payments and other costs required by this article for which federal financial participation has been sought.

(e) A lawsuit related to this article is filed against the state and a preliminary injunction or other order has been issued that results in a financial disadvantage to the state. For purposes of this subdivision, "financial disadvantage to the state" means either of the following:

(1) A loss of federal financial participation.

(2) A net ~~cost to the~~ General Fund cost incurred due to the Act ~~that is equal to or greater than one-quarter of 1 percent of the General Fund expenditures authorized in the most recent annual Budget Act~~.

(f) The proceeds of the fee and any interest and dividends earned on deposits are not deposited into the Hospital Quality Assurance Revenue Fund or are not used as provided in section 14169.53

(g) The proceeds of the fee, the matching amount provided by the federal government, and interest and dividends earned on deposits in the Hospital Quality Assurance Revenue Fund are not used as provided in section 14169.68.

Section 14169.75 of Article 5.230 of the Welfare and Institutions Code is amended to read:

§14169.75. Notwithstanding subdivision (k) of section 14167.35, subdivisions (a), (i), and (j) of section 14167.35, creating the Hospital Quality Assurance Revenue Fund, are not repealed and shall remain operative as long as this article remains operative. ~~Notwithstanding Section 14169.72, this article shall become inoperative on January 1, 2018. No hospital shall be required to pay the fee after that date unless the fee was owed during the period in which the article was operative, and no payments authorized under Section 14169.53 shall be made unless the payments were owed during the period in which the article was operative.~~

SECTION 5. GENERAL PROVISIONS

(a) If any provision of this measure, or any part thereof, is for any reason held to be invalid or unconstitutional, the remaining provisions shall not be affected, but shall remain in full force and effect, and to this end the provisions of this measure are severable.

(b) This measure is intended to be comprehensive. It is the intent of the People that in the event this measure or measures relating to the same subject shall appear on the same statewide election ballot, the provisions of the other measure or measures shall be deemed to be in conflict with this measure. In the event that this measure receives a greater number of affirmative votes, the provisions of this measure shall prevail in their entirety, and all provisions of the other measure or measures shall be null and void.

Providing Care for 12 Million Children, Seniors and Working Families

Thanks to a historic bipartisan legislative agreement in 2013, without a single "No" vote and with the governor's signature, California will receive billions a year in new federal funding for health care for children and seniors. However, this law expires in 2017.

The Medi-Cal Funding and Accountability Act (Act) is a simple, common sense solution that makes the reforms permanent and guarantees ongoing federal health care funding. This change is needed now to ensure that California receives its fair share from Washington DC and to ensure the money is spent as intended.

Government Accountability

At a time of great uncertainty about health care, the Act ensures new federal matching funds are used for those who truly need it. The Act holds the Legislature accountable and prohibits government, bureaucrats or other special interests from diverting funds away from health care for unrelated purposes. Any changes to the use of the funds would have to be approved by voters first.

$3 Billion Annually in New Federal Matching Funds

Hospitals have agreed to participate in a program that unlocks approximately $3 billion a year in new federal matching funds, maximizing California's share. The money must be spent to provide health care services to children and resources for Medi-Cal to serve elderly and low-income Californians. Without these resources, the money would have to come from privately insured patients.

Protect Taxpayers and Access to Hospital Care

People with private insurance shouldn't have their premiums increased to subsidize Medi-Cal when federal money is available to help cover the cost. Funding guaranteed by the Act will also help prevent closures or cutbacks in local hospitals and emergency rooms.

Statewide Support

Hospitals and health care providers across California have joined together to sponsor this common sense solution, which protects services for children and seniors. There is no organized opposition to the measure.

Paid for by Californians United for Medi-Cal Funding Accountability, sponsored by California Association of Hospitals and Health Systems. Major funding by California Health Foundation and Trust and Sutter Health. 1215 K Street, Suite 800, Sacramento CA 95814 101615

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Coalition List

Health Care Associations

- California Hospital Association
- California Children's Hospital Association
- Hospital Association of San Diego & Imperial Counties
- Hospital Association of Southern California
- Hospital Council of Northern & Central California
- Alliance of Catholic Health Care
- American Academy of Pediatrics - California
- Association of California Healthcare Districts
- Association of California Nurse Leaders
- California Academy of Physician Assistants*
- California Ambulance Association*
- California Ambulatory Surgery Association*
- California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) *
- California Association of Health Facilities
- California Association of Health Plans
- California Association of Health Underwriters*
- California Association of Medical Product Suppliers*
- California Association of Neurological Surgeons*
- California Association for Nurse Practitioners**
- California Association of Nurse Anesthetists
- California Association of Physician Groups
- California Black Health Network*
- California Chapter of the American College of Cardiology*
- California Council of Community Mental Health Agencies (CCCMHA)*
- California Dental Association
- California Medical Association*
- California Orthopaedic Association*
- California Pharmacists Association
- California Primary Care Association*
- California Psychological Association*
- California Radiological Society*
- California Society of Addiction Medicine (CSAM)*
- California Society of Health-System Pharmacists
- California Society of Industrial Medicine and Surgery*
- California Society of Pathologists
- Children's Specialty Care Coalition
- Infectious Disease Association of California*
- Medical Oncology Association of Southern California, Inc. (MOASC)*
- Mental Health America in California*
- Network of Ethnic Physician Organizations*
- Osteopathic Physicians & Surgeons of California
- PEACH, Inc. (Private Essential Access Community Hospitals)
- Southern California Public Health Association*

Children's Hospitals

- Children's Hospital Los Angeles
- Children's Hospital Orange County
- CHOC Children's at Mission Hospital
- Miller Children's Hospital Long Beach
- Rady Children's Hospital – San Diego
- Valley Children's Healthcare

Hospitals + Healthcare Districts

- Alta Bates Summit Medical Center
- Arroyo Grande Community Hospital
- Bakersfield Memorial Hospital
- Barton Health
- Beverly Hospital*
- California Hospital Medical Center

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- California Pacific Medical Center
- Catalina Island Medical Center
- Cedars-Sinai Medical Center
- Coalinga Regional Medical Center
- Community Hospital Long Beach
- Community Hospital of San Bernardino
- Desert Regional Medical Center*
- Doctors Hospital of Manteca*
- Doctors Medical Center of Modesto*
- Dominican Hospital
- Eastern Plumas Health Care
- Eden Medical Center
- El Camino Hospital
- Emanuel Medical Center
- Fairchild Medical Center
- Fountain Valley Regional Hospital*
- French Hospital Medical Center
- Gardens Regional Hospital and Medical Center*
- Glendale Memorial Hospital and Health Center
- Grossmont Healthcare District*
- Henry Mayo Newhall Hospital*
- Hi-Desert Medical Center*
- Hollywood Presbyterian Medical Center
- John F. Kennedy Memorial Hospital*
- John Muir Behavioral Health
- John Muir Medical Center – Concord Campus
- John Muir Medical Center – Walnut Creek Campus
- Lakewood Regional Medical Center*
- Lodi Health
- Long Beach Memorial Medical Center
- Los Alamitos Medical Center*
- Los Robles Hospital and Medical Center*
- Madera Community Hospital
- Mammoth Hospital
- Marian Regional Medical Center
- Marian Regional Medical Center - West
- Marina Del Rey Hospital*
- Mark Twain St. Joseph's Hospital
- Marshall Medical Center
- Memorial Hospital, Los Banos
- Memorial Medical Center
- Menlo Park Surgical Hospital
- Mercy General Hospital
- Mercy Hospital
- Mercy Hospital of Folsom
- Mercy Medical Center Merced
- Mercy Medical Center Mt. Shasta
- Mercy Medical Center Redding
- Mercy San Juan Medical Center
- Mercy Southwest Hospital
- Methodist Hospital of Sacramento
- Mills-Peninsula Health Services
- Mission Community Hospital
- Northridge Hospital Medical Center
- Novato Community Hospital
- Orchard Hospital
- PIH Health – Downey
- PIH Health – Whittier
- Pacific Alliance Medical Center
- Palmdale Regional Medical Center*
- Palo Verde Hospital*
- Parkview Community Hospital Medical Center
- Placentia-Linda Hospital*
- Pomona Valley Hospital Medical Center
- Providence Holy Cross Medical Center
- Providence Little Company of Mary Medical Center San Pedro
- Providence Little Company of Mary Medical Center Torrance
- Providence Saint Joseph Medical Center
- Providence Tarzana Medical Center
- Redlands Community Hospital
- Ridgecrest Regional Hospital
- Saint Agnes Medical Center*
- Saint Francis Memorial Hospital
- Saint John's Health Center
- San Bernardino Mountains Community Hospital District
- San Gabriel Valley Medical Center
- San Ramon Regional Medical Center*
- Sequoia Hospital
- Sharp Chula Vista Medical Center
- Sharp Coronado Hospital and Healthcare Center
- Sharp Grossmont Hospital

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* New Endorsements (2015)

- Sharp Mary Birch Hospital for Women and Newborns
- Sharp Mesa Vista
- Sharp Memorial Hospital
- Sierra Nevada Memorial Hospital
- Sierra View Medical Center*
- Sierra Vista Hospital
- Sierra Vista Regional Medical Center*
- St. Bernadine Medical Center
- St. Elizabeth Community Hospital
- St. John's Pleasant Valley Hospital
- St. John's Regional Medical Center
- St. Joseph's Behavioral Health Center
- St. Joseph's Medical Center
- St. Mary Medical Center
- St. Mary's Medical Center
- St. Rose Hospital
- Stanford Health Care
- Stanford Health Care – ValleyCare
- Sutter Amador Hospital
- Sutter Auburn Faith Hospital
- Sutter Coast Hospital
- Sutter Davis Hospital
- Sutter Delta Medical Center
- Sutter Lakeside Hospital and Center for Health
- Sutter Maternity & Surgery Center of Santa Cruz
- Sutter Medical Center, Sacramento
- Sutter Roseville Medical Center
- Sutter Santa Rosa Regional Hospital
- Sutter Solano Medical Center
- Sutter Tracy Community Hospital
- Temecula Valley Hospital
- Totally Kids Rehabilitation Hospital
- Twin Cities Community Hospital*
- Valley Presbyterian Hospital
- West Anaheim Medical Center*
- White Memorial Medical Center
- Woodland Healthcare

Clinics

- Anderson Family Health & Dental Center*
- Antelope Valley Community Clinic*
- Burre Dental Center*
- Community Clinic Association of Los Angeles County (CCALAC)*
- Community Health Partnership (10 Clinics)*
- Del Norte Community Health Center*
- Eureka Community Health Center*
- Ferndale Community Health Center*
- Forestville Teen Clinic*
- Forestville Wellness Center*
- Fortuna Community Health Center*
- Gravenstein Community Health Center*
- Happy Valley Family Health Center*
- Harbor Community Clinic*
- Humboldt Open Door Clinic*
- Kids Come First Health Center*
- L.A. Mission College Student Health Center*
- Maclay Health Center for Children*
- McKinley Community Health*
- Mendocino Coast Clinics*
- Mission Neighborhood Health Center*
- Mobile Health Services*
- Neighborhood Healthcare (10 Clinics)*
- NEVHC Canoga Park Health Center*
- NEVHC Health Center for the Homeless, North Hollywood*
- NEVHC Mobile Medical Unit*
- NEVHC Pacoima Health Center*
- NEVHC Pediatric Health & WIC Center*
- NEVHC Rainbow Dental Center*
- NEVHC San Fernando Health Center*
- NEVHC Santa Clarita Health Center*
- NEVHC Sun Valley Health Center*
- NEVHC Valencia Health Center*
- North East Medical Services (10 Clinics)*
- Northcountry Clinic*
- Northcountry Prenatal Services*
- Northeast Valley Health Corporation*
- Occidental Area Health Center*
- Open Door Community Health Centers (8 Clinics)*
- Peach Tree Health*
- Primary Care Neuropsychiatry (PCN)*

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* New Endorsements (2015)

- QueensCare Health Centers (5 Clinics)*
- Redwood Community Health Coalition (18 Clinics)*
- Russian River Health Center*
- Russian River Dental Clinic*
- Saban Community Clinic*
- San Fernando Teen Health Center*
- San Ysidro Health Center*
- Santa Rosa Community Health Centers (8 Clinics)*
- Sebastopol Community Health Center*
- Shasta Community Health Center*
- Shasta Community Health Dental Center*
- Shasta Lake Family Health and Dental Center*
- Sierra Family Medical Clinic*
- South Bay Family Health Care*
- South Central Family Health Center (4 Clinics)*
- Southside Coalition of Community Health Care Centers*
- St. John's Well Child & Family Center (10 Clinics)*
- Tarzana Treatment Centers, Inc.*
- Van Nuys Adult Health Center*
- WCHC Mental Health Services*
- West County Health Centers*
- Westside Family Health Center*
- Willow Creek Community Health Center*

Health Systems

- Citrus Valley Health Partners
- Community Medical Centers
- Community Memorial Health System
- Cottage Health System
- PIH Health
- Palomar Health
- Providence Health & Systems, Southern California
- Sharp HealthCare
- Dignity Health
- Kaiser Permanente
- John Muir Health
- NorthBay Healthcare
- Southwest Healthcare System*
- Sutter Health
- Tenet Healthcare*

Community Based Organizations

- A New PATH (Parents for Addiction Treatment & Healing)*
- Age Well Senior Services*
- Asian Pacific Islander American Public Affairs Association (APAPA)
- CORA – Community Overcoming Relationship Abuse*
- California Senior Action League*
- California Youth Connection*
- Community Health Improvement Partners*
- Congress of California Seniors**
- Curry Senior Center*
- Family Voices of California
- Helping Others Pursue Excellence (HOPE)*
- National Association of Hispanic Elderly*
- Orange County LULAC Foundation*
- Sacramento Steps Forward*
- San Clemente Collaborative
- Solano Coalition for Better Health*
- The Children's Initiative
- The Wall-Las Memorias Project*
- United Advocates for Children and Families*
- Women's Empowerment*

Dental Societies

- Berkeley Dental Society*
- Central Coast Dental Society*
- Los Angeles Dental Society*
- Mid-Peninsula Dental Society*
- San Francisco Dental Society*

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* New Endorsements (2015)

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Elected Officials

- California Latino Elected Officials Coalition
- Mayor Kevin L. Faulconer, City of San Diego
- Mayor Kevin Johnson, City of Sacramento*
- Walter Allen III, Council Member, City of Covina*
- Jim B. Clarke, Council Member, Culver City*
- Fiona Ma, Member, California State Board of Equalization*

Business Organizations

- California Business Roundtable
- California Chamber of Commerce
- California Asian Pacific Chamber of Commerce
- Alhambra Chamber of Commerce*
- Arcadia Chamber of Commerce*
- Azusa Chamber of Commerce*
- Beaumont Chamber of Commerce*
- Beverly Hills Chamber of Commerce*
- BizFed – The Los Angeles County Business Federation*
- Brea Chamber of Commerce
- Burbank Chamber of Commerce*
- Cerritos Regional Chamber of Commerce*
- Chamber of Commerce Mountain View*
- The Chamber of the Santa Barbara Region*
- Duarte Chamber of Commerce*
- East Bay Leadership Council*
- El Dorado County Joint Chambers of Commerce*
- El Dorado County Chamber of Commerce*
- El Dorado Hills Chamber of Commerce*
- Elk Grove Chamber of Commerce*
- Folsom Chamber of Commerce*
- Fountain Valley Chamber of Commerce*
- Fremont Chamber of Commerce*
- Fresno Chamber of Commerce
- Fullerton Chamber of Commerce
- Gateway Chambers Alliance*
- Greater Grass Valley Chamber of Commerce*
- Greater Los Angeles African American Chamber of Commerce*
- Greater Riverside Chamber of Commerce*
- Greater San Fernando Valley Chamber of Commerce*
- Greater Stockton Chamber of Commerce*
- Hayward Chamber of Commerce*
- Hollywood Chamber of Commerce*
- Huntington Beach Chamber of Commerce*
- Industry Manufacturers Council*
- Inland Empire Economic Partnership
- La Canada Flintridge Chamber of Commerce*
- Lake Elsinore Chamber of Commerce*
- Lake Tahoe South Shore Chamber of Commerce*
- Los Angeles Area Chamber of Commerce*
- Menifee Valley Chamber of Commerce*
- Montebello Chamber of Commerce*
- Monterey Peninsula Chamber of Commerce*
- Mount Shasta Chamber of Commerce*
- Murrieta Chamber of Commerce*
- North Orange County Legislative Alliance
- North San Diego Business Chamber*
- Northridge Chamber of Commerce*
- Norwalk Chamber of Commerce*
- Perris Valley Chamber of Commerce*
- Rancho Cordova Chamber of Commerce*
- Regional Chamber Alliance*
- Rocklin Area Chamber of Commerce*
- Roseville Chamber of Commerce*
- Sacramento Metropolitan Chamber of Commerce*
- San Diego East County Chamber of Commerce*
- San Diego Regional Chamber of Commerce
- San Francisco Chamber of Commerce*
- San Gabriel Valley Economic Partnership*
- San Jose Silicon Valley Chamber of Commerce

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* New Endorsements (2015)

- Santa Clara Chamber of Commerce and Convention-Visitor's Bureau*
- Santa Clarita Valley Chamber of Commerce*
- Santa Monica Chamber of Commerce*
- Santa Paula Chamber of Commerce*
- Shingle Springs Cameron Park Chamber of Commerce*
- Silicon Valley Chamber Coalition*
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Personal Endorsements - Title and/or organization name used for identification purposes only

- Mike Genest, Former Director, California Department of Finance*
- Tom Scott, State Executive Director, National Federation of Independent Business (NFIB)*
- Whitney Ayers, Regional Vice President, Hospital Association of Southern California*
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November 14, 2013

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed constitutional and statutory initiative (A.G. File No. 13-0022) relating to conditions for amending, repealing, replacing, or rendering inoperative the Medi-Cal Hospital Reimbursement Improvement Act of 2013—current law that concerns the imposition of fees on certain private hospitals.

BACKGROUND

Overview of Medi-Cal

Medi-Cal Administration and Coverage. The federal Centers for Medicare and Medicaid Services (CMS) administers the federal Medicaid Program. In California, this federal program is administered by the state Department of Health Care Services (DHCS) as the California Medical Assistance Program, and is known more commonly as Medi-Cal. This program currently provides health care benefits to about 7.9 million low-income persons who meet certain eligibility requirements for enrollment in the program (hereafter referred to as the currently eligible population). Under the Patient Protection and Affordable Care Act (ACA), also known as federal health care reform, the state will expand Medi-Cal to cover over one million low-income adults who are currently ineligible (hereafter referred to as the expansion population), beginning January 1, 2014.

Medi-Cal Financing. The costs of the Medicaid Program are generally shared between states and the federal government based on a set formula. The federal government's contribution toward reimbursement for Medicaid expenditures is known as federal financial participation (FFP). The percentage of Medicaid costs paid by the federal government is known as the federal medical assistance percentage (FMAP).

In general, the FMAP for Medi-Cal costs associated with the currently eligible population has been set at 50 percent. (However, for certain currently eligible subpopulations and certain administrative activities, the state receives a higher FMAP percent.) As Figure 1 shows (see next page), for three years beginning January 1, 2014, the FMAP for nearly all Medi-Cal costs

associated with the expansion population will be 100 percent. Beginning January 1, 2017, the FMAP associated with the expansion population will decrease over a three-year period until reaching 90 percent on January 1, 2020, where it will remain thereafter under current federal law.

Figure 1
FMAP for Expansion Population

Calendar Year	FMAP
2014	100%
2015	100
2016	100
2017	95
2018	94
2019	93
2020 and thereafter	90

FMAP = federal medical assistance percentage.

Federal Medicaid law permits states to finance the nonfederal share of Medicaid costs through several sources, including (but not limited to):

- ***State General Funds.*** State general funds are revenues collected primarily through personal income, sales, and corporate income taxes.
- ***Charges on Health Care Providers.*** Federal Medicaid law permits states to (1) levy various types of charges—including taxes, fees, or assessments—on health care providers and (2) use the proceeds to draw down FFP to support their Medicaid programs and/or offset some state costs. These charges must meet certain requirements and be approved by CMS for revenues from these charges to be eligible to draw down FFP. A number of different types of providers can be subject to these charges, including hospitals.

Medi-Cal Delivery Systems. Medi-Cal provides health care through two main systems: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment directly from DHCS for each medical service delivered to a beneficiary. In the managed care system, DHCS contracts with managed care plans to provide health care for Medi-Cal beneficiaries enrolled in these plans. Managed care enrollees may obtain services from providers—including hospitals—that accept payments from the plans. The DHCS reimburses plans with a predetermined amount per enrollee, per month (known as a capitation payment) regardless of the number of services each enrollee actually receives.

Medi-Cal Hospital Financing

About 400 general acute care hospitals licensed by the state currently receive at least one of three types of payments Medi-Cal makes to pay for services for patients. As follows, these hospitals are divided into three categories based on whether the hospital is privately owned or publicly owned, and who operates the hospital.

- ***Private Hospitals.*** These are hospitals owned and operated by private corporations.
- ***District Hospitals.*** These are public hospitals owned and operated by municipalities and health care districts.
- ***County Hospitals and University of California (UC) Hospitals.*** These are public hospitals owned and operated by counties or the UC system.

Below we describe the three types of payments—direct payments, supplemental payments, and managed care payments—that Medi-Cal makes for hospital services.

Direct Payments. Direct payments are payments for services provided to Medi-Cal patients through FFS. The nonfederal share of Medi-Cal direct payments to private and district hospitals is funded from the state General Fund, while the nonfederal share of direct payments to county and UC hospitals is self-funded.

Supplemental Payments. Supplemental payments (considered a type of FFS payment) are made in addition to direct payments. Medi-Cal generally makes supplemental payments to hospitals periodically on a lump-sum basis, rather than individual increases to reimbursement rates for specific services. There are various types of supplemental payments related to hospital services provided to Medi-Cal patients, including a category of payments to private hospitals known as Disproportionate Share Hospital (DSH) replacement payments that we discuss further later in this analysis. Depending on the type of supplemental payment, the nonfederal share may be comprised of General Fund support, revenues from charges levied on hospitals, or other state and local funding sources.

Managed Care Payments. Managed care payments are payments from managed care plans to providers for services delivered to Medi-Cal patients enrolled in these plans. The capitation payments that plans receive from DHCS are meant to cover the expected costs to plans from making payments to providers, including hospitals. The nonfederal share of capitation payments to managed care plans is comprised of General Fund support, charges levied on hospitals, and other state and local funding sources.

Federal Limits on FFS Hospital Payments. Federal regulations specify that to be eligible for FFP, the total amount of Medi-Cal FFS payments to private hospitals—that is, the sum of all direct and supplemental payments for private hospital services—may not exceed a maximum amount known as the upper payment limit (UPL). (There are separate UPLs that apply to payments to hospitals owned and operated by local governments such as counties, and hospitals owned and operated by the state such as UC hospitals.) The UPL is a statewide aggregate ceiling on FFS payments to all private hospitals. This means there are no limits on FFS payments to individual private hospitals, as long as total FFS payments to all private hospitals do not exceed the UPL. In California, the UPL for hospital services has historically been between 5 percent to 10 percent above the total costs incurred by hospitals from providing these services, as defined under cost-reporting procedures approved by CMS.

Federal Limits on Managed Care Hospital Payments. The UPL does not apply to managed care payments for hospital services. However, federal Medicaid law requires qualified actuaries to certify capitation payments to managed care plans as being "actuarially sound" before these

payments may receive FFP. This certification involves the actuaries' assessment that capitation payments reflect "reasonable, appropriate, and attainable" costs to plans from making payments to providers, including hospitals. In practice, actuarial soundness requirements directly limit the total amount of capitation payments that DHCS may make to plans, and thus indirectly limit the total amount of payments that plans may make to hospitals.

Hospital Quality Assurance Fee

Chapter 657, Statutes of 2013 (SB 239, Hernandez), enacts the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (hereafter referred to as the Act). The Act imposes a charge known as a quality assurance fee (hereafter referred to as the fee) on certain private hospitals beginning January 1, 2014.

If approved by CMS and implemented, the fee imposed by the Act will constitute the fourth consecutive hospital quality assurance fee program implemented in California since 2009 (each of the prior three programs had a statutory sunset date). The fee program authorized under the Act is broadly similar in structure to the prior three fee programs. The Act establishes a general structure for (1) how the fee is to be assessed and (2) how the proceeds from the fee are to be spent. We describe both components of this structure below.

Fee Assessment. Under the Act, the state will assess the fee for each inpatient day at each private hospital. The fee rate per inpatient day will vary depending on payer type, with the highest rates assessed on Medi-Cal inpatient days and lower rates assessed on days paid for by other payers, such as private insurance. The fee rate ranges from $145 for each inpatient day covered by a non-Medi-Cal payer to $618 per inpatient day covered by Medi-Cal. Private hospitals will pay the fee in quarterly installments.

Use of Fee Moneys to Offset State Costs. Under the Act, DHCS will administer and collect the fee from hospitals and deposit the proceeds into the Hospital Quality Assurance Revenue Fund. Moneys in this fund—the proceeds of the fee and any interest earned on the proceeds—are available only for certain purposes. These purposes include the following that serve to offset state costs (in order of descending priority):

- Up to $1 million of the moneys annually will be allocated to reimburse DHCS for the staffing and administrative costs related to implementing the fee.
- A certain portion of the moneys (determined by a formula) will offset General Fund costs for providing children's health care coverage, thereby achieving General Fund savings. Later we describe how the allocation for this General Fund offset is to be determined under the Act.

Use of Fee Moneys for Quality Assurance Payments. After moneys in the fund are allocated to offset state costs, the remaining moneys are available to support payment increases to hospitals, collectively known as quality assurance payments (in order of descending priority).

- A large portion of the moneys will provide the nonfederal share of certain increases to capitation payments to managed care plans, up to the maximum actuarially sound amount permitted by federal law. The plans are required to pass along these capitation increases entirely to private hospitals, county hospitals, and UC hospitals.

- A large portion of the moneys will provide the nonfederal share of certain supplemental payments to private hospitals, bringing total FFS payments to private hospitals as close as possible to the UPL.
- Some of the moneys may be used to fund direct grants to public hospitals. Any grant amounts retained by public hospitals are not considered Medi-Cal payments, and thus are not eligible for FFP.

At the end of this background discussion, Figure 2 (see page 7) displays our detailed projections of the annual amounts of fee moneys used to offset state costs and support quality assurance payments to hospitals under the Act.

Net Benefit and General Fund Offset for Children's Coverage. Under the Act, beginning July 1, 2014, the annual amount of moneys used to offset General Fund costs for children's health care coverage will equal 24 percent of the "net benefit" to hospitals, hereafter referred to as net benefit. (For the period between January 1, 2014 and June 30, 2014, the amount of General Fund offset is set at $155 million per quarter rather than a percentage of the net benefit.) The Act defines net benefit as total fee revenue collected from hospitals in each fiscal year, minus the sum of the following quality assurance payments:

- Fee-funded supplemental payments and direct grants.
- Fee-related capitation increases for hospital payments.

Fee-related capitation increases consist of (1) fee-funded increases related to hospital services for the currently eligible population and (2) increases related to hospital services for the expansion population. Due to the enhanced FMAP for the Medi-Cal expansion, the net benefit from a capitation increase for the expansion population is generally greater than the net benefit from an equal increase for the currently eligible population. For example, a capitation increase of $100 million for the currently eligible population would result in a net benefit of roughly $50 million, since hospitals would provide the nonfederal share for this increase through fee revenue. In contrast, the net benefit from a capitation increase of $100 million for the expansion population would be between $90 million and $100 million, depending on the FMAP in effect for the year in question.

Fee Program Periods. The Act (1) specifies the schedule of fee rates for the period between January 1, 2014 and December 31, 2016, and (2) requires DHCS to periodically redevelop the schedule of fee rates thereafter. Each schedule of fee rates will apply to separate and consecutive "program periods," each lasting no more than three years. While the schedules may differ by program period, each schedule will conform to the general structure for assessing the fee and using the proceeds as specified in the Act. That is, for each program period, DHCS will develop a schedule of fee rates that: (1) varies per inpatient day by payer type, with higher rates assessed on Medi-Cal days, and (2) enables the maximum amount of supplemental payments and capitation increases for hospital payments that receive FFP.

The Act designates the period of January 1, 2014 through December 31, 2016 as the first program period, and the period of January 1, 2017 through June 30, 2019, as the second program period. Under the Act, DHCS will determine the duration of subsequent program periods. During

the first program period, moneys in the Hospital Quality Assurance Revenue Fund will be continuously appropriated without further legislative action. In subsequent program periods, the Legislature will authorize expenditures from the fund in the annual budget act.

FFS Maintenance-of-Effort (MOE) for Hospital Services. The Act contains a provision to ensure that fee-related moneys are used to supplement and not supplant existing funding for hospital services provided to Medi-Cal patients. Specifically, the Act stipulates that for hospital services provided to Medi-Cal patients through FFS on or after January 1, 2014, the total amount of payments supported by General Fund expenditures shall not be less than the total amount that would have been paid for the same services on December 1, 2013. The Act specifically exempts DSH replacement payments from this MOE requirement. We estimate that for the 2012-13 fiscal year, the state provided $2 billion in General Fund expenditures for the types of FFS payments subject to the Act's MOE requirement.

Conditions Rendering Fee Inoperative. The Act includes several poison pill provisions specifying certain conditions that would render the Act inoperative, including, but not limited to:

- A judicial determination by the State Supreme Court or a State Court of Appeal that revenues from the fee must be included for purposes of calculating the Proposition 98 funding level required for schools. We describe the Proposition 98 funding requirement later in this analysis.
- A lawsuit related to the Act results in a General Fund cost of at least 0.25 percent of General Fund expenditures authorized in the most recent annual budget act (about $240 million in 2013-14).

Absent conditions that would trigger the Act's poison pill provisions and render the Act inoperative, the Act becomes inoperative by its terms as of January 1, 2017, due to a sunset provision. Therefore, under current law, the fee will be in place only through the first program period. (Moreover, authorization of the Hospital Quality Assurance Revenue Fund expires on January 1, 2018.) However, as noted, the Act prescribes a general structure for assessing the fee and using the proceeds that would apply to subsequent program periods if legislation were enacted to both extend the fee and maintain the fund.

Projected Fiscal Effects of the Act. Figure 2 provides our projections of (1) total fees collected as authorized by the Act, (2) uses of the fee revenues under the Act, and (3) fiscal effects on the state and hospitals of the Act.

Figure 2

Projected Fiscal Effects of Hospital Quality Assurance Fee Under the Act[a]

(In Millions)

	2013-14 (Half-Year Impact)	2014-15	2015-16	2016-17 (Half-Year Impact)
Total fees collected	$1,797	$4,103	$4,714	$2,553
Uses of Fee Revenues				
Direct grants to public hospitals	27	56	67	38
General Fund offset for children's coverage	310	745	863	460
Fee revenues used to draw down FFP	1,460	3,302	3,784	2,054
Payment Increases and Federal Match				
Medi-Cal payment increases to hospitals[b]	3,144	7,149	8,245	4,433
FFP[c]	1,685	3,847	4,461	2,379
Net benefit to hospitals[d]	1,374	3,102	3,598	1,918

[a] Medi-Cal Hospital Reimbursement Improvement Act of 2013.
[b] Sum of fee-related supplemental payments and capitation payment increases.
[c] Includes: (1) FFP leveraged by fee revenue, and (2) 100 percent federal funds for payment increases associated with the expansion population. During calendar years 2014, 2015, and 2016, the FMAP for the expansion population will be 100 percent.
[d] Sum of Medi-Cal payment increases to hospitals and direct grants to public hospitals less total fees collected.
FFP = federal financial participation; FMAP = federal medical assistance percentage.

PROPOSAL

This measure would amend the State Constitution to (1) restrict the Legislature's ability to amend, repeal, or replace the Act by statute, and (2) require voter approval to amend or replace the Act outside of these restrictions. The measure would also amend by statute the Act's poison pill provisions and remove the Act's sunset provision. The measure would also remove the Act's poison pill provision related to Proposition 98, and amend the Constitution to specify that revenues from the fee imposed by the Act and all interest earned thereon shall not be considered as revenues subject to the Proposition 98 funding requirement calculation. Below we describe the specific amendments that the measure would place in the Constitution, and then describe the statutory amendments that the measure would enact.

Constitutional Amendments

Requirements for Amending, Repealing, or Replacing the Act. This measure amends the Constitution to require two-thirds majorities in both houses of the Legislature to pass any statute that repeals the Act in its entirety. In addition, any statute that amends or replaces the Act requires voter approval in a statewide election before taking effect, unless both of the following conditions are met:

- The Legislature passes the statute with two-thirds majorities in both houses.

- The statute (1) is necessary for securing federal approval to implement the fee program, or (2) only changes the methodology used for developing the fee or quality assurance payments.

We note that under current law, the Legislature may pass legislation to broadly amend or repeal the Act with simple majorities in both houses, although some amendments could require passage by two-thirds majorities in both houses.

Fee Proceeds and Interest Exempt From Proposition 98 Calculation. Proposition 98, a constitutional amendment adopted by voters in 1988 and amended in 1990, established a set of formulas that are used to annually calculate a minimum state funding level for K-12 education and the California Community Colleges. In many cases, additional state General Fund revenues result in a higher Proposition 98 funding requirement. This measure amends the Constitution to specify that the proceeds of the fee and all interest earned on such proceeds shall not be considered in calculating the Proposition 98 funding level required for schools.

Statutory Amendments

Changes to Poison Pill Provisions. The measure amends the Act's poison pill provisions in the following ways:

- The measure deletes the provision triggered by a state judicial determination that revenues from the fee are subject to the Proposition 98 calculation. As noted earlier in this analysis, the measure amends the Constitution to specify that proceeds and interest from the fee are not subject to the Proposition 98 calculation, thereby precluding such a judicial determination.
- The measure inserts a new poison pill provision that renders the Act inoperative if the Legislature does not appropriate moneys in the Hospital Quality Assurance Revenue Fund within 30 days following enactment of the annual budget act.
- The measure amends the provision triggered by a General Fund cost from a lawsuit related to the Act. Specifically, the measure redefines the threshold cost to be an overall net cost to the General Fund due to the Act remaining operative, rather than 0.25 percent of General Fund expenditures authorized in the budget act.

Removal of Sunset Provisions. The measure deletes the Act's sunset provision. The measure also nullifies the current-law sunset of the Hospital Quality Assurance Revenue Fund, and instead specifies that the fund shall remain operative as long as the Act remains operative. These combined changes permanently extend the fee program under the Act—starting with the second program period—absent one of the following conditions being met.

- An event occurs that triggers one of the Act's poison pill provisions (as amended by the measure).
- Additional statute that amends, repeals, or replaces the Act is adopted and takes effect in accordance with the measure's Constitutional requirements.

FISCAL EFFECTS

Significant Ongoing Fiscal Benefits to State and Local Governments in Future Years

Continuation of Fee-Related Fiscal Benefits. Under current law, the Act becomes inoperative on January 1, 2017. As a result, both the imposition of the fee and its related fiscal effects are currently scheduled to end with the first program period. By removing the Act's sunset provision, the measure provides the authority for implementation of the fee to continue without interruption through subsequent program periods. Implementation of the fee across program periods would be governed by the Act's general structure for assessing the fee and using the proceeds. Thus, following the first six months of 2016-17, the measure would maintain ongoing significant fiscal benefits to state and local governments that otherwise would cease to exist under current law.

Specifically, barring conditions that would trigger the Act's poison pill provisions, the measure would permanently extend the following fiscal benefits to the state and local governments.

- General Fund offset for children's coverage. Under the Act's current provisions (continued by this measure), annual state savings would be equal to 24 percent of the fee's net benefit.
- Direct grants, capitation increases, and other quality assurance payments that benefit counties, the UC system, health care districts, and other units of government that own and operate public hospitals.

Estimated Level and Growth of Fiscal Benefits. For each year, the exact amount of fiscal benefits to state and local governments would depend on the total amount of fee revenue collected, the amount of quality assurance payments made to hospitals, and the resulting calculation of net benefit. As these factors are currently unknown and their estimation subject to some uncertainty, to project the measure's fiscal impact, we rely on assumptions about the annual growth in federally allowable quality assurance payments to hospitals. Figure 3 (see next page) summarizes our multiyear projection of the measure's fiscal effect on the state General Fund by providing fee revenues that offset state General Fund costs for children's coverage. We estimate that the General Fund offset for children's coverage would be around $500 million during the last six months of 2016-17, reach more than $1 billion by 2019-20, and grow between 5 to 10 percent annually thereafter. We also estimate that quality assurance payments to state and local public hospitals would be around $90 million during the last six months of 2016-17, reach around $250 million by 2019-20, and grow between 5 percent to 10 percent annually thereafter. Below we discuss some considerations that affect our estimates.

Figure 3

Projected Additional General Fund Offset for Children's Coverage Under Measure

(In Billions)	
2016-17[a]	$0.5
2017-18	1.0
2018-19	1.1
2019-20	1.2

[a] Savings from continuing hospital quality assurance fee through last six months of 2016-17.

Federal Sources of Uncertainty

We briefly highlight potential federal decisions that, if implemented, could lead to significant deviations from our estimates of the measure's fiscal effects.

Allowable Rate of Provider Charges. Federal regulations currently discourage states from levying provider charges that exceed 6 percent of net patient revenue. Historically, hospital fee programs in California have approached this threshold by assessing fees as high as 5.5 percent of net patient revenue. We note that states have previously litigated and successfully blocked regulations promulgated by CMS that would have reduced the allowable rate of provider charges. If the federal government were to successfully reduce permissible provider charges—for example, to 3 percent rather than 6 percent of net patient revenue—this could significantly lower estimated annual savings within our multiyear projection. Such a change would also affect our estimate of savings growth beyond 2019-20.

Oversight of Quality Assurance Payments. Federal cost containment strategies could also affect the amount of quality assurance payments available under the fee. For example, changes in federal Medicaid policy governing UPL calculations would affect supplemental payments. As another example, CMS has expressed its intention to tighten its oversight of capitation payment development in Medicaid managed care and "look under the hood" of states' actuarial certification practices. Although it is difficult to quantify the overall impact of these scenarios on quality assurance payments given the varying forms such restrictions could take, they would generally lead to lower net benefits to hospitals under the fee program, and thus lower estimated savings to state and local governments from adopting the measure.

Summary of Fiscal Effects

We estimate that the measure would result in the following major fiscal impacts:

- State savings from increased revenues that offset state costs for children's health coverage of around $500 million beginning in 2016-17 (half-year savings) to over $1 billion annually by 2019-20, likely growing between 5 percent to 10 percent annually thereafter.

- Increased revenues to support state and local public hospitals of around $90 million beginning in 2016-17 (half-year) to $250 million annually by 2019-20, likely growing between 5 percent to 10 percent annually thereafter.

Sincerely,

_____
Mac Taylor
Legislative Analyst

_____
Michael Cohen
Director of Finance

HURST+BROOKS+ESPINOSA

November 2, 2015

TO: Matt Cate
Executive Director, CSAC

FROM: Kelly Brooks
Partner, Hurst Brooks Espinosa

Re: Medicaid Section 1115 Waiver Renewal

On October 31, 2015, the state and federal governments announced conceptual agreement on a Medicaid Section 1115 waiver renewal AND a temporary extension of the existing waiver until December 31, 2015. The Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) will be working over the next two months to develop the details of Waiver programs and components through the Special Terms and Conditions (STCs), the legal document governing the waiver.

The total initial federal funding in the renewal is $6.218 billion, with the potential for additional federal funding in the global payment program to be determined after the first year. Funding details are summarized in the chart below.

	Year 1	**5-Year Total**
Global Payment Program	$236 million	$236 million*
Public Hospital Redesign and Incentives in Medi-Cal	$800 million	$3.732 billion
Whole Person Care	$300 million	$1.5 billion
Dental Incentives	$150 million	$750 million
TOTAL	**1.486 billion**	**$6.218 billion**

**The Global Payment Program may increase in Years 2-5 based on a study to be completed in 2016.*

Many of the core elements outlined below were included in the state's revised Waiver proposal that was developed and submitted to CMS in early October. The conceptual agreement includes the following core elements:

Global Payment Program (GPP). The GPP will provide funding for services to the uninsured in designated public hospital systems (DPH) by combining existing funding streams – Disproportionate Share Hospital (DSH) funds and Safety Net Care Pool (SNCP) funding – into a single global payment

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system. The global payments are intended to incentivize the provision of primary and preventive care and to move away from the hospital-focused and cost-based structures on which the funding is currently based. The funding of the GPP will include 5 years of the DSH funding that otherwise would have been allocated to DPHs along with $236M in initial federal funding for one year of the SNCP component. It is anticipated that DSH payments will be approximately $1.1 billion in 2016.

The SNCP component funding for years two through five would be subject to an independent assessment of uncompensated care, which is to be completed within six months of waiver implementation. Please recall that California had proposed that the SNCP component of the funding decrease over the course of the five years from the current level of $236 million annually in federal funding in the first years to $160 million in federal funding in the last year ($1.007 billion in federal funding over the five years). It is not clear how the independent assessment of uncompensated care will impact future SNCP funding.

The continuation of the SNCP funding had been a major point of disagreement during the negotiations. CMS was hesitant to move away from cost based payments for the remaining uninsured.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME will be the successor to the existing Delivery System Reform Incentive Payments (DSRIP) program. PRIME funding for delivery system transformation and alignment incentive program will be available for DPHs and district/municipal hospitals (DMPH). The funding will be allocated as follows:

	Designated Public Hospitals	**District/Municipal Hospitals**	**TOTAL**
Year 1	$700 million	$100 million	$800 million
Year 2	$700 million	$100 million	$800 million
Year 3	$700 million	$100 million	$800 million
Year 4	$630 million	$90 million	$720 million
Year 5	$535.5 million	$76.5 million	$612 million
5-Year Total	**$3.2655 billion**	**$466.5 million**	**$3.732 billion**

Whole Person Care Pilot (WPC). The WPC program would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations. The funding of this program would be up to $1.5B in federal funds over 5 years.

The Administration envisions a competitive application process for counties or groups of counties that are interested in pursuing programs focused on high risk, vulnerable populations that provide a "whole person," integrated approach to their care. Amounts would be awarded based on approved applications submitted by counties. Counties (along with any other public entity with which they partner) would be responsible for the non-federal share through an intergovernmental transfer (IGT). Counties would be required to include, as applicable, private and public partners who share responsibility for the services and outcomes to the targeted populations in their community.

Dental Transformation Incentive Program. The funding of this program is $750M in total funding over 5 years. California proposed to improve dental health for Medi-Cal members, particularly children, by focusing on high-value care, improved access, and utilization of performance measures to drive

delivery system reform. The proposed incentive payments would be focused on three key areas: 1) increasing preventive dental services for children, 2) preventing and treating more early childhood cavities, and 3) promoting continuity of care for beneficiaries.

Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries. California will be comprehensively addressing the question of network adequacy and access to care for Medi-Cal beneficiaries. The assessment will include at a minimum an analysis of compliance with network adequacy and access requirements under California state law that apply to Medi-Cal as well as commercial plans. The assessment will also include a comparison of Medi-Cal plans with commercial plans in the same geographic services areas.

Independent studies of uncompensated care and hospital financing. Additional details on this proposal are not yet available.

Next Steps. The work associated with the Waiver renewal is far from over. DHCS and CMS will continue the difficult work associated with crafting a new waiver and will be developing the details governing each of the core elements. The STCs will contain the detail for each of the core elements and legal authority for each of the programs.

Though cliché, the devil will be in the details. CSAC will be closely monitoring, and providing input where appropriate, on the STCs development knowing that there are ramifications for counties in claiming and program development. CMS and DHCS will be concluding writing of the STCs by December 31, 2015.

State implementing legislation will also be drafted in 2016 once the STCs are finalized and the Legislature returns to Sacramento.

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November 2, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Implementation of IHSS Overtime Rules

Background. In October 2013, the U.S. Department of Labor (DOL) issued regulations making home care workers paid by third-party providers eligible for overtime pay (time and one-half) and federal minimum wage protections. The regulations under the Fair Labor Standards Act (FLSA) also narrowed the federal definition of "companionship care" to apply only to those who spend less than 20 percent of their time aiding clients in bathing, cooking their meals, managing their medications or performing other personal care services, thereby essentially broadening the number of home or direct care workers eligible for overtime pay and minimum wage protections, since many home care workers spend far more than 20 percent of their time on these activities.

Almost immediately following the issuance of the DOL regulations, the Agency was challenged in a lawsuit by the Home Care Association of America (Association) in an effort to block their implementation. In December 2014, the federal court ruled that the portion of the regulation that made home care workers paid by third-party providers eligible for overtime pay and minimum wage protections exceeded DOL's authority and subsequently delayed implementation of the regulations. Under state law, California's implementation of overtime was also delayed pending further action by the federal court.

However, last month, the Washington, D.C. Court of Appeals denied the Association's request for a stay of the ruling that entitles home health workers to overtime pay and minimum wage. The denial of a stay means that the DOL rules went into effect on **October 13, 2015**, even as the plaintiffs appeal the case to the United States Supreme Court (they have 90 days to do so).

DOL practices will result in the agency not enforcing the new regulations until 30 days from that date, or November 12. However, from November 12 through December 31, 2015, DOL will continue the time-limited, non-enforcement phase that has been in place − it will exercise prosecutorial discretion in determining whether to bring enforcement actions, with particular consideration given to the extent to which states and other entities have made good faith efforts to bring their home care programs into compliance with the Fair Labor Standards Act (FLSA) since the promulgation of the Final Rule.

It should be noted that the date the DOL will begin enforcement does not imply that employers can't be sued for the newly compensable activities per the effective date of October 13th as specified by DOL.

State Financing. The 2014-15 state Budget Act included a negotiated deal between the Brown Administration, Legislature and labor representatives to implement the federal overtime rules as they apply to California's In-Home Supportive Services (IHSS) workers. The Administration had estimated the cost for complying with the regulations to be $403.5 million in 2014-15 and $707.6 million annually thereafter.

Following the Washington, D.C. Court of Appeals' decline to issue a stay, the California Department of Finance has indicated that $270 million is allocated in the current year 2015-16 Budget Act to cover overtime pay for IHSS workers. This allocation is also intended to cover any retroactive pay for overtime activities dating back to the implementation date as well as county Public Authority administrative costs.

State Policy. California, as noted above, will pay overtime wages for IHSS workers. California has also committed to paying for overtime related to worker travel and waiting time. However, as part of the 2014-15 Budget Act, the state included a number of policy changes in an effort to curb the use of overtime by IHSS workers:

- 66-Hour Weekly Limit: The state now breaks the number of hours a recipient receives and a provider works into one 1-week increments, and has adopted a strict 66 hour-per-week limit for IHSS workers, with sanctions for workers who exceed that limit, and even if the worker incurs the hours for providing services to more than one recipient.

- Grace Period. There is a three 3-month grace period for all providers on the 66-hour limit, after which…

- Termination. If a provider exceeds 66 hours of care, they may be sanctioned or, if it happens on multiple occasions, be terminated as a provider by the state.

Further, while federal regulations exempt family members from FLSA standards, there is political pressure in California to include those workers in at least some or all of the overtime benefits.

County Implementation Considerations. County Public Authorities and the Statewide Public Authority must now oversee the implementation of the FLSA overtime rules. Administrative activities will include:

- Notifying both recipients and providers of the new law and regulations,
- Training, assisting, receiving, and compiling new timesheets that include overtime,
- Tracking recipient overtime, and
- Communicating with the state regarding providers who exceed the 66-hour limit.

Conclusion. CSAC will continue to work closely with the California Association of Public Authorities (CAPA) and the County Welfare Directors Association (CWDA), as well as the California Department of Social Services on implementation issues.

Both the CSAC Health and Human Services Policy Committee and the CSAC Government Finance and Operations Policy Committee staff will also continue to engage with counties and stakeholders on fiscal and policy issues related to FLSA overtime rules for home care workers.

Resources:
The Department of Labor has created a new web portal with interactive web tools, fact sheets and other materials to help families, other employers and workers understand the new requirements. These, along with information about upcoming webinars on the rule, are available at www.dol.gov/whd/homecare/

California's Budget Act of 2014-15 legislation regarding IHSS provider overtime rules:

SB 855 (Chapter 29, Statutes of 2014)

SB 873 (Chapter 685, Statutes of 2014)

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November 2, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Medi-Cal County Inmate Claiming Program

Background. The 2010 budget – AB 1628 (Chapter 729, Statutes of 2010) – and AB 396 (Chapter 394, Statutes of 2011) – by then Assembly Member, now Senator, Holly Mitchell – authorizes DHCS to allow counties to receive FFP to the extent available for acute inpatient hospital services provided off the grounds of the jail for stays longer than 24 hours for both adults and juveniles.

DHCS has been working in consultation with CSAC and our county affiliate organizations since early 2014 on developing a framework and guidance for counties to receive FFP for these services under the Medi-Cal County Inmate Program (MCIP). The MCIP encompasses four subprograms: 1) Medi-Cal Adult County Inmate Program; 2) Juvenile County Ward Program; 3) County Compassionate Release Program; and 4) County Medical Probation Program. The eligibility criteria and scope of services vary under these programs and will be described in the official guidance released by DHCS.

Major Considerations. As we continue to work on the program framework and guidance, there are a number of areas that require more consideration.

Administrative Cost Methodology. One condition of the MCIP being implemented is that the program must be cost neutral for DHCS. Counties are not required to participate (seek federal reimbursement for their claims), however participating counties are required to reimburse DHCS for their administrative costs, which include staffing and overhead costs to operate the program. DHCS has provided an estimate of these costs, which are shown in the chart below. Counties will be responsible for reimbursing DHCS for costs incurred beginning in FY 2014-15.

Position	# of Positions	Salary	Benefits	*OE&E	Subtotal	SFY 14/15	SFY 15/16	SFY 16/17
Accounting Officer	0.5	$60,000	$29,000	$28,000	$58,500	$ -	$58,500.00	$58,500.00
AGPA	1	$69,000	$ 33,000	$28,000	$130,000	$130,000.00	$130,000.00	$130,000.00
AGPA	1	$69,000	$33,000	$28,000	$130,000	$130,000.00	$130,000.00	$130,000.00
Attorney I	0.5	$102,000	$49,000	$28,000	$89,500	$ 89,500.00	$ 89,500.00	$ 89,500.00
SSMI	1	$79,000	$38,000	$28,000	$145,000	$145,000.00	$145,000.00	$145,000.00
					Total	**$494,500.00**	**$553,000.00**	**$553,000.00**
					County Share	$247,250.00	$276,500.00	$276,500.00
					FFP Share	$247,250.00	$276,500.00	$276,500.00

* Operating expenses and equipment

CSAC and other county representatives are working with DHCS to determine the best allocation methodology to distribute the costs amongst participating counties.

Retroactive Claiming and Eligibility. Retroactive eligibility refers to the time period prior to the implementation of the MCIP program – prior to county contracts with the state for jail claiming service being signed. Under the MCIP, claims will be available for reimbursement under their respective subprogram as of the following dates:

- Medi-Cal Adult County Inmate Program - Eligible as of November 1, 2010
- Juvenile County Ward Program– Eligible as of January 1, 2012
- County Compassionate Release Program– Eligible as of January 1, 2013
- County Medical Probation Program –Eligible as of January 1, 2013

DHCS has stated that individuals must be made eligible for the MCIP in order draw down federal funds for their hospital stay. Counties have experienced several issues related to eligibility determinations for this population, including delayed implementation of MCIP aid codes on the state side. Counties have also expressed the inability to switch an individual out of suspended Medi-Cal to an alternative aid code, which adversely affects whether this person is made eligible for the MCIP. Additional guidance from DHCS on how to prove an inmate is eligible given these issues is needed. We will continue to seek DHCS' input and will provide updates as they arise.

Timing. Given the delays in implementing the program, CSAC and our county affiliates acknowledge the need to expedite the implementation of this program. Counties should be aware that CSAC and other county representatives have worked hard to ensure the availability of the federal funds is not lost due to claiming limitations. DHCS has submitted placeholders to the Centers for Medicare and Medicaid Services (CMS) to earmark federal funds for prior years, which we appreciate.

Next Steps. While we are awaiting the next iteration of documents from DHCS, we will convene our county affiliates to finalize an administrative costs methodology. We also will be seeking a target implementation date from DHCS and a timeline of activities to ensure that this process is moving forward. Further, we will be raising the issues mentioned in the 'Major Considerations' section of this document.

CSAC will provide counties with updates as additional implementation activities continue.

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November 2, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: California Children's Services Program Redesign – INFORMATION ONLY

Background. This past June, the Department of Health Care Services (DHCS) released their redesign proposal for the California Children's Services (CCS) program– the 'Whole-Child Model'. DHCS' proposal would mirror the existing fully integrated model under the Health Plan of San Mateo, and would additionally shift CCS services from fee-for-service to managed care on a phased-in approach. DHCS proposes to begin this redesign with the County Organized Health Systems (COHS) counties.

The COHS counties include:

- CenCal Health (Santa Barbara and San Luis Obispo Counties);
- Central California Alliance for Health (Santa Cruz, Monterey, and Merced Counties);
- Partnership Health Plan of California (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties)
- CalOptima (Orange)

Six COHS counties – Marin, Napa, San Mateo, Solano, Santa Barbara and Yolo – are currently already considered "carved in," but, in those counties -- with the exception of San Mateo -- the health plans carry the financial risk for the child, while the county still provides service authorization and care coordination services.

Under the DHCS Whole-Child Model, health plans would assume full financial risk for providing services to CCS-eligible children and required to coordinate all primary care and specialty care for CCS patients. The role of case management and service authorization for CCS patients would be transferred from the county CCS program to the health plan. County CCS programs would retain the responsibility for eligibility determinations, including the child's medical, financial and residential eligibility.

Based on the Department's phased-in approach, COHS counties would begin implementation no earlier than January 2017 and the Two-Plan counties would be implemented no earlier than July 2017. The carve-out for the remaining counties would expire in January 2019, at which time the carve-in could potentially be implemented in the remaining counties.

Legislation. Earlier this month, the Governor signed **AB 187** by Assembly Member Rob Bonta into law. This measure would extend the CCS carve-out sunset until January 2017. In his signing message, Governor Brown indicated that he was signing the bill as an expression of good faith. Recall, the Administration's Whole-Child Model would be implemented no earlier than January 2017 as well.

County Considerations. While the Whole-Child model shifts some of the county authority to the health plans, how that shift looks in counties may vary. Health plans may consider contracting with the counties to continue to carry out the service authorization and/or care coordination – given the county's intimate knowledge of CCS cases. Any coordination would be at the sole discretion of the health plan. As the Administration moves forward with this proposal, counties should consider the implications of service authorization and care coordination moving to the health plans, including the impact on county resource needs.

CSAC is a member of the DHCS CCS Stakeholder Advisory Group and will continue to follow this issue, including analyzing potential county impacts and possible legislation.

Attachments:
AB 187 (Chapter 738, Statutes of 2015)
DHCS Whole-Child Care Model – June 11, 2015

Resources:
CCS Redesign Webpage:
http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.aspx

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Assembly Bill No. 187

CHAPTER 738

An act to amend Section 14094.3 of the Welfare and Institutions Code, relating to children's services.

[Approved by Governor October 10, 2015. Filed with Secretary of State October 10, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 187, Bonta. Medi-Cal: managed care: California Children's Services program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for the department to enter into contracts with managed care systems, hospitals, and prepaid health plans for the provision of various Medi-Cal benefits. Existing law prohibits services covered by the California Children's Services program (CCS) from being incorporated into a Medi-Cal managed care contract entered into after August 1, 1994, until January 1, 2016, except with respect to contracts entered into for county organized health systems in specified counties.

This bill would extend the termination of the prohibition against CCS covered services being incorporated into a Medi-Cal managed care contract entered into after August 1, 1994, until January 1, 2017.

The people of the State of California do enact as follows:

SECTION 1. Section 14094.3 of the Welfare and Institutions Code is amended to read:

14094.3. (a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until January 1, 2017, except for contracts entered into for county organized health systems or Regional Health Authority in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.

(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.

(e) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor, or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

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Department of Health Care Services
California Children's Services (CCS) Redesign
Whole-Child Model
June 11, 2015

Based on an extensive six-month stakeholder process to identify strategies to improve and integrate care for children who qualify for the California Children's Services (CCS) program, the Department of Health Care Services (DHCS) has developed a proposed "Whole-Child Model" to be implemented in *specified* counties only, no sooner than January 2017. This approach meets the six goals for CCS Redesign (listed below); including the primary goal to provide comprehensive treatment, and focus on the whole-child and their full range of needs rather than only their CCS eligible conditions. In the counties that have not been chosen for this Whole-Child approach, DHCS and stakeholders will continue to work on alternative concepts and proposals to improve the care for CCS recipients.

CCS Redesign Goals:

- **Implement Patient and Family-Centered Approach:** Provide comprehensive treatment and focus on the whole-child rather than only their CCS-eligible condition(s).
- **Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
- **Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
- **Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.
- **Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
- **Cost Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments to support a coordinated service delivery approach.

Based on stakeholder feedback to seek a better integrated and coordinated system but proceed carefully with changes to the program, the department's proposal provides a balanced, measured approach, maintaining the core CCS provider standards and network of specialty care, and implementing a gradual change in a modest portion of the state (less than one-third), with an extended phase-in and stringent readiness and monitoring requirements to ensure continuity of care and continued access to high-quality specialty care.

Current CCS System and Need to Improve Integration and Reduce Fragmentation

Under the current system, most children with CCS-eligible conditions are enrolled in both the CCS fee-for-service system and Med-Cal managed care, and receive services in two or more separate systems of care that do not always coordinate effectively. In addition, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

These silos of care are preventive services for non-CCS conditions provided by Primary Care Providers, who may be pediatricians, family practitioners, or general practitioners contracted through Medi-Cal managed care health plans, and CCS-condition specific care provided by CCS-paneled pediatric subspecialists, as well as CCS-paneled acute inpatient hospital services. Behavioral health services may also be provided through a health plan or county mental health plan. Further, Regional Center services or In-Home Supportive Services may be provided through other state or county agencies. Most, but not all, county CCS programs are responsible for medical eligibility determination, care coordination, and service authorization for CCS-eligible services.

While having children in a single integrated system of care would be ideal, the fragile nature of the CCS population requires any change to be carefully vetted and staged to prevent unnecessary disruption or erosion in care. After significant discussion and review of models discussed at the Redesign Stakeholder Advisory Board (RSAB) DHCS has developed a multi-year framework for a "whole child" approach that relies on existing successful models and delivery systems.

Section 1. Whole Child Delivery Model

The department proposes a Whole-Child Model which means an organized delivery system that will assure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals, specialty care providers, and counties. The first phase will incorporate CCS services into the integrated care systems of most County-Organized Health Systems (COHS). COHS are county developed and operated delivery systems with strong community ties. CCS services are already integrated into three COHS in six counties, through the CCS "carve-in," so three of these plans already have experience with key elements of this model. In addition to Health Plan of San Mateo, which has already implemented most elements of this model, the COHS will include Partnership Health Plan (four counties already carved-in), CalOptima, Central California Alliance for Health, and CenCal Health (one county already carved-in). Health plans would be at full financial risk, with a whole-child approach to provide and coordinate all primary and specialty care, similar to the Health Plan of San Mateo model. These plans will be required to demonstrate support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Implementation in COHS counties without CCS already "carved-in" will start no earlier than January 2017, and is subject to a successful readiness review by DHCS.

The Whole-Child approach may also be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The Medi-Cal Two-Plan model delivery system provides consumers a choice between a commercial health plan and a county developed health plan. The determination of these counties will be based on an application of interest to DHCS from at least one managed care plan in a Two-Plan model county, with demonstrations of support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Based on the application, and subject to federal approval, DHCS may propose that CCS covered services be incorporated into only one Medi-Cal managed care health plan in a Two-Plan model county. Implementation will begin no earlier than July 2017, and is subject to a successful readiness review by DHCS.

The table below lists the counties with CCS services currently "carved-in" to Medi-Cal managed care plans, and the additional counties proposed for carve-in as part of the Whole-Child Model.

Counties with current CCS carve-in (6)	Marin, Napa, San Mateo, Solano, Santa Barbara, Yolo
Proposed Additional CCS Whole-Child Counties (19)	Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, Trinity, and up to four 2-plan model counties

Overall, DHCS is taking a measured approach that builds on current organized delivery systems, and increases coordination of primary, specialty, and behavioral health services within Medi-Cal managed care plans. Among other benefits, this model proposes to improve care transitions and access to specialty care for youth aging out of CCS, since those youth will most likely be transitioning into Medi-Cal managed care, and the proposed changes will require all Medi-Cal managed care plans to include CCS providers in the health plan's network.

Section 2. Key Features of the Whole-Child Model

- Existing fully integrated models will continue as part of the Whole-Child Model, such as Health Plan of San Mateo and Kaiser Permanente.

- Children included in the Whole-Child Model in each specified county will include CCS Medi-Cal, Optional Targeted Low-Income Children's Program (former Healthy Families), and CCS State-only populations.

- DHCS will require health plans to follow continuity of care requirements to support existing member and provider relationships.

- In the remaining 33 counties where the Whole-Child Model is not offered, DHCS proposes to extend the CCS carve-out for three years, to January 1, 2019, and consider potential implementation of the Whole-Child Model in additional counties. In the meantime, DHCS will promote medical home models and care coordination partnerships between counties, providers, and health plans in these counties, with continued discussion of best practices and future modernization efforts into the remaining counties.

- To improve continuity of care and access to specialty providers for youth aging out of CCS and transitioning to Medi-Cal managed care, the department will require all Medi-Cal managed care health plans, on a phased-in basis, to contract with CCS providers or providers who meet the CCS panel requirements.

- This model will maintain the CCS core program infrastructure including the regional provider network, through the existing DHCS credentialing process, including CCS provider paneling.

- DHCS will work in partnership with recognized experts and stakeholders to develop comprehensive CCS quality measures and ongoing public data reporting.

Section 3. Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring

To provide seamless and coordinated access to a full array of primary, specialty, and behavioral health services, detailed readiness requirements will be developed in consultation with stakeholders. Health plans will be required to meet these readiness requirements prior to implementation, and DHCS and the Department of Managed Health Care (DMHC) will conduct program monitoring and oversight for access and quality measures. Key readiness requirements for health plans will include:

- Evidence of adequate network of CCS-paneled providers.
- Specific policies and procedures regarding access to specialty care outside of the designated catchment area consistent with the existing CCS regional provider network.
- Evidence of health plan policies and procedures that include CCS provider standards.
- CCS family advisory committees in each county that meet at least quarterly.
- Detailed protocols for enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system. Specific components will include: Health homes; culturally appropriate care; initial health assessment and annual reassessments; developing a care plan for each child; establishing interdisciplinary care teams; providing health promotion; transitions of care; referrals to social support services; referral to and coordination with behavioral health services; coordination with In-Home Supportive Services and Regional Centers; and links to other community services.
- Evidence of culturally and linguistically appropriate resources and readiness, including physical access.
- Specific policies around transitions, both initial enrollment and aging out of CCS, to ensure continuity of care.
- Integrated electronic health records system.
- Access to a grievance and appeals process for resolution of member issues.

Section 4. CCS Program Improvement and Stakeholder Engagement

DHCS will continue stakeholder engagement through all phases of implementation of the Whole-Child Model, and will also host ongoing discussions of program improvements applicable to all counties and identified in the Title V Needs Assessment, such as improved transitions for youth aging out of CCS, improving access for Durable Medical Equipment, and care coordination protocols. The CCS Advisory Group will replace the Redesign Stakeholder Advisory Board, and ongoing improvement efforts will continue to be guided by the department's six Redesign goals.

Section 5. County Roles, including Medical Therapy Program

Counties have served as a valued partner with providers and the state to provide CCS care coordination and service authorization for children and youth with special health care needs. However, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

To establish a single, unified care coordination team that can ensure access across an array of services, responsibility for CCS care coordination and service authorization activities will shift in

phases from counties to the health plans in the Whole-Child model counties. Counties and health plans, with support from DHCS, will jointly develop Memorandums of Understanding (MOUs) to document transition plans for these activities. DHCS will work collaboratively with counties on the accounting process and adjustments to support this structure; no changes to the county realignment structure are expected to be necessary. Counties (or the state, for dependent counties) will continue to perform initial and periodic financial, residential, and medical eligibility determinations.

In addition, the Whole-Child Model seeks to strengthen partnerships among local Medical Therapy Programs, health plans, and providers, to promote improved outcomes and integrated care. Counties will maintain responsibility for Medical Therapy Programs, but enhanced partnerships will be promoted by DHCS and addressed in local MOUs with health plans and counties.

Section 6. Proposed Timeline for CCS Whole-Child Model Implementation

Phase 1: June 2015 – December 2016

- Stakeholder discussions and development of detailed health plan requirements, quality measures, contracts, and readiness criteria.
- County-Health Plan MOUs developed.
- Evaluation of applications of interest in Two-Plan model counties.
- Program Improvement efforts continue.

Phase 2: January – July 2017

- Initial phased-in implementation begins in COHS counties, pending readiness review.
- Ongoing quality monitoring and reporting.
- Assess initial implementation and feedback from families and stakeholders.

Phase 3: July 2017 – December 2018

- Incorporate feedback from assessment of initial implementation.
- Initial phased-in implementation begins in Two-Plan Model counties, pending federal approval and readiness review.
- Ongoing quality monitoring and reporting.
- Stakeholder discussions around Whole-Child Model effectiveness, and potential changes for implementation in additional counties.

Phase 4: January 2019 - Ongoing

- CCS carve-out sunsets in remaining counties.
- Consider potential implementation of the Whole-Child Model in additional counties.