State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

October 30, 2013

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RE: California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment

Medi-Cal Expansion to Newly Eligible Individuals / Integration of Medi-Cal Outpatient Mental Health Services into Managed Care

Dear Mr. Nelb, Ms. Garner, and Ms. Nagle:

The State of California proposes to amend the Special Terms and Conditions (STCs) of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration (Demonstration Waiver), pursuant to STC paragraph 7.

California is fully committed to the ideals of health care reform and expanding Medicaid coverage to individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) is a key step in creating a culture of coverage within the State. Through the existing Demonstration Waiver's Low Income Health Programs (LIHPs), California has

been able to provide health care coverage to a significant portion of this population through December 2013.

This Waiver amendment would allow the State to extend Medicaid services to the childless adult population described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, much of whom are already enrolled in LIHPs today. This Waiver amendment would allow for a seamless transition of those in LIHP-Medi-Cal Expansion programs into the Medi-Cal managed care delivery system. This Demonstration Waiver would also provide the State with the necessary authority to enroll newly eligible populations who qualify for Medi-Cal based on expanded income eligibility criteria.

Concurrently with this amendment request, DHCS is requesting an expansion of the current Medi-Cal managed care benefits to include outpatient mental health services. This amendment would allow the Department of Health Care Services (DHCS) to require Medi-Cal managed care health plans (MCPs) to cover outpatient mental health services provided by licensed health care professionals acting within the scope of their license as detailed below.

The State is requesting that both components of this Demonstration Waiver amendment request be approved prior to January 1, 2014 to ensure that all necessary preparations are completed. DHCS staff are prepared to collaborate in the coming months with the Centers for Medicare and Medicaid Services (CMS) in order to secure prompt approval of this amendment.

BACKGROUND

California Assembly Bill (AB) X1-1 authorizes the expansion of Medi-Cal eligibility to childless adults with annual incomes up to 133 percent of the Federal Poverty Level, effective January 1, 2014.

The “Newly Eligible” population consists of:

1) LIHP Medicaid Coverage Expansion (MCE) populations as defined in STC paragraph 52 of the current Demonstration Waiver. These individuals are adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL.

2) Adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL, are not pregnant, not Medicare eligible, and not otherwise eligible for, and enrolled in, mandatory coverage.

California Senate Bill (SB) X1-1 requires the following, effective January 1, 2014:

- Mental health services included in the essential health benefits package adopted by the State pursuant to Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code and approved by the United States Secretary of Health and Human Services under Section 18022 of Title 42 of the United States Code to be covered Medi-Cal benefits.

  Medical Managed Care Plans (MCPs) to provide specified mental health benefits covered in the state plan excluding those benefits provided by county mental health plans under the Specialty Mental Health Services (SMHS) Waiver.

IMPACT TO SERVICES

Effective January 1, 2014, DHCS will require MCPs to cover the following outpatient mental health services when they are provided by licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies, and supplements
- Psychiatric consultation

For individuals newly eligible for Medi-Cal under this expansion effort, the managed care delivery system models and their geographic distribution, as well as participating health plans, are identified in Attachment M of the Special Terms and Conditions. The "Newly Eligible" beneficiaries will receive benefits identified in Attachment N. The available delivery systems and benefits for this new population will be consistent with what is available to all populations in managed care.

WAIVER AUTHORITY

DHCS believes the existing waivers of freedom of choice, statewideness, and comparability encompass this proposed Demonstration Waiver amendment. To the extent necessary, DHCS requests that its authority to operate under these waivers extends to the amendments contained in this request.

EXPENDITURE AUTHORITY

This proposed Demonstration Waiver amendment will not impact the existing Waiver Expenditure Authority.

PUBLIC NOTICE AND TRIBAL NOTICE
As required by STC Paragraph 7 and STC Paragraph 14, DHCS provided Tribal Notice on the Demonstration Waiver amendment as follows:

- On August 21, 2013, DHCS issued a tribal notice regarding the State's intention to request Waiver amendments for the inclusion of the newly eligible individuals into Medi-Cal managed care and the carve-in of Medi-Cal outpatient mental health services Into the managed care delivery system.
- On August 30, 2013, DHCS presented on these Waiver amendment proposals at the "Medi-Cal Tribal and Designee Quarterly Webinar Regarding Proposed Changes to the Medi-Cal Program."

DHCS has provided, and will continue to provide, Public Notice through the following means:

- Various Stakeholder Meetings, including but not limited to Stakeholder Advisory Committee meetings, conducted, and to be continued to be conducted, through in-person meetings, webinars, and teleconferences.
- Legislative and budget hearings
- Published Governor's Budget

As previously stated, both components of this amendment are mandated through state legislation.

BUDGET NEUTRALITY
DHCS will provide an updated Attachment K (Budget Neutrality) worksheet to CMS in the coming weeks.

With regard to the "Newly Eligible" population, DHCS understands CMS's position on 1115 budget neutrality in all states is that no savings will be permitted for this population. While DHCS maintains that managed care and expanded coverage for this population will generate health care savings, we recognize that given the lack of reliable cost information for this population at this time and that developing a reasonable Without Waiver equivalent would be more challenging than for populations for whom we have experience. However, DHCS maintains that given the same challenges with the lack of reliable data that there should be no risk to the State's budget neutrality margin for expanding coverage to this optional population. The model to accomplish this through the 1115 Budget Neutrality already exists in California as demonstrated by the treatment of the MCE population. Actual expenditures based on the "Newly Eligible"

population's per member per month (PMPM) cost experience would be used as the expenditure limit for this population. DHCS is working with actuarial consultants to develop actuarially sound rates for the "Newly Eligible" population which will be subject to CMS review and approval.

For the mental health services addition, Attachment K will be updated on both the Without Waiver (WOW) and With Waiver (WW) components to incorporate the additional mental health services. On the WOW side, this will be based on five-year historical FFS experience, accounting for the implications of the changes to the benefit (e.g. removal of limitations on visits, and rate changes) and on the WW side, the add-on value will be developed by the DHCS's actuaries for each rate category.

Thank you for your assistance and continued support of California's commitment to improving health care delivery and innovation. DHCS is happy to assist you and your staff in any way as you review the proposed Demonstration Waiver amendment. If you have any questions, please contact: Danielle Stumpf, at (916) 449-5000.

Sincerely,

Toby Douglas
Director

Enclosures:

- Special Terms and Conditions language
- Updated Attachment N

Cc:

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Special Terms and Conditions (Proposed changes to the STCs)

148. Budget Neutrality Annual Expenditure Limit. For each DY, two annual limits are calculated.

a. Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each eligibility group (EG) described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section entitled General Reporting Requirements for each EG, including the hypothetical population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
ii. Starting in SFY 2011, actual expenditures for the MCE EG will be included in the expenditure limit for California. The amount of actual expenditures to be included will be the actual MCE per member per month cost experience for DY 6-10;
iii. Starting in the fourth quarter of SFY 2012 (March-June), and continuing through August 31, 2014, actual expenditures for the CBAS and ECM benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS and ECM services (whether provided through managed care or fee-for-service) to the SPD Medicaid-only population and to dual eligibles;
iv. Starting in the third quarter of SFY 2013-14 (January – March), actual expenditures for adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act "Newly Eligible" population will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual Newly Eligible per member per month cost experience starting January 1, 2014.
v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)[1]	Trend Rate	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM	DY 9 PMPM	DY 10 PMPM
		State Plan Groups				
Families - COHS	5.30%	$171.68	$180.78	$190.36	$197.40	$207.28
Families – TPM/GMC	5.3%	$150.40	$158.37	$166.76		
Existing SPD – COHS	7.4%	$1,069.73	$1,148.89	$1,233.91		
Existing SPDs – TPM/GMC and Special Populations SPDs	7.4%	$730.43	$784.48	$842.53		
CCS – State Plan Special Needs Child	3.28%	$1,390.66	$1,436.27	$1,483.38	$1,532.04	$1,582.29
		Hypothetical Populations[2]				
MCE	5.00%	$300.00	$315.00	$330.75	$347.29	$0
CBAS	3.16%		$916.60	$945.57	$975.45	$1,006.27
ECM			$10.00	$10.00	$10.00	$10.00
Newly Eligible	TBD	TBD	TBD	TBD	TBD	TBD

These four MEGs will be updated to include the addition of the mental health services effective January 1, 2014.

Key: TPM = Two Plan Model counties, GMC = Geographic Managed Care counties

[1] The applicable reporting forms for expenditures in each eligibility group are described in STC **Error! Reference source not found.**.

[2] These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit. As described in paragraph (a)(ii), (a)(iii), and a(iv) above, the actual expenditures for these hypothetical populations are included in the budget neutrality limit.