

**AGENDA**  
**Healthcare Reform Committee**  
**Wednesday, October 16, 2013**  
**Red Lion Woodlake**  
**500 Leisure Lane**  
**Sacramento, CA 95815**  
**1:30 p.m. to 5:00 p.m.**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

		<b>Room</b>	<b>Tab</b>
1:30 p.m.	Planning Council Member Issue Requests	Edgewater F	
1:35 p.m.	Welcome and Introductions <i>Beverly Abbott, Chairperson</i>		
1:40 p.m.	Update: Cal Medi-Connect <i>Brenda Grealish, MHS Division Chief, DHCS</i>		<b>A</b>
2:20 p.m.	Update: Behavioral Health Service Needs Plan <i>Jaye Vanderhurst, LCSW</i>		<b>B</b>
2:45 p.m.	Update: Health Homes <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
3:15 p.m.	Break		
3:30 p.m.	Exchanges and the Uninsured <i>Molly Brassil, CMHDA : Invited</i>		
4:15 p.m.	Healthy Families shift to Medi-Cal <i>Cindy Claflin, Co-Vice Chairperson</i>		
4:45 p.m.	Next Steps/Develop Agenda for Next Meeting <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
4:55 p.m.	Wrap up: Report Out/ Evaluate Meeting <i>Steven Grolnic-McClurg, LCSW, Co- Vice Chairperson</i>		
5:00 p.m.	Adjourn Committee		

**COMMITTEE MEMBERS**

Beverly Abbott, Chair	Doreen Cease	Joseph Robinson
Steven Grolnic-McClurg, Co-Vice Chair	Suzie Gulshan	Cheryl Treadwell
Cindy Claflin, Co-Vice Chair	Terry Lewis	Jaye Vanderhurst
Josephine Black	Dale Mueller	



# HEALTHCARE REFORM COMMITTEE CHARTER

ADOPTED 10/17/12

## OVERVIEW

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The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

## PURPOSE

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The purpose of the Healthcare Reform Committee (HCR) is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from Federal Healthcare Reform that impacts California's mental health system.

The HCR promotes the inclusion of five core elements from the Mental Health Services Act to guide all mental health work:

- Promoting Consumer and Family oriented services at all Levels
- Ensuring Cultural Competence
- Increasing Community Collaboration
- Promoting Recovery/wellness/resilience orientation
- Providing Integrated service experiences for clients and families

## MEMBERSHIP

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The Committee membership is listed in Attachment A.

The Chairperson and two Vice-Chairs will be appointed by the CMHPC Leadership. In the Chairperson's absence one of the Vice Chairs will serve as the Chairperson. Terms will begin with the first meeting of the calendar year, and end with the last meeting of the calendar year.

## MEETING TIMES

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The Committee meets four times a year, rotating locations in conjunction with the standing meeting times of the plenary and other committees. The Committee meets on Wednesday from 1:30 to 5:00 PM. Future meeting dates are listed below:

2013:

April 17 in Ontario  
June 19 in Oakland

October 16 in Sacramento

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

The Chair and Vice Chairs hold meetings as needed to plan for the full Committee meetings.

## ROLES AND RESPONSIBILITIES

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Members are expected to serve as advocates for the Committee's charge, and as such, could include, but are not limited to:

- Attend meetings. Speaking on behalf as requested.
- Speak at relevant conferences and summits when requested by the Committee leadership
- Develop products such as white papers, opinion papers, and other documents
- Distribute the Committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

## GENERAL PRINCIPLES OF COLLABORATION

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The following general operating principles are proposed to guide the Committee's deliberations:

- The Committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the Committee's common goals.
- To that end, members will:
  - Commit to expending the time, energy and organizational resources necessary to carry out the Committee's mission
  - Be prepared to listen intently to the concerns of others and identify the interests represented
  - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
  - Regard disagreements as problems to be solved rather than battles to be won
  - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

## MEETING PROTOCOLS

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The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

#### DECISION-MAKING

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Council and non-council members of the Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote using the gradients of agreement. Minority views will be included in the meeting highlights.

#### MEDIA INQUIRIES

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In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC's Executive Officer.

#### SUPPORT

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Narkesia Swanigan, Associate Governmental Program Analyst, [narkesia.swanigan@cmhpc.ca.gov](mailto:narkesia.swanigan@cmhpc.ca.gov)

Attachment A: Healthcare Reform Committee Membership

NAME	ORGANIZATION
Beverly Abbott, Chairperson	Consultant
Steven Grolnic-McClurg, LCSW, Co-Vice Chairperson	Mental Health Director, Contra Costa County
Cindy Claflin, Co-Vice Chairperson	United Advocates for Children & Families
Joseph Robinson, LCSW, CADC II	California Association of Social Rehabilitation Agencies
Josephine Black	Independent Living Center, Inc.
Dale Mueller, EdD, RN	California State University Dominguez Hills
Jaye Vanderhurst, LCSW	Mental Health Director, Napa County
Cheryl Treadwell	Department of Social Services
Terry Lewis	Department of Mental Health, Los Angeles County
Suzie Gulshan	Mental Health Board, Orange County
Deborah B. Pitts, PhD	University of Southern California

## CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

### Excerpt from State Statutes

**5772.** The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.
- (c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:
  - (1) To review and approve the performance outcome measures.
  - (2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.
  - (3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.
  - (4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.
- (d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
- (g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
- (h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
- (i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

(l) To suggest rules, regulations, and standards for the administration of this division.

(m) When requested, to mediate disputes between counties and the state arising under this part.

(n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.

(o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

(p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

# DRAFT HEALTHCARE REFORM WORKPLAN CHART

## Overarching Framework for HCR

<p><b>Five Core Elements of the MHSA should guide all work on MH</b></p> <ul style="list-style-type: none"> <li>○ Consumer and family oriented services</li> <li>○ Cultural competence</li> <li>○ Recovery/wellness/resilience orientation,</li> <li>○ Community collaboration</li> <li>○ Integrated service experiences for clients and families</li> </ul> <p>Crosscutting issues</p> <ul style="list-style-type: none"> <li>● Reducing disparities in mental health services</li> <li>● Preserving meaningful stakeholder processes</li> </ul>			
HCR COMMITTEE THEMES			
ELEMENTS/ COMPONENTS	MEANINGFUL STAKEHOLDER INVOLVEMENT	FIVE CORE ELEMENTS OF MHSA PERSEVERED	DOING WHAT IT SAID IT WOULD DO? IMPROVING LIVES?
<p><b>Medicaid Expansion -</b></p> <p>The ACA established a Medicaid funded program for most of California's uninsured by 2014. The LIHP began this process in starting 2011 in certain counties</p> <p>(Lead: Bev and Narkesia)</p>	<p>Participate in the DHCS stakeholder group meeting process. Provide input as appropriate.</p> <p>The Behavioral Health Service Needs Plan due: <b>April 1, 2013</b></p>	<p>Review the California Mental Health and Substance Use System Needs Assessment. Make sure it includes the five principles of MHSA.</p> <p>Provide input if necessary.</p>	
<p><b>(a) Behavioral Health Service Needs Plan and Behavioral Health Needs Assessment</b></p> <p>(Lead: Jaye)</p>	<p>Participate in all stakeholder calls regarding the dual demonstration project; give input as appropriate</p>	<p>Review all documents with the 5 principles in mind; particularly person centered care (very much evident in the documents); cultural competence; wellness oriented services; and integrated service</p>	<p>Track outcomes measures selected for the dual eligible demonstration projects. Suggest new outcome measures specific to our focus as appropriate</p>
<p><b>Dual Eligible demonstration projects</b></p> <p>Integrates Medi-Cal and Medicare funding for clients who are eligible for both and creates demonstration projects to explore various configurations of</p>			

## DRAFT HEALTHCARE REFORM WORKPLAN CHART

<p>services and systems. Originally 4 counties were selected. The Governor’s Budget for 2013 expanded this to 8 counties and described it as an initiative not a demonstration</p> <p>(Lead: Bev)</p> <p><b>Health Homes</b></p> <p>Under HCR all clients will eventually have a health home, which will be responsible for the coordination of all their medical care.</p> <p>Individuals with SMI may be part of a health home. Where will these health homes be? In primary care or in MH clinics</p> <p>(Lead: Steve)</p>		<p>experiences for clients and families. Give input as appropriate</p>	
<p><b>Exchanges and the Uninsured</b></p> <p>For those who are not eligible under the LIHP/Medicaid Expansion (due to income), they will be required to purchase insurance and will be able to do so through “Exchanges” – which have to offer BH services at some level.</p> <p>(Lead: Bev and Narkesia)</p>			
<p><b>Public Safety Realignment</b> – newly eligible MC populations<sup>1</sup></p>			

<sup>1</sup> Important because parolees/probationers will be newly eligible – will this help access? This population has not been Medi-Cal eligible. What is the funding distribution between criminal justice and rehabilitation, treatment and other services?

# DRAFT HEALTHCARE REFORM WORKPLAN CHART

<p>(Susie)  <b>Children Issues</b>                  (Lead: Cindy and Terri)</p>	<p>Healthy families changing to medical Statewide with particular focus in rural areas</p> <p><b>Healthy Families shift to Medi-Cal 857,000 Children</b></p> <p>Effective: January 2013</p> <ul style="list-style-type: none"> <li>• 415,000 Already contract with Medi-Cal (statewide)</li> <li>• 249,000 Enrolled in managed care programs</li> <li>• 150,000 Enrolled in health plans – No Medi-Cal (statewide)</li> <li>• <i>43,000 Live in 28 rural counties with – No Medi-Cal</i></li> </ul> <p><b>Concern: Approx. 200,000 children disrupted (statewide)</b></p> <p>Physicians Who Accept Medi-Cal: 20% Decrease in payments</p> <p>State Pursuing Rate Cut in the Courts: 10% additional</p> <p>Further decrease</p> <p>May be difficult to take on new patients: Reduction in service</p>	<p>This is something we need to keep an eye on many children will not be covered due to doctors in their rural areas who will except medi-cal. This will in turn cause the parents to have to leave their communities to get medical services. There could be a transportation issue for a lot of families etc.</p>	<p>This is not going to improve lives this is going to end up causing a lot of families not to seek medical services when they need it.</p>
<p><b>Workforce Capacity</b>                  (Lead: Dale and Joseph)</p>	<p><b>MFT in Medicare Issue</b></p> <p>Review the Workforce Section in the BH Service Plan and give input as appropriate</p>		



CALIFORNIA MENTAL HEALTH PLANNING COUNCIL  
Healthcare Reform Committee  
DRAFT Meeting Highlights  
June 19, 2013

**Committee Members Present:**

Beverly Abbott, Chair  
Steven Grolnic-McClurg, Co-Vice Chair  
Jaye Vanderhurst, LCSW  
Dale Mueller, EdD, RN  
Suzie Gulshan  
Terry Lewis  
Josephine Black  
Doreen Cease  
Deborah Pitts

**Staff Present**

Narkesia Swanigan

**Others Present**

Gwen Foster, California Social Work Education Center  
Sheree Kruckenberg, California Hospitals Association  
Sandra Naylor-Goodwin, California Institute for Mental Health (CiMH)  
Sergio Aguilar, Office of Statewide Health Planning and Development (OSHPD)  
Lupe Alonzo-Diaz, OSHPD

Beverly Abbott, Chairperson, convened the Healthcare Reform (HCR) Committee meeting at **1:30 p.m.**

**Welcome and Introductions**

Abbott reviewed the HCR Committee operating policies and procedures and welcomed members and guests.

**Department of Health Care Services Responses**

Beverly Abbott, Chairperson, reported that Jane Adcock, Executive Officer, California Mental Health Planning Council (CMHPC) met with Vanessa Baird at the Department of Health Care Services (DHCS) to discuss the questions the HCR Committee had about the development of the Behavioral Health Service Needs Plan and how the CMHPC could be involved. At the April HCR Committee meeting Rollin Ives, DHCS joined via teleconference and suggested Adcock meet with Baird to address HCR Committee's questions and concerns. Abbott stated that Adcock was informed that Ives is the contact for the Behavioral Health Services Needs Plan. The HCR Committee will address any further and future questions or concerns with Ives.

**Update: Behavioral Health Service Needs Plan**

Jaye Vanderhurst, LCSW, provided that Centers for Medicare and Medicaid Services (CMS) has not received from DHCS the Behavioral Health Service Needs Plan (Service Plan) yet. CMS has received the Mercer analysis that may help to inform the Service Plan. The DHCS, however, maintains that until there is direction from CMS as to what the expansion pieces look like, they are not able to submit the Service Plan.

*Abbott asked if anyone has a sense of what the Service Plan will consist of?*

*Vanderhurst indicated that counties are not waiting for a Service Plan. Counties know that new eligible are entitled to same plan as the old, people who are newly eligible will not have same level of impairments, and are anticipating that the first point of contact is where counties need to step up. Counties need to make decisions for how Alcohol and Drug is incorporated. For mental health Counties know there is 100% FFP. Counties are aware that they need to be strategic about capacity.*

*Vanderhurst continues that Counties are looking at budget, staffing, productivity, referrals, primary care partners, and phase in.*

*Abbott inquired about the differential between phase 1 and phase 2.*

*Vanderhurst responded that phase 1 would be having the ability to do a comprehensive assessment and link to services for newly eligible. Phase 2 is focusing on service delivery, looking at evidence based practices.*

*Steven Grolnic-McClurg stated that he does not know what will come from the Service Plan, but in his county he believes the newly eligible will place more demand on the provider network. There is no clarity on how smoothly people will be signed up for Medicaid.*

*Terry Lewis reported that L.A. County is not waiting for direction from the State and that they are currently working on certifying health care navigators to be service area providers in the community for the newly enrolled.*

Vanderhurst concluded that counties are not waiting for the Service Plan, but are moving ahead and looking to the State to address the workforce issues.

### **Update: Cal Medi-Connect**

Beverly Abbott provided an update on the Dual Eligible/Cal Medi- Connect process. Abbott reported that DHCS has been postponed until January 1, 2014. DHCS explained that there is trailer bill language to de-link the components of the Coordinated Care Initiative (CCI) to ensure that if one component does not go forward, the others can. Bev inquired with DHCS if they were feeling pessimistic about the implementation of the Dual Eligible piece of the CCI. DHCS stated that they feel it will go forward and they still think they will make it the implementation date. Abbott continued that there are many complicated pieces and the thought is to delink it to so other components can still go ahead, whether or not Long Term Care (LTC) is integrated. The new trailer bill language enables the integration of all of the dual eligible in managed care, however, the dual eligible pilot would not include the Medi-Cal and Medicare piece.

Abbott expressed that the planning process has been good and the HCR Committee has advocated for DHCS not thinking of stakeholders as just LTC groups but community based provider agency.

### **May Budget Revise Implication for Healthcare Reform**

Susan Rajlal, Los Angeles County Legislative Analyst informed the HCR Committee of discussions taking place with legislatures and share what L.A. County legislative efforts. Rajlal provided the following information regarding mental health items in the budget that has been enacted by the legislature:

- Essential Benefits for the newly eligible be consistent with those already enrolled in Medi-Cal meaning only offer one system of care.

- County mental health plan, managed care plan have an administrator of the mental health (MH) program. The county mental health system of care is responsible for all those who live in the county. Having an administrator is excellent way to preserve funding for the county.
- Reserve funding to have a financially stable community MH effort.
- Successful in retaining 1991 and 2011 realignment agreements, although the governor reneged and took away part money for the Cal Works on the gross funding from the 2011 realignment.
- MH will get more money: 93 million per month statewide, 49.7 million in gross funds this year, 66.7 million in state general funds, 92.6 million in federal funds statewide beginning in January for the implementation of the Affordable Care Act, and 236 million from Steinberg's call to action for MH wellness.
- Covered CA will begin enrolling people in October for Health Benefits Exchange.
- Much is undecided and unknown as there has not been a lot of leadership from state level.
- Counties are determining how many people they will have to service, L.A. County estimates an additional 100 thousand people with MH needs beginning in January 2014. All of those people will not have specialty MH needs.
- Looking at partnerships to see who will see what people at what acuity. In CA most of the people without specialty MH needs probably get medication, treatment and referrals from their primary care physician.
- Counties are trying to determine how to create a system that serves well? How do we give support to people to primary care physician? How do we get buy in from primary care? How do we begin to work with public health and primary care to integrate services? Who are going to be our partners in doing this? How do we want our community MH system to look like?
- Implementation of HCR will be a challenge for some areas as some counties have dealt with underfunding for so long that getting ready for the new influx of people is probably overwhelming.
- Other issues include making services accessible, early intervention is critical piece in satisfying the triple aim, workforce to work in more integrated fashion with primary care and community partners, how will we develop a large quality workforce that is also culturally competent, how will MH component share savings with county MH, and how will early intervention and control cost balance.

Rajjal concluded that MH is at a turning point, things are looking good.

### **Primary and Mental Health Integration Project**

Sandra Naylor-Goodwin, PhD, MSW, from the CiMH presented information regarding CiMH's Learning Collaboratives. Naylor-Goodwin provided a general overview of Healthcare Reform to date, then explained the Learning Collaboratives, their findings, and recommendations.

*Please see powerpoint for detailed information on this presentation.*

### **Behavioral Health Workforce Issues**

Lupe Alonzo-Diaz, Deputy Director and Sergio Aguilar, Healthcare Reform Program Analyst from the Healthcare Workforce Development Division of the OSHPD, provided a brief overview of OSHPD's Health Workforce Development (HWD) efforts. Their presentation included healthcare workforce challenges, OSHPD HWD programs, OSHPD priorities for 2013-2015, focus on MH in OSHPD's existing programs, the MHSA WET programs, and opportunities to engage the CMHPC.

*Please see powerpoint for detailed information on this presentation.*

The meeting adjourned at 5:00 P.M.

Respectfully Submitted,

Narkesia Swanigan

**X** INFORMATION

TAB SECTION: A

\_\_\_ ACTION REQUIRED:

DATE OF MEETING: 10/16/13

PREPARED BY: Tracy Thompson

DATE MATERIAL  
PREPARED: 09/16/13

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AGENDA ITEM: Update: Cal Medi-Connect

ENCLOSURES:

- Behavioral Health Quality Measures for the Demonstration
- Coordinated Care Initiative: Executive Summary

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:

### Dual Eligibles Coordinated Care Demonstration - Cal MediConnect

California's Medi-Cal program and the federal Medicare program have partnered to launch a three-year demonstration beginning in 2013 that would promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both programs.

The duals demonstration, now called the Cal MediConnect Program, aims to create a seamless service delivery experience for dual eligible beneficiaries, with the ultimate goals of improved care quality, better health and a more efficient delivery system.

Cal MediConnect is part of California's larger Coordinated Care Initiative (CCI). Building on many years of stakeholder discussions, the CCI was enacted in July 2012 through [SB 1008](#) (Chapter 33, Statutes of 2012) and [SB 1036](#) (Chapter 45, Statutes of 2012).

The Cal MediConnect program will be implemented no sooner than October 2013 in eight counties: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino.

### Coordinated Care Initiative Overview

Passage of the Coordinated Care Initiative (CCI) in July 2012 marked an important step toward transforming California's Medi-Cal (Medicaid) care delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries.

Created through a public process involving stakeholders and health care consumers, the CCI was enacted through [SB 1008](#) (Chapter 33, Statutes of 2012) and [SB 1036](#) (Chapter 45, Statutes of 2012).

The CCI will be implemented in eight counties beginning in 2013. The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

### Major Parts of the Coordinated Care Initiative

- **Cal MediConnect:** A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and

X INFORMATION

TAB SECTION: A

\_\_\_ ACTION REQUIRED:

DATE OF MEETING: 10/16/13

PREPARED BY: Tracy Thompson

DATE MATERIAL  
PREPARED: 09/16/13

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**AGENDA ITEM:** cont. Update: Cal Medi-Connect

community-based services through a single organized delivery system. No more than 456,000 beneficiaries will be eligible for the duals demonstration in the eight counties.

- **Managed Medi-Cal Long-Term Supports and Services (LTSS):** All Medi-Cal beneficiaries, including dual eligible beneficiaries, required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

## Behavioral Health Quality Measures for the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withhold Measure
Behavioral Health Shared Accountability Process Measure. Phase A (9/1/13 – 12/31/13)  Phase B (1/1/14 – 12/31/14)	Phase A: Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.  Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider	State-defined measures		X	Year 1
Behavioral Health Shared Accountability Outcome Measure	Reduction in Emergency Department Use for Seriously Mentally Ill and Substance Use Disorder enrollees (greater reduction in Demonstration Year 3)	State defined measure		X	Years 2 & 3
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X		Years 2 & 3
Screening for Clinical Depression and Follow-up	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X		Years 2 & 3
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	CMS/State defined process measure	X		Year 1
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure		X	Year 1-3
Plan All-Cause Readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X		Years 2 & 3
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care.  • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	X		Year 1
Antidepressant medication management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS	X		
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X		

## Behavioral Health Quality Measures for the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withhold Measure
Individualized care plans	Percent of members with care plans by specified timeframe	CMS/State defined process measure	X		
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe	CMS/State defined process measure	X		
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including:  -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey	AHRQ/CAHPS	X		

## Coordinated Care Initiative Executive Summary

FACT SHEET | Updated March 2013

Passage of the Coordinated Care Initiative (CCI) in 2012 marked an important step toward transforming California's Medi-Cal (Medicaid) care delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries.

Created through a public process involving stakeholders and health care consumers, the CCI was enacted through [SB 1008](#) (Chapter 33, Statutes of 2012) and [SB 1036](#) (Chapter 45, Statutes of 2012).



The CCI will be implemented in 8 counties in 2013

### Two Parts of the Coordinated Care Initiative

- 1 *Cal MediConnect*: A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan. The CCI provides state authority for Cal MediConnect. The MOU executed in March 2013 with the federal Centers for Medicare & Medicaid Services (CMS) provides federal approval.
- 2 *Managed Medi-Cal Long-Term Supports and Services (LTSS)*: Nearly all Medi-Cal beneficiaries age 21 and older,<sup>1</sup> including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

### Better Care Improves Health and Drives Lower Costs

The CCI is expected to produce greater value for the Medicare and Medi-Cal programs by improving health outcomes and containing costs; primarily through shifting service delivery into the home and community and away from expensive institutional settings. Better prevention will keep people healthy. Better care coordination will reduce unnecessary tests and medications. Better chronic disease management will help people avoid unnecessary hospital care.

<sup>1</sup> Populations excluded from passive enrollment into Cal MediConnect and mandatory enrollment in Medi-Cal managed care can be found on a populations summary fact sheet: [www.calduals.org/wp-content/uploads/2013/03/CCIPopulationSummary.pdf](http://www.calduals.org/wp-content/uploads/2013/03/CCIPopulationSummary.pdf)

Under the CCI, the participating managed care health plans will receive a monthly payment to provide beneficiaries access to all covered, medically necessary services through a process called “capitation.” These capitated payments create strong financial incentives for health plans to ensure beneficiaries receive preventive care and home- and community-based options to avoid unnecessary admissions to the hospital or nursing home.

Significant stakeholder feedback informed the beneficiary protections needed to drive success and quality in the CCI’s design and implementation. The CCI includes comprehensive protections to ensure beneficiary health, safety, and high quality care delivery, including medical care, LTSS, and behavioral health.

## Coordinated Care Initiative Goals

By consolidating the responsibility for all of these covered services into a single health plan, the CCI expects to achieve the following goals:

- 1 Improve the quality of care for beneficiaries.
- 2 Maximize the ability of beneficiaries to remain safely in their homes and communities, with appropriate services and supports, in lieu of institutional care.
- 3 Coordinate Medi-Cal and Medicare benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services settings using a person-centered approach.
- 4 Promote a system that is both sustainable, person- and family-centered, and enables beneficiaries to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and mental health and substance use disorder services.

## Location and Timing

The CCI will be implemented in eight counties no sooner than October 2013. The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The participating health plans are part of the state’s existing network of Medi-Cal health plans and have experience providing Medicare managed care. Each underwent a rigorous selection process.

## Implementation Status

With the signing of the MOU in March 2013, the state and federal governments will now conduct a comprehensive readiness review to evaluate each health plan’s major systems

Counties and Primary Health Plans Implementing the CCI	
County	Health Plans
<a href="#">Alameda</a>	Alameda Alliance for Health
	Anthem Blue Cross
<a href="#">Los Angeles</a>	L.A. Care
	Health Net
<a href="#">Orange</a>	CalOptima
	Care 1st
<a href="#">San Diego</a>	Community Health Group
	Health Net
	Molina Health
<a href="#">San Mateo</a>	Health Plan of San Mateo
	Inland Empire Health Plan
<a href="#">Riverside</a>	Molina Health Care
<a href="#">San Bernardino</a>	Inland Empire Health Plan
	Molina Health Care
	Anthem Blue Cross
<a href="#">Santa Clara</a>	
	Santa Clara Family Health Plan

and ensure they are prepared to provide the required continuity of care, seamless access to medically necessary services, and coordinate care across LTSS, behavioral health and medical care. Health plans must pass this review before three-way contracts between the health plans, CMS, and DHCS are signed and before any beneficiary is enrolled.

### ***Enrollment Process***

Enrollment will begin no sooner than October 2013. Notification of these changes will be mailed to eligible participants starting in July 2013.

Enrollment will be phased in over 12 months in all participating counties, except Los Angeles and San Mateo. In Los Angeles, enrollment will be phased in over 15 months. In San Mateo, enrollment will happen all at once in October 2013 (except for those in a non-demonstration plan D-SNP, which will be completed by January 2014).

### ***Understanding Enrollment for Different Populations***

- For people with both Medicare and Medi-Cal eligible for Cal MediConnect:** The state will use a passive enrollment process. This means that the state will enroll eligible individuals into a health plan that combines their Medicare and Medi-Cal benefits unless the individual actively chooses not to join and notifies the state of this choice. The state will send eligible individuals multiple notices describing their choices, including the option to “opt out” of joining a Cal MediConnect health plan.

**“Opting out”:** This is when an eligible beneficiary chooses not to join a demonstration health plan and keep his or her Medicare benefits separate and out of the demonstration health plan. Beneficiaries who enroll in a Cal MediConnect health plan may opt out or change health plans at any time.

**Note:** Opting out applies only to Medicare benefits. Beneficiaries must still get their Medi-Cal benefits through a health plan, as described below. This
- For nearly all people with Medi-Cal:** The state will require mandatory enrollment into a Medi-Cal health plan. This means that nearly all people with Medi-Cal in the eight CCI counties **MUST** get all their Medi-Cal benefits, including long-term services and supports, through a Medi-Cal health plan. Most people with only Medi-Cal already are enrolled in a Medi-Cal health plan; now they will also get their long-term supports and services through their health plan.
- For people with both Medicare and Medi-Cal who do not enroll in a Cal MediConnect Health Plan:** The state will require enrollment in a Medi-Cal plan for all Medi-Cal long-term services and supports and any Medicare deductibles or costs. For dual eligible beneficiaries, enrolling in a Medi-Cal health plan does not change their Medicare benefits. They can still go to their Medicare doctors, hospitals, and providers.

## **Participating Populations**

An estimated 456,000 dual eligible beneficiaries will be eligible for passive enrollment into the Cal MediConnect program in the eight counties, with a maximum of 200,000 in Los Angeles County. An estimated one-third of those beneficiaries already are enrolled in managed care for Medi-Cal, Medicare, or both. Certain people with Medicare and Medi-Cal will not be eligible to enroll in a Cal MediConnect health plan. (A full list of the populations included and excluded is listed in another fact sheet.)

While nearly all people with Medi-Cal in the eight CCI counties will be required to enroll in a Medi-Cal health plan, there are some exceptions. (All exceptions are listed in a separate fact sheet.)

Dual eligible beneficiaries and Medi-Cal seniors and persons with disabilities are among California's highest-need residents. They tend to have many chronic health conditions and need a complex range of medical and social services from many providers. This fragmentation leads to beneficiary confusion, poor care coordination, inappropriate utilization, and unnecessary costs.

Under the CCI, enrolled beneficiaries will have one point of contact for all their covered benefits. They will have one health plan membership card and access to a nurse or social worker whose job is to act as a care coordinator or navigator and help beneficiaries receive the services needed to achieve their personal health goals and continue living in the setting of their choice. The state is developing care coordination standards that will guide how services are linked.

### Managed Long-Term Supports and Services

The following Medi-Cal long-term services and supports will only be available through a health plan in the eight CCI counties. The health plan may be a Cal MediConnect health plan or a Medi-Cal only plan, depending on a beneficiary's coverage and choices.

- **In-Home Supportive Services (IHSS)** is personal care for people who need help to live safely at home. In a health plan, people will keep their IHSS providers and can still hire, fire, and manage them. The county IHSS social worker will still assess consumers' needs and approve IHSS hours. The rights to appeal will stay the same.
- **Community Based Adult Services (CBAS)** is adult day health care provided at special centers. This service is available through the health plans.
- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people 65 and older. Health plans will work with MSSP providers to provide this service.
- **Nursing home care** is long-term care provided in a facility. Health plans will work with enrollees, their doctors and the nursing homes to coordinate care.

### Behavioral Health Coordination

Cal MediConnect health plans are responsible for ensuring enrollees have seamless access to all necessary behavioral health services. They will be financially responsible for all Medicare behavioral health services. However, Medi-Cal specialty mental health and Drug Medi-Cal services are carved out of Cal MediConnect benefit packages because they are financed and administered by counties. Cal MediConnect health plans will be expected to coordinate services with county behavioral health agencies.

**X** INFORMATION

**TAB SECTION: B**

\_\_\_ ACTION REQUIRED:

**DATE OF MEETING: 10/16/13**

**PREPARED BY:** Tracy Thompson

**DATE MATERIAL  
PREPARED: 09/16/13**

---

**AGENDA ITEM:** Update: Behavioral Health Service Needs Plan

- ENCLOSURES:**
- Draft Medicaid Benefit Plan Options Analysis Cover Letter
  - Draft Medicaid Benefit Plan Options Analysis
  - Behavioral Health Stakeholder Update

**OTHER MATERIAL RELATED TO ITEM:**

---

**ISSUE:**

At the April Healthcare Reform (HCR) Committee meeting Rollin Ives from the Department of Health Care Services (DHCS), provided a general overview of DHCS recent developments of California's Behavioral Health Service Needs Plan (Service Plan). The DHCS provided an outline of the Service Plan to the Centers for Medicare and Medicaid Services (CMS) in October 2012 and asked for an extension in submitting the Service Plan. CMS granted the extension until April 1, 2013. On April 1<sup>st</sup> the DHCS submitted a Draft Medicaid Benefit Plan Options Analysis (Options Analysis) in place of the Service Plan. The Options Analysis serves as an indication of work products the State is using to help the DHCS come to a final decision. The Options Analysis also provides California's decision makers and stakeholders information regarding the expansion. CMS is currently reviewing selective assumptions in the Options Analysis.

The Governor's Budget May Revision proposed a state-based approach to the optional expansion of health care through the Affordable Care Act. Jaye Vanderhurst, LCSW, Napa County Mental Health Director, member of the HCR committee will provide an update on the Service Plan progress to date.





TOBY DOUGLAS  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

## MEMORANDUM

DATE: April 22, 2013  
TO: All Interested Parties  
FROM: Department of Health Care Services  
SUBJECT: Behavioral Health Service Plan Update

---

The 1115 Bridge to Reform Demonstration Waiver Special Terms and Conditions requires the completion of a behavioral health *Service Plan* which will describe, at a high level, California's recommendations for serving the Medi-Cal expansion population as well as demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population.

Last October 2012, the Department submitted to CMS the outline for this required work product that described the component pieces with the intent to submit the actual *Service Plan* on or before April 1<sup>st</sup>, 2013. However, since the Administration, Legislature, counties and stakeholders are still actively exploring Medi-Cal expansion options, CMS understands that DHCS has been unable to finalize the behavioral health the *Service Plan* and appreciates the need for to extend the due date for this work product.

After discussions with CMS regarding an interim work product for the April 1<sup>st</sup> due date, CMS agreed to have DHCS submit the draft *Medicaid Alternative Benefit Plan (ABP) Options Analysis* prepared by Mercer with technical assistance from DHCS and funding support from the California HealthCare Foundation (CHCF) and the California Endowment.

The *Options Analysis* was developed for the purpose of providing California decision makers and stakeholders information regarding the Medicaid expansion alternative benefit plan options. In response to input from legislative staff and advocates, Mercer is currently reviewing selected assumptions in the analysis. The final report will be shared in the near future. While not the *Service Plan*, CMS appreciates the Mercer analysis will be an analytical component among many that will help inform the final behavioral health *Service Plan*.

DHCS is committed to completing the *Service Plan* when we have resolution of Medi-Cal expansion issues currently pending, so that we are fully planning for mental health and substance use disorder service needs of the expansion population. We have communicated to CMS that we plan to submit the *Service Plan* on or before October 1, 2013.

Once decisions have been made, DHCS will incorporate the chosen direction into the behavioral health *Service Plan* which will provide a high-level overview of the selected benefit package, benefit delivery system(s), and projected costs and levels of utilization. DHCS will then require several months to complete a reasonable stakeholder review, incorporate edits and receive final Administration sign off. The proper timing and forums for further stakeholder meetings are under active consideration.

DHCS greatly appreciates the continued flexibility and support of CMS in working with California to successfully plan for meeting the mental health and substance use disorder needs of the expansion population.

Please send any questions or comments to:  
[1115BehavioralHealthAssessment@dhcs.ca.gov](mailto:1115BehavioralHealthAssessment@dhcs.ca.gov)



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



EDMUND G. BROWN JR.  
GOVERNOR

April 1, 2013

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**CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9): MEDICAID  
ALTERNATIVE BENEFIT PLAN OPTIONS ANALYSIS TO INFORM DECISIONS  
REGARDING BEHAVIORAL HEALTH SERVICE PLAN DEVELOPMENT**

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

Enclosed is the *Medicaid Alternative Benefit Plan (ABP) Options Analysis* prepared by Mercer with technical assistance from the Department of Health Care Services (DHCS) with funding from the California HealthCare Foundation (CHCF) and The California Endowment.

Mercer worked with DHCS to assess Medicaid ABP options available as required by the Patient Protection and Affordable Care Act (ACA) for the newly eligible optional expansion in 2014. The Technical Assistance Collaborative, Inc. (TAC) and the Human Services Research Institute (HSRI) provided behavioral health service utilization projections and cost estimations. TAC/HSRI also developed with DHCS the [California Mental Health and Substance Use System Needs Assessment](#), delivered

March 1, 2012. Manatt Health Solutions assisted in providing policy guidance. Mercer worked with DHCS, Manatt, TAC and HSRI to identify Medicaid ABP options and to establish guidelines and principles for assessing these options. Mercer developed a series of summary documents to compare benefits across potential Medicaid ABP options.

This analysis was designed to provide relative cost comparisons between the ABP options with the least and most comprehensive benefits and projected costs of both options through state fiscal year (SFY) 2020. Medi-Cal was selected as the most comprehensive coverage available among the four options, though not necessarily in each service coverage category. The Anthem Choice plan appeared to represent the least comprehensive coverage available among the four options. These established the “bookends” of the Medicaid ABP Cost Estimate. After consultation with legislative staff and advocates in early March, Mercer is considering a number of minor analytical changes that may change the final estimates. DHCS will share the final Mercer ABP report when completed.

The purpose of this options analysis is to provide California policy makers and stakeholders with information regarding the Medicaid ABP options. In carefully considering various options, this document is an essential component and will be a key factor in developing the final Service Plan.

The Section 1115 Bridge to Reform Demonstration Special Terms and Conditions (STCs) paragraph 25.d requires the completion of a Behavioral Health Services Plan which will describe, at a high level, California’s recommendations for serving the Medi-Cal expansion population as well as demonstrate the State’s readiness to meet the mental health and substance use disorder needs of this population.

In October 2012, when we originally requested the revised April 1, 2013 due date for this deliverable, the State of California and the Centers for Medicare and Medicaid Services (CMS) had anticipated that the Administration and the Legislature would have made decisions regarding which benefit package and delivery system California had chosen for the optional Medicaid expansion population. As of the date of this letter, the Administration, Legislature and counties are still actively exploring benefit package and delivery system options, and several key decisions remain to be made by both the Administration and the Legislature that will directly affect the Service Plan.

Once those decisions are made, DHCS will incorporate them into the Service Plan, which will provide a high level overview of the selected benchmark benefit package, benefit delivery system(s), projected costs, and levels of utilization as well as the concurrent implementation strategies for financing, enrollment, quality oversight/monitoring, access, and work force development. DHCS will require several

April 1, 2013

months to complete a reasonable stakeholder review, incorporate edits and receive final approval within the Administration of this Service Plan.

DHCS greatly appreciates the flexibility that CMS has provided in allowing our submission of the *Medicaid Alternative Benefit Plan (ABP) Options Analysis* on April 1, 2013 and a subsequent Service Plan on or before October 1, 2013.

If you or your staff have any questions or need additional information regarding this report, please contact Brian Hansen, Health Reform Advisor, at (916) 319-8518.

Sincerely,



Toby Douglas  
Director

Enclosure

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February 25, 2013

# MEDICAID ALTERNATIVE BENEFIT PLAN OPTIONS ANALYSIS – **DRAFT**

## MERCER

Prepared with funding from the California HealthCare  
Foundation and The California Endowment

To help the California Department of Health Care Services  
develop information about the policy decision for the  
Alternative Benefit Plan options

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# 1

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## Introduction

The California HealthCare Foundation contracted with Mercer Government Human Services Consulting (Mercer) to work with the California Department of Health Care Services (DHCS) in an assessment of Medicaid benefit options available as required by the Patient Protection and Affordable Care Act (ACA) for the newly eligible optional expansion population in 2014. Specifically, Mercer assessed coverage among Medicaid benefit options and developed cost estimates with technical assistance from DHCS. Mercer does not take any opinion in this report with respect to which of the benchmark plan options should be selected by the State. Instead, this summary and the supporting detailed analyses are intended to support dialogue among key stakeholders and to inform policy decisions.

In completing this project, Mercer worked closely with DHCS as well as its partners and consultants, the California HealthCare Foundation, The California Endowment, Manatt Health Solutions, Technical Assistance Collaborative, Inc. (TAC), and Human Services Research Institute (HSRI). The California Endowment contracted with TAC and HSRI to provide the behavioral health cost estimates contained in this report. Mercer would also like to acknowledge the contributions of CalPERS and Kaiser in reviewing the benefit coverage used in our review.

# 2

## Background and Approach

### Medicaid Alternative Benefit Plans and the ACA

In preparation for the optional expansion of Medi-Cal under ACA in 2014, California must select one or more benefit options for the newly eligible optional expansion. States must provide benchmark or benchmark-equivalent coverage described under section 1937 of the Social Security Act, as modified by the ACA, as a Medicaid Alternative Benefit Plan (ABP).

States have options in selecting a Medicaid ABP, including the option to propose offering the current Medicaid state plan benefit package and may offer different ABPs to targeted populations to meet their needs. All Medicaid ABPs must be based upon one of the following four “base benchmark” benefit options:

1. The Standard Blue Cross/Blue Shield (BC/BS) Preferred Provider Option (PPO) offered through the Federal Employees Health Benefit program (FEHBP);
2. State employee coverage that is offered and generally available to state employees;
3. The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state; and/or
4. Secretary-approved coverage, which, as noted above, can include the Medicaid state plan benefit package offered in that state. Under this option, *states may propose to provide the current Medicaid state plan benefit or another benefit other than the three commercial coverage options.*

Furthermore, the following also apply to all Medicaid ABPs:

- Coverage of the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for individuals under age 21
- Coverage of family planning services and supplies
- An assurance from the state that non-emergency medical transportation to and from providers will be made available, through the ABP coverage or otherwise
- Access to services provided at federally qualified health centers (FQHCs) and rural health clinics (RHCs) through the ABP coverage or otherwise
- Compliance with federal mental health parity requirements
- Coverage of all Essential Health Benefits (EHBs)

### Covering EHBs in Medicaid Alternative Benefit Plans

Similar to the requirements for coverage under the Affordable Insurance Exchanges (Exchange) rules, Medicaid ABP coverage must include the EHBs, which includes coverage in each of the following 10 categories<sup>1</sup>:

1. Hospitalization
2. Emergency services

<sup>1</sup> To date, no additional guidance has been provided that further defines these categories or sets a measure by which the State may determine if the provided services in the benchmark plan will amount to satisfactory coverage of the EHB.

3. Ambulatory patient services
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

If a benchmark option does not contain all 10 categories of EHB, that option would need to be supplemented in order to cover any missing EHB. The federal Centers for Medicare & Medicaid Services (CMS), in its November 20, 2012 letter to State Medicaid Directors explained that the resulting ABP must cover all EHB categories. The letter continues to detail the approval options:

- *“If the 1937 [Medicaid ABP] coverage option selected is one of the options available for defining EHBs, the state would be deemed to have met the requirement for EHB coverage in an Alternative Benefit Plan to the extent that the selected coverage option includes all EHB categories.”*
- *“If the state selects a 1937 [Medicaid ABP] coverage option that is not one of the options for defining EHBs in the individual and small group market, states will select any one of the EHB base benchmark options and will then compare the coverage between the 1937 coverage option and the selected EHB base benchmark plan and, if needed, supplement the section 1937 coverage option.”*

Of the base benchmark options, three of the four are currently options for defining EHBs in the individual and small group market. Only the “Secretary-approved” option (which is also the option for providing the current Medi-Cal benefit) may trigger the review process identified in the second bullet above. At present, Mercer assumes that this event is triggered even where the State is simply seeking approval to use its current Medicaid benefits.

States are not restricted to one Medicaid ABP and may tailor ABPs to meet the needs of specific populations. However, California should weigh the additional administrative burden associated with the administration of multiple benefit packages that may make that possibility less appealing. Conversely, aligning the ABP with the current Medi-Cal benefit may reduce the administrative costs associated with the newly eligible optional expansion population and help maximize potential leverage among the benefit administrators.

## **Comparison of Benefits Across Potential Medicaid ABP Options Supporting Summaries and Documents**

In order to facilitate the analysis of potential benchmark plan options, Mercer developed a series of summary documents. These documents contain the details regarding which services (including detailed subservice categories within the 10 mandatory EHB service categories) are covered by each of the four base benchmark plan options DHCS selected for review. Mercer worked directly with local carriers that offer the base benchmark plan options to the extent possible. Mercer also participated in several work sessions with DHCS, Manatt, TAC and HSRI wherein we collectively identified ABP options, prepared summaries and established guidelines and principles for assessing the Medicaid ABP options. The following are descriptions of Appendix A and B; these supplemental works were developed to assist the State in the benchmark plan selection process.

**Medicaid ABP Coverage Summary (attached as Appendix A)** – This analysis was designed to provide the State with a side-by-side comparison of the base benchmark plan options (Medicaid ABP options) including analysis of the current Medi-Cal benefit. Each of the base benchmark plan options are included side by side (horizontally) with details regarding coverage (or non-coverage), as well as, limitations for all category of service detailed line items. Services were categorized according to the 10 EHB categories of service plus additional categories for long-term care (LTC) services and support. In addition, the Medicaid ABP required coverage areas of EPSDT, FQHC services, Mental Health Parity, transportation and family planning services were added as service categories in one of the EHB categories and “other.”

The four plans reviewed in the ABP Coverage Summary are:

1. **CalPERS Anthem Choice Preferred Provider Organization (State Employee Plan ABP Option)** – Based on preliminary analysis performed by Milliman<sup>2</sup> for the California Health Benefit Exchange and subsequent review of plan documentation by Mercer, the CalPERS Anthem Choice (Anthem Choice) plan appeared to represent the least comprehensive coverage option available within the category of state employee plan options. Mercer reviewed the coverage under the Anthem Choice plan for the purpose of establishing the least comprehensive option available to California. The Anthem Choice plan information contained in Appendix A is the product of Mercer’s analysis and has been fully peer reviewed by the plan administrators at CalPERS.
2. **Standard Blue Cross/Blue Shield Preferred Provider Option (Federal Employee Health Benefit Plan ABP Option)** – The information on the Standard BCBS PPO option is contained in Appendix A and is the product of Mercer’s analysis of the benefit brochures for this option. Most information has been peer reviewed by the BCBS plan. Where a peer review was not available, the coverage details remain Mercer’s best judgment.
3. **Kaiser Traditional HMO (Largest insured commercial, non-Medicaid ABP option)** – All of the HMO information contained in Appendix A has been provided by Kaiser.
4. **Medi-Cal State Plan Benefit (Secretary-approved coverage ABP Option)** – For purposes of this analysis, DHCS asked Mercer to compare the current Medi-Cal benefit as the potential Secretary-approved base benchmark plan option. All of the Medi-Cal information contained in Appendix A has either been provided or peer reviewed by DHCS staff.

**Medicaid ABP Cost Estimates (attached as Appendix B)** – This analysis was designed to provide the State with relative cost comparisons between the ABP options with the least and most comprehensive benefits and projected costs of both options through state fiscal year (SFY) 2020. Based upon the information gathered in the Medicaid ABP Coverage Summary, Medi-Cal appeared to represent the most comprehensive coverage available among the four options, though not necessarily in each service coverage category. The Anthem Choice plan appeared to represent the least comprehensive coverage available among the four options. These established the “bookends” of our Medicaid ABP Cost Estimate (Appendix B), with benefits provided under the other two ABP benefit options assumed to fall between Anthem Choice and Medi-Cal.

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<sup>2</sup>[http://www.healthexchange.ca.gov/FederalGuidance/Documents/Milliman-Essential\\_Health\\_Benefits\\_Comparison-Cost\\_of\\_Services2-21-2012.pdf](http://www.healthexchange.ca.gov/FederalGuidance/Documents/Milliman-Essential_Health_Benefits_Comparison-Cost_of_Services2-21-2012.pdf)

# 3

## Assessment of EHB and ABP Requirements

### Essential Health Benefits

As noted earlier, all Medicaid ABPs must include EHBs, including coverage of services and items in all 10 statutory categories of service. Mercer's assessment of the coverage available under the four ABP benefit options considered as part of this assessment is that each plan option, including Medi-Cal, appears to have some coverage in nine of the 10 EHB categories. For the tenth category of EHB, habilitative services, there remains some ambiguity around what CMS will consider to be coverage of habilitative services in State Medicaid programs.

While each plan appeared to cover services within the nine remaining EHB categories, there may be significant coverage variation among the plans within each of the coverage categories. Treatment and coverage limitations around amount, duration, and scope of the services covered within a category may create important coverage distinctions among the plan options that California should consider in selecting one or more ABPs. For example, DHCS has stated that the Medi-Cal substance use disorder services benefit, while covered, may be less robust than the coverage available in one or more of the commercial options. Similarly, coverage limitations within the commercial plan options may be greater in Rehabilitative and Habilitative Services and Devices category than in Medi-Cal. Additional federal guidance is also needed to understand the parameters and processes for assessing coverage of EHBs when states elect the Secretary-approved ABP option. CMS has not yet said if or how it will establish standards to assess whether or not coverage within each category of EHB in a Medicaid ABP is sufficient or "substantially equal" to the benchmark reference plan.

### Habilitative Services

Most commercial benchmark plan options do not cover habilitative services. In part, this is because of the lack of uniformity in defining habilitative services in the commercial market. CMS has proposed in regulations that states have the opportunity to define habilitative benefits using a transitional approach in which states may either define the habilitative services category or leave it to issuers. Under the proposed rule, if the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, a health insurance issuer must select from two options: (1) provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) decide which habilitative services to cover and report on that coverage to HHS. Depending upon the outcome of the proposed rule, there is the potential for a cost impact associated with the utilization of services for populations that are in need of habilitative services. However, Mercer is unable to comment on the EHB coverage of habilitative services or quantify any impact at this point.

### Mental Health and Substance Use Disorder Services and Parity

In addition to covering the 10 categories of EHB, all Medicaid ABPs must provide coverage that is in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)<sup>3</sup>. Under MHPAEA, financial requirements (e.g., deductibles, copayments, coinsurance) and treatment limitations

<sup>3</sup> <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf> at page 2

(e.g., visit or day limits) applicable to such Mental Health and Substance Use (MHSU) disorder benefits can be no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage). In addition, the plan or coverage cannot impose separate cost-sharing requirements or treatment limitations that are applicable only with respect to MHSU benefits<sup>4</sup>. Regulations set quantitative and qualitative tests for parity.

The potential ABPs all offer some level of MHSU services. However, Mercer did not assess the coverage for compliance with MHPAEA as federal guidance around Medicaid mental health parity and ABPs is outside of the scope of this report. It is important to note that MHPAEA does not compel coverage of services, but instead creates minimums for how covered services are made available. However, because one of the categories that must be included in the EHB is MHSU, there must be some services included in the ABP and all of those services will have to comply with MHPAEA.

### **Pediatric Services, Including Oral and Vision Care**

All Medicaid ABPs must cover EPSDT services; therefore, coverage of the pediatric services EHB category is assumed to be met through the EPSDT requirement. Mercer notes that this is expected to impact only those individuals ages 19 and 20 in the newly eligible optional expansion population, which by definition includes only individuals age 19 through 64.

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<sup>4</sup> 29 USC § 1185a

# 4

## Medicaid ABP Option Cost Estimates

As a product of workgroup discussion, Mercer estimated the costs of the least comprehensive ABP option and the most comprehensive option (CalPERS Anthem Choice and Medi-Cal respectively), identified those service category differences that have meaningful impact on the cost comparisons and estimated the cost variances between the two options for those service categories. These estimates are further described in Appendix B. Mercer did not model any offsetting costs such as general fund revenues from additional tax receipts on new federal revenues.

### Estimate of the Population Size and Demographic Characteristics

The newly eligible optional expansion population will consist of currently uninsured California residents below 133% of the Federal Poverty Level (FPL). The uninsured, in general, are assumed to have a higher rate of disability/acuity than the general population. To determine the level of disability among the currently uninsured California residents below 133% FPL, Mercer used the 2010 Current Population Survey (CPS) data for those uninsured, ages 19 through 64, below 125% of FPL (the closest cut of data available). This dataset has three classifications of individuals (based on self-declaration):

- Severe Work Disability
- Non-Severe Work Disability
- No Work Disability

This dataset showed 7% of this uninsured group had a severe work disability, and an additional 2% had a non-severe work disability. As a margin of conservatism, we would classify both the severe and non-severe as a “disabled-like” risk group. This assumption would mean that the total potential newly eligible optional expansion population has a 9% disability rate.

However, because disabled individuals will have greater health care needs, they will be more likely than non-disabled members to enroll, and enroll sooner. At the same time, otherwise healthy individuals (non-disabled) will be less likely to enroll as quickly. Therefore, the “disabled-like” population will make up a larger percentage of the population that actually enrolls than the percentage they make up of the total potentially eligible population. To approximate this behavior, Mercer assumes that 95% of the eligible disabled population will enroll in Medi-Cal immediately in CY 2014, and by CY 2020, 100% of the disabled population will be enrolled under the newly eligible optional expansion.

As a product of workgroup discussion, Mercer used the CalSIM “enhanced” enrollment projections for the newly eligible optional expansion analysis. The UCB-UCLA CalSIM data set and analyses are commonly referenced and broadly available. Given the timeframe required for the analysis, a complete analysis of “take-up” and enrollment projections was not feasible. While total potential total benefit costs are provided in this analysis based on the CalSIM projections, actual costs may be higher or lower than the estimates represented in this analysis. DHCS is completing an analysis of initial and long-term take-up rates and demographics for the newly eligible optional expansion populations. However, it is not anticipated that future refinements would materially affect the range of the differentials on a PMPM basis.

We calculated how many disabled would enroll in each year (starting with 95% of the disabled in 2014), and assumed the *remainder* would be comprised of the non-disabled population. The results are shown in the subsequent table.

<u>Year</u>	<u>Disabled Enrolled</u>	<u>Disabled Enrolled Pct of Total</u>
2014	121,410	15.6 %
2015	122,475	14.6 %
2016	124,410	14.1 %
2017	126,360	14.2 %
2018	128,325	14.1 %
2019	130,305	14.3 %
2020	132,300	14.5 %

The existing Medi-Cal program covers non-disabled adults ages 19 through 64 in the Adult & Family Category of Aid (COA) group, and disabled adults ages 19 through 64 in the Seniors and Persons with Disability (SPD) COA group. To estimate the resulting costs of the Medi-Cal newly eligible optional expansion population, Mercer blended the PMPM costs of each of these two groups based on their projected proportion of newly eligible optional expansion enrollment.

### **Pricing the Medi-Cal ABP Option**

Mercer used the CY 2010 and CY 2011 fee-for-service (FFS) Medi-Cal claims data for enrolled adults, adjusted for the estimated demographics of the newly eligible optional expansion population.

We believe this dataset represents the most reliable and applicable information for estimating costs related to the newly eligible optional expansion population. These historical PMPM costs were then trended forward for cost and utilization trends to CY 2014. It is important to note that the resulting cost estimates included in this report do not represent capitation rates developed in an actuarially sound manner. Specifically, the cost estimates include costs for services and even for some subpopulations that would likely be carved out of managed care and provided on a FFS basis by the State. Actuarially sound capitation rates for the newly eligible optional expansion population would therefore likely be lower than the total cost estimates included in this report.

It is also important to note that Mercer did not include the costs of services provided under California’s non-state plan section 1915(c) home and community based waivers in pricing the Medi-Cal Option. Based on discussion with DHCS and the project team members, it was decided to not include these particular waiver services for cost projection purposes. This is consistent with the Governor’s budget proposal to not provide LTC services in the benefits for the newly eligible.

TAC/HSRI conducted detailed analyses to estimate the potential utilization and costs of behavioral health services for the newly eligible optional expansion. The data used for the analyses was CY 2009 Medi-Cal claims data, the same data used for the California Mental Health and Substance Use Needs Assessment Report. DHCS noted that no major benefit service or system design changes had occurred and extrapolating data from 2009 (because of time and resource constraints) would be the best option. TAC/HSRI then supplied Mercer with CY 2014 costs which Mercer subsequently trended forward to create cost estimates for state fiscal year (SFY) 2015 through 2020.

## Pricing the Anthem Choice ABP Option

In order to arrive at an estimate for the Anthem Choice ABP option, Mercer used the amounts calculated for the service category differentials and subtracted those from the Medi-Cal PMPM amount. Although there is a pricing differential calculated for EPSDT<sup>5</sup>, this is not intended to imply that California could elect to provide the Anthem Choice benefit without EPSDT coverage. Rather, this amount reflects our estimate of the amount that would be required by federal rules to be added to the Anthem Choice option.

## Pricing Service Category Differentials and Projecting Cost Estimates

From the information gathered in the Medicaid ABP Coverage Summary (Appendix A), Mercer identified nearly all variances in coverage between the two bookend options. For purposes of pricing, only those service coverage differences that would represent a more than nominal cost impact have been considered. The amounts identified in the service category pricing differentials reflect only the amount associated with the coverage differential between the two benefit packages, but do not necessarily reflect the full cost of the benefit line item.

As a product of workgroup discussion, the cost estimates developed assumed payment rates for the newly eligible optional expansion population would be consistent with other Medi-Cal payment rates.

The total cost of the Medicaid benefits for the newly eligible optional expansion to the State general fund is significantly less than for the existing Medicaid program due to the higher Federal Medical Assistance Percentage (FMAP) funding provided by the federal government for this population. For CY 2014 through CY 2016, the federal government will pay 100% of the total cost. Starting in CY 2017 the FMAP is reduced to 95%, and ultimately drops to 90% in CY 2020.

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<sup>5</sup> The EPSDT category encompasses EPSDT supplemental services reported under Vendor code 82, Pediatric Concurrent Care, Pediatric Day Health Care, pediatric dental and vision benefits.

# 5

## Analysis and Considerations

### Results/Findings

#### ***Cost Estimates and Non-Federal Share for ABP Options***

Mercer estimates the cost of the Medicaid benefits for the newly eligible optional expansion to be \$440.92 PMPM in SFY 2014 if Medi-Cal is selected as the ABP and \$379.33 PMPM in SFY 2014 if Anthem Choice is selected. From this information, Mercer has established a range in which all of the Medicaid ABP options would be expected to fall.

Using the Medi-Cal ABP estimate, Mercer estimates that the cost of the Medicaid benefits for the newly eligible optional expansion in SFY 2014 is projected to be approximately \$2.06 billion, of which all but \$3 million<sup>6</sup> will be entirely paid by the federal government. The SFY 2014 cost for the Anthem Choice ABP would be \$1.78 billion, of which all but \$3 million will be entirely paid by the federal government. It should be noted that these costs represent only one half of the fiscal year because the newly eligible optional expansion would not begin until January 1, 2014.

By CY 2020, when the federal contribution will have reached its lowest level of 90%, Mercer projects the estimated annual cost of the Medicaid benefits for the newly eligible optional expansion to be \$6.39 billion if the Medi-Cal benefit is the ABP, including a non-federal share of approximately \$639 million. The estimated annual cost for the Anthem Choice ABP in CY 2020 would be \$5.56 billion, including a non-federal share of approximately \$556 million. This amounts to a cost differential of approximately \$834 million, representing a non-federal share differential of approximately \$83 million annually.

These estimates do not include amounts associated with Medicaid administrative expenditures. It is our understanding that Medi-Cal administrative costs currently run at or below 2% of total program costs. Mercer expects administrative costs related to the administration of the newly eligible optional expansion population to be relatively consistent with current program administrative costs on a percentage basis<sup>7</sup>. It is assumed that administrative costs borne by the counties will also remain consistent.

Mercer's analysis is intended to quantify the benefit coverage differential and resulting cost differential between Medi-Cal and Anthem Choice. As a product of workgroup discussion, in addition to quantifying the cost differential with respect to LTC service coverage differences, Mercer has identified the aggregate projected cost of the LTC services identified in this analysis (i.e., nursing facility services, IHSS/personal care state plan services, and ADHC/CBAS services). The aggregate cost of LTC services identifiable and included in the data set pulled for this analysis is projected to be approximately \$49.93 PMPM in SFY 2014. This does not include all possible LTC services as some LTC services are offered through section 1915(c) HCBS waivers which were excluded from this analysis.

<sup>6</sup> The \$3 million is the projected costs related to non-federally eligible abortion services.

<sup>7</sup> The estimates for administration of the county run specialty behavioral health services are up to 13%.

### *The “Medically Frail”*

These estimates do not contain assumptions about the portion of the newly eligible optional expansion population that may be “medically frail” and exempted from mandatory enrollment in a Medicaid ABP under federal rules. Some newly eligible optional expansion individuals may be entitled to the Medi-Cal state plan benefit even if California were to opt for an ABP that was not the Medi-Cal state plan benefit. Therefore, the aggregate cost differential between Medi-Cal and Anthem Choice may be much less than Mercer’s estimate depending upon the outcome in the final regulations on ABP exempted populations and how many individuals in the newly eligible expansion population would qualify for an exemption based on medical frailty.

CMS recently proposed regulations around Medicaid ABP requirements and exempt populations that may impact the cost estimates in this report, but were not available in time for Mercer to assess the impact in this analysis and final regulations have not been issued. Once this guidance is finalized, the results of this analysis may need to be reviewed for consistency with the rules and impact on the projected costs.

### **Caveats**

#### *Caveats Related to the Behavioral Health Analyses from TAC/HSRI*

As with all projections, these estimates are subject to uncertainty.

First, they do not account for supply effects. The estimates assume that current demand is not greatly suppressed because of lack of supply. The increase in users will be smaller if providers are unable or unwilling to increase capacity to fully meet demand.

Second, TAC/HSRI cannot be certain about the proportion of individuals with mental health or substance use disorder service needs that will enroll in Medicaid. In Massachusetts, for example, anecdotal information suggests that adults with substance use disorder service needs are among the last to enroll in Medicaid.

Third, the data on users of behavioral health services come from surveys, and like all surveys, the results have a margin of error. This is the reason the mid-range estimate was selected to estimate potential service users in the total newly eligible optional expansion population.

Fourth, the estimates assume that newly eligible optional expansion population enrollees will have a similar probability of using services<sup>8</sup> once they obtain Medicaid coverage as the current Medi-Cal mental health and substance use disorder service users. However, use rates may differ since the newly eligible optional expansion population is known to be dissimilar from both existing Medicaid disabled population and Medicaid non-disabled populations.

#### *General Caveats*

In performing our analysis, Mercer relied on data and other information provided to us by multiple State agencies and insurance carriers. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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<sup>8</sup> Not including inpatient hospitalization.

All estimates in this report are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any estimates or projection must be interpreted as having a likely range of variability from the estimate. Mercer has prepared these projections exclusively for the California HealthCare Foundation and the California Department of Health Care Services. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. The estimates and projections included in this report are not a guarantee of results which might be achieved.

To the extent that areas identified in this report have supporting rules Mercer has endeavored to identify them. The State recognizes that, at present, ACA rules and guidance are not static and are subject to change. To that end, we believe this report is accurate as of the day of its release.

This report is intended to be read and used as a whole and not in parts. Any and all decisions in connection with the information contained within this report are the sole responsibility of the State.

There are no third party beneficiaries with respect to this report, and the authors, Mercer Health & Benefits LLC, do not accept any liability to any third party. In particular, the authors shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results set forth herein.

Mercer is not advocating for or against expanding Medicaid in the state of California or for or against selecting any of the ABP options. The results of this study simply illustrate the potential costs for the State to consider as it decides how best to implement the many provisions of the ACA. Implementation of the newly eligible optional expansion would not be without some element of risk to the State, as enrollment and cost projections could differ significantly from actual future results.

Finally, Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that the State secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

# APPENDIX A

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## Medicaid ABP Coverage Summary

Mercer conducted a detailed review of the State employee health benefit and FEHBP plans and developed a comparison of several key aspects. The comparison was then used to collect information from the HMO base benchmark plan options. The comparisons will be a helpful tool to facilitate the State's selection of a base benchmark plan. At this time, the amount of flexibility states will have to alter benefit levels and covered services while maintaining actuarial equivalency is still unclear. This comparison will be a helpful resource to weigh options as more information becomes available. The areas reviewed included:

- EHB Index
- Covered Services
- Limitations

### EHB Index

The EHB Index lists plan information for all of the agreed upon potential base benchmark options. For purposes of review, Mercer has included an additional category, LTC. This category is not one of the 10 EHB categories, but is incorporated in the coverage review and cost estimations.

### Covered Services

Covered Services is the core analysis of the base benchmark options, which may be used to determine the ABP administered by the State. It is organized by LTC, the 10 EHB categories, and includes covered services within each of the categories.

The analysis was completed using plan descriptions for the State employee health benefit and benefit brochures for the FEHBP plan options and other documentation for the State Medi-Cal benefit. All of the HMO analyses were provided by the plan itself.

Covered benefits are fairly consistent across the ABP options as shown in Appendix A. Key variations in covered services include: skilled nursing facility services; non-medical, in-home or in-community support services; adult residential treatment services; family and group therapy; respite care; medication support services; ABA therapy for autism; outpatient drug-free treatment; and personal care services.

The responses provided for the CalPERS Anthem Choice benefit package indicated coverage of targeted case management (TCM) services. However, Mercer used professional judgment in concluding that commercial coverage of case management is unlikely to provide the extensive coordination of services provided under Medi-Cal TCM. As a result, Mercer included both physical health care TCM and behavioral health care specific TCM in the list of services for which there is a difference in coverage between Anthem and Medi-Cal.

Habilitative services were both defined differently and covered at varying degrees among the ABP options. CMS has stated that it intends to propose rules that will give states the authority to define the habilitative benefit for the ABP and seek comments on the parameters of the benefit. As such, the State will need to look for future guidance in this area.

## Limitations

The Limitations section was developed to assist the State in determining if there are any covered benefit limitations that present potential barriers to service delivery or unreasonably restrict access to medically efficient care that adequately prevents, ameliorates or cures conditions and diseases as effectively as possible. The limitations to covered services offered in the base benchmark options, if selected, will become part of the ABP. The most common limitations among the benchmark plan options include day limits, session limits and frequency limits associate with specific covered services.

The limitations were fairly consistent across the ABP options as shown in Appendix A. Key variances in limitations and exclusions are: home health services; audiology; chiropractic; non-emergency medical transportation and non-medical transportation; and physical, occupational and speech therapies.

MHSU services are provided by all of the ABP options. Notably, Anthem Choice appears to limit several of its MHSU services to coverage only when medically necessary to stabilize an acute psychiatric condition.

DRAFT

EHB Plan Option	Network Type	Plan Name
<b>The State employee health benefit plans</b>		
<i>Under the 1937 authority, the State may select as a benchmark any health benefits coverage plan that is offered and generally available to State employees in the State. For purposes of this analysis, Mercer has included only one plan that was selected by the State and is most likely the leanest of the State employee plan options available.</i>		
Anthem Choice	PPO	Anthem Choice
<b>The largest insured commercial non-Medicaid HMO operating in the State</b>		
Kaiser Large Group	HMO	Kaiser Traditional
<b>FEHBP – Equivalent health insurance coverage</b>		
Blue Cross/Blue Shield	PPO	Standard Option
<b>Medicaid Benefit Package</b>		
<i>Under the 1937 authority the State may seek Secretary-approved coverage. This option may be any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.</i>		
California Medicaid Program		Medi-cal
<b>Non-EHB Categories</b>		
Long-Term Care		
<b>Essential Health Benefits Categories</b>		
Hospitalization		
Emergency services		
Ambulatory patient services		
Maternity and newborn care		
Mental health and substance use disorder services, including behavioral health treatment		
Prescription drugs		
Rehabilitative and habilitative services and devices		
Laboratory services		
Preventive and wellness services and chronic disease management		
Pediatric services, including oral and vision care		

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Long Term Care</b>				
Short-term nursing facility (up to 30 days)	Y	N	N	Y
Long-term nursing facility > 30 days (in lieu of hospital)	Y	N	N	Y
Non-medical, in-home or in-community support services (e.g., assistance with activities of daily living)	N	N	N	Y
Skilled nursing facility	Y	Y	N	Y
Hospice care	Y	Y	Y	Y
<b>Hospitalization</b>				
Hospital services	Y	Y	Y	Y
Hospital room and board	Y	Y	Y	Y
Inpatient physician/surgeon services	Y	Y	Y	Y
Assistant surgeon	Y	Y	Y	Y
Anesthesiologist services	Y	Y	Y	Y
Organ and tissue transplantation	Y	Y	Y	Y
<b>Emergency Services</b>				
Emergency room (not followed by admission)	Y	Y	Y	Y
Ambulance services	Y	Y	Y	Y
<b>Ambulatory Patient Services</b>				
Urgent care	Y	Y	Y	Y
Office visit	Y	Y	Y	Y
Office visit (specialist)	Y	Y	Y	Y
FQHC services <sup>1</sup>	Y	N	Y	Y
Home health care	Y	Y	Y	Y
Christian Science practitioners	Y	N	Y	Y
Christian Science facilities	N	N	Y	Y
Outpatient surgery	Y	Y	Y	Y
Targeted case management <sup>2</sup>	Y	Y	Y	Y
Bariatric surgery	Y	Y	Y	Y
Reconstructive surgery	Y	Y	Y	Y
Cosmetic surgery	N <sup>3</sup>	N	N <sup>3</sup>	N
Abortion	Y	Y	Y	Y
Anesthesiologist services when provided as an outpatient procedure	Y	Y	Y	Y
Dialysis/hemodialysis	Y	Y	Y	Y
Audiology	Y	Y	N	Y
Chiropractic	Y	N	Y	Y
Podiatry	Y	Y	Y	Y
TMJ	Y	Y	Y	Y
Adult dental	N	N	Y	Y
Adult vision	Y	Y	N	Y
Second opinion	Y	Y	Y	Y
Non-emergency medical transportation (e.g., wheelchair, van)	Y	N	N	Y
Non-medical transportation (e.g., bus or taxi to medical appointments)	Y	N	N	Y
Sign language interpreter services	N	Y	N	Y
<b>Maternity and Newborn Care</b>				
Maternity and newborn care	Y	Y	Y	Y
Birth centers	Y	N	Y	Y
Perinatal Services Program <sup>4</sup>	Y	N	U	Y
Newborn hearing screening	Y	Y	Y	Y
<b>FOOTNOTES</b>				
1. Federally qualified health centers (FQHC)/rural health centers (RHC): Provider type that includes clinics or health centers commonly known as community health centers, migrant health centers or health care for the homeless programs. Please indicate coverage with a "Y" if FQHCs/RHCs are included in the plan's network providers.				
2. Services furnished to assist eligible individuals to gain access to medical, social, educational services. Services include, but are not limited to: assessment of an individual's needs, developing a care plan, referral and related activities that help link eligible individuals to needed services, monitoring and follow-up activities to ensure care plan is adequate and status of the individual. Also includes arranging for appointments and/or transportation, arranging translation services, crisis assistance planning to coordinate and arrange immediate services or treatment needed.				
3. Cosmetic services available for reconstructive surgery to restore a bodily function or to correct deformities resulting from documented injury or disease or caused by congenital anomalies, or surgery which is medically necessary following documented injury or disease to restore function.				
4. Services for pregnant women can range from conception through 60 days postpartum. Comprehensive Perinatal Services Program (CPSP) services are in addition and meant to supplement the maternity services that are part of the American College of Obstetricians and Gynecologists (ACOG) visit standards. The core services provided under CPSP include, but are not limited to: client education and orientation to comprehensive perinatal services, individual case coordination and linkages to other programs specific to pregnant and nursing women like the Women, Infants and Children Program (WIC).				

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment</b>				
<b>Mental Health Services</b>				
Non-waiver covered mental illness	Y	Y	Y	Y
Benchmark plan option offered at parity	U	Y	Y	U
Crisis intervention	Y	Y	Y	Y
Crisis stabilization-emergency room	Y	Y	Y	Y
Crisis stabilization	Y	Y	Y	Y
Adult residential treatment services	N	Y	N	Y
Mental health day treatment	Y	Y	Y	Y
Psychologist services	Y	Y	Y	Y
Family mental health therapy	N	Y	N	Y
Group mental health therapy	N	Y	N	Y
Individual mental health therapy	Y	Y	Y	Y
Therapeutic behavioral services (EPSDT only)	Y	N	N	Y
Respite care	N	Y	N	Y
Medication support services	N	Y	Y	Y
Mental health case management/targeted case management	Y	Y	Y	Y
Electroconvulsive therapy (ECT)	N	Y	Y	Y
Applied Behavior Analysis (ABA) therapy for autism	N	Y	N	Y <sup>5</sup>
Psychological and/or neuropsychological testing	Y	Y	Y	Y
Psychological and/or neuropsychological evaluation	Y	Y	Y	Y
<b>Substance use Disorder Services</b>				
Inpatient detox	Y	Y	Y	Y
Outpatient detox	Y	Y	Y	Y
Inpatient substance use disorder services	Y	Y	Y	Y
Outpatient substance use disorder services	Y	Y	Y	Y
Outpatient drug-free treatment	N	Y	Y	Y
Substance use disorder screening <sup>6</sup>	Y	Y	Y	Y
Peer/recovery support services	N	Y	N	Y
<b>Prescription Drug</b>				
Prescription drug coverage	Y	Y	Y	Y
Smoking cessation drugs (includes over-the-counter smoking cessation drugs for pregnant women)	Y	Y	Y	Y
Non-cancer clinical trials	N	N	Y	N
Pain medication for the terminally ill	Y	Y	Y	Y
Naltrexone	Y	Y	Y	Y
Narcotic replacement therapy	Y	Y	Y	Y
AIDS/HIV drugs	Y	Y	Y	Y
Antipsychotic drugs	Y	Y	Y	Y
Blood and blood derivatives	N	Y	Y	Y
Prenatal vitamins	N	Y	Y	Y
Weight-loss drugs	N	Y	N	Y
Erectile dysfunction drugs (off-label use only)	Y	Y	N	Y
<b>Rehabilitative and Habilitative Services and Devices</b>				
Physical therapy	Y	Y	Y	Y
Speech therapy	Y	Y	Y	Y
Occupational therapy	Y	Y	Y	Y
Acupuncture	Y	Y	Y	Y
Cardiac rehabilitation	Y	Y	Y	Y
Personal care services <sup>7</sup>	N	N	N	Y
Pulmonary rehabilitation	Y	Y	Y	Y
Respiratory care for vent dependent	Y	Y	U	Y
Durable medical equipment	Y	Y	Y	Y
Hearing aids	Y	N	Y	Y
Surgically implanted hearing devices	Y	Y	Y	Y
Orthotics	Y	Y	Y	Y
Prostheses	Y	Y	Y	Y
Prosthetic devices for laryngectomy	Y	Y	U	Y
Dentures	N	N	N	N
<b>FOOTNOTES</b>				
5. ABA therapy for autism services are available through the Department of Developmental Services (DDS) Home- and Community-Based Services waiver.				
6. Substance use disorder screening is defined as meeting the requirements of the USPSTF A and B recommendations as adopted by PPACA.				
7. Personal care services are services furnished to a beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least twelve consecutive months or that is expected to result in death within twelve months and who is unable to remain safely at home without the services. Ancillary services including meal preparation and cleanup, routine laundry, shopping for food and other necessities, and domestic service. Authorized for the individual by a physician in accordance with a plan of treatment.				

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Laboratory Services</b>				
Outpatient laboratory services	Y	Y	Y	Y
Outpatient x-ray services	Y	Y	Y	Y
Complex imaging services	Y	Y	Y	Y
<b>Preventive and Wellness Services and Chronic Disease Management</b>				
Adult physical exam	Y	Y	Y	Y
Adult male screening	Y	Y	Y	Y
Adult female screening	Y	Y	Y	Y
Well baby	Y	Y	Y	Y
Well child (immunizations)	Y	Y	Y	Y
Nutritional counseling	Y	Y	Y	Y
Assisted reproductive technology (ART)	N	N	N	N
Infertility services (non-ART)	N	Y	Y	Y
Family planning office visit	Y	Y	Y	Y
Family planning services and supplies <sup>8</sup>	Y	Y	Y	Y
Hearing exam	Y	Y	N	Y
Oxygen	Y	Y	Y	Y
Smoking cessation	Y	Y	Y	Y
<b>Pediatric Services, Including Oral and Vision Care</b>				
EPSDT compliant <sup>9</sup>	N	N	N	Y
Pediatric concurrent care <sup>10</sup>	N	Y	N	Y
Pediatric day health care (PDHC) <sup>11</sup>	N	N	N	Y
Pediatric medical	Y	Y	Y	Y
Pediatric dental	N	N	Y <sup>12</sup>	Y
Pediatric vision	N	Y	N	Y
<b>FOOTNOTES</b>				
8. Family-planning services include preconception counseling, maternal and fetal health counseling, and general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability. It also includes sterilization; IUD and IUCD insertions, or any other invasive contraceptive procedures/devices; contraceptive drugs or devices; treatment for complications resulting from previous family planning procedures; and laboratory procedures, radiology and drugs associated with family planning procedures.				
9. EPSDT: A comprehensive pediatric benefit for individuals under age 21. Under EPSDT, if medically necessary, coverage is available in excess of benefit limits stated in the Evidence of Coverage for children or adults. Please indicate coverage with a "Y" if you believe your plan is compliant with EPSDT laws.				
10. Allows eligible children and their families to receive palliative care services during the course of the child's illness, while concurrently pursuing curative treatment for the child's life limiting or life threatening medical condition. Includes: care coordination, 24/7 on-call nursing, pain and symptom management, expressive therapies (including art, music and massage), family education, pre-and post-death bereavement support and respite.				
11. PDHC is a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning and social interaction designed to optimize the individual's medical status and developmental functioning so that he or she can remain within the family.				
12. Includes coverage of preventative and basic dental services for all ages, not just pediatric enrollees.				

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Long Term Care</b>				
Short-term nursing facility (up to 30 days)	Medically necessary skilled care, not custodial care, in a skilled nursing facility, up to 100 days per calendar year.			
Long-term nursing facility > 30 days (in lieu of hospital)	Medically necessary skilled care, not custodial care, in a skilled nursing facility, up to 100 days per calendar year.		FLTCP (federal long-term care insurance program) is not part of the BCBS Standard plan, must be purchased separately	
Non-medical, in-home or in-community supports services (e.g., assistance with activities of daily living)				
Skilled nursing facility	100 days per year; 3-day precertification requirement	100 days per benefit period	Not covered without Medicare Part A	
Hospice care	Re-certification required after 90 days	Hospice services are covered inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area	\$250 copay per episode, 30 days per admission	
<b>Hospitalization</b>				
Hospital services	Inpatient hospitalization requires 3-day precertification (non-emergency), maxillofacial, musculoskeletal, septoplasty and sinus-related, and penile implant			Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management targeted case management services; and iii) electroconvulsive therapy (ECT)
Hospital room and board				Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management targeted case management services; and iii) electroconvulsive therapy (ECT)
Inpatient physician/surgeon services				Includes psychiatric inpatient hospital services. Mental Health and Substance Use Disorder EHBs may not be billed for days when Psychiatric Inpatient Hospital Services are billed except for the following: i) psychology services (as limited above); ii) mental health case management targeted case management services; and iii) electroconvulsive therapy (ECT)
Assistant surgeon				
Anesthesiologist services				
Organ and tissue transplantation				
<b>Emergency Services</b>				
Emergency room (not followed by admission)	Covered for emergency \$50 copay; not covered for non-emergency care			
Ambulance services				
<b>Ambulatory Patient Services</b>				
<b>Urgent care</b>				
Office visit				
Office visit (specialist)				
FQHC services				
Home health care	45 visits per year; 3-day precertification requirement	100 visits per year Home based services, with the exception of hospice, must be delivered inside the service area	(2) hours per day, up to 25 visits per calendar year	
Christian Science practitioners	24 sessions per person per calendar year			
Christian Science facilities	Only covered illness or injury in a Christian Science hospital			
Outpatient surgery				
Targeted case management				
Bariatric surgery	3-day precertification requirement. For California residents, bariatric surgery only at Centers of Medical Excellence. For non-California residents, an additional \$250 copayment applies for each admission to a facility other than designated Centers of Medical Excellence			
Reconstructive surgery	3-day precertification			
Cosmetic surgery				
Abortion	Medically necessary		When life of mother is in danger	Performed as a physician service to protect the life of the mother, or in cases of rape or incest
Anesthesiologist services when provided as an outpatient procedure	3-day precertification for colonoscopy, knee and hip joint replacement			
Dialysis/hemodialysis		Home based services, with the exception of hospice, must be delivered inside the service area		Chronic dialysis covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Hemodialysis routine test can be conducted per treatment, weekly or monthly
Audiology	Hearing aid-one every 36 months			Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services
Chiropractic	15 visits, combined with acupuncture		1 office visit/year, 1 x-ray, 12 osteopathic/chiropractic manipulations/year	Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services
Podiatry	Routine foot care in conjunction with diabetes and circulatory disorders			Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services
TMJ	3-day precertification requirement		Orthodontic care for treatment of TMJ excluded	
Adult dental				Exempted Medi-Cal Beneficiaries
Adult vision	This benefit is limited coverage for cataracts surgery and/or the repair or alleviation of accidental injury	Vision screening and refraction only		Exempted Medi-Cal Beneficiaries
Second opinion	Anthem Blue Cross' Telemedicine Network Specialty Center			
Non-emergency medical transportation (e.g., wheelchair, van)	Bariatric surgery: up to 3 trips (to & from) Center of Medical Excellence (CME) (pre-surgical, initial surgery, 1 follow-up); (initial surgery, 1 follow-up); not to exceed \$130 per trip - Transplant Services: ground transportation (to & from) when designated CME is 75 or more miles from the recipient's place of residence. Coach airfare when 300 or more miles from recipient's residence. Amount cannot exceed \$10,000 per transplant			Non-emergency ground transportation: is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxi, or another form of public or private conveyance. Additionally, transportation necessary to obtain medical services is covered subject to the prescription of a physician, dentist or podiatrist
Non-medical transportation (e.g., bus or taxi to medical appointments)	Bariatric surgery: up to 2 trips (to & from) for 1 companion (initial surgery, 1 follow-up); not to exceed \$130 per trip - Transplant Services: ground transportation (to & from) when designated CME is 75 or more miles from the donor's place of residence. Coach airfare when 300 or more miles from donor's residence. Amount cannot exceed \$10,000 per transplant			ATAR is required for all non-emergency ground medical transportation. ATAR is not required for non-emergency transportation from an acute care hospital to a long term care facility. Medi-Cal does not cover waiting time or night calls for transport from an acute care facility to Nursing Facility A (NF-A) care. Non-emergency transportation between a recipient's home and an Adult Day Health Care (ADHC) center is not covered
Sign language interpreter services				Medi-Cal does not pay for service in a facility that is required by law provide sign language interpreters. The interpreter may be used for obtaining medical history; obtaining informed consent and permission for treatment; explaining diagnosis, treatment and prognosis of an illness; communicating prior to, during and after medical procedures; providing complex instructions regarding medication; explaining instructions for care upon discharge from a medical facility; providing mental health assessment, therapy or counseling

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Maternity and Newborn Care</b>				
Maternity and newborn care	Plan provides for the first 30 days of the newborn routine nursery care under the subscriber's plan			
Birth centers	An alternative birthing center includes the birthing room. The birthing room must be physically located within a hospital. A birthing center must be certified or approved by the state dept of health			
Perinatal services program				
Newborn hearing screening				
<b>Mental Health and Substance Use Disorder Services, including Behavioral Health</b>				
<b>Limitation</b>				
<b>Mental Health Services</b>	3-day precertification requirement			
Non-waiver covered mental illness	Treatment of the following conditions is excluded under this Plan: Personality disorders; Sexual deviations and disorders; Abuse of drugs, except as provided in the Substance Abuse benefits description on pages 52-53; Conduct disorders; Mental retardation and developmental delays; Attention deficit disorders; Inpatient treatment for eating disorders is excluded under this Plan, unless the inpatient stay is necessary for the treatment of anorexia nervosa or bulimia nervosa; Marriage and family counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse, or domestic partner or children; Non-therapeutic treatment, custodial care and educational programs.			
Benchmark plan option offered at parity				
Crisis intervention	Covered when medically necessary to stabilize an acute psychiatric condition			Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. May be provided for no more than 8 hours in any 24-hour period
Crisis stabilization-emergency room				Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. Claiming for this service is limited to 20 hours for any admission
Crisis stabilization	Covered when medically necessary to stabilize an acute psychiatric condition			Hospitalization Services and Adult Residential Treatment Services may not be billed for the same day. Claiming for this services is limited to 20 hours for any admission
Adult residential treatment services				Only one service may be billed per day. Psychology Services, Family Group/Individual Therapy, Therapeutic Behavioral Services, Mental Health Day Treatment, Crisis Intervention, Crisis Stabilization and Hospitalization Services may not be billed for the same day. Limited to residential care for alcohol and drug exposed pregnant women and women in the postpartum perinatal period
Mental health day treatment	Covered when medically necessary to stabilize an acute psychiatric condition			Only one service may be billed per day. Adult Residential Treatment Services and Hospitalization Services may not be billed on the same day
Psychologists services				Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology, and speech therapy services
Family mental health therapy				Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day
Group mental health therapy				Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day
Individual mental health therapy				Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day
Therapeutic behavioral services (EPSDT only)	Covered when medically necessary to stabilize an acute psychiatric condition			Adult Residential Treatment Services and Hospitalization Services may not be billed for the same day
Respite care				Part of autism benefit
Medication support services				Hospitalization Services may not be billed for the same day
Mental health case management targeted case management	Covered when medically necessary to stabilize an acute psychiatric condition			
Electroconvulsive therapy (ECT)				
Applied Behavior Analysis (ABA) therapy for autism				ABA therapy for autism services are available through the Department of Developmental Services (DDS) Home and Community Based Services waiver
Psychological and/or neuropsychological testing	In conjunction with services to stabilize individual	We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license: Psychological testing when necessary to evaluate a Mental Disorder		
Psychological and/or neuropsychological evaluation	In conjunction with services to stabilize individual			
<b>Substance Use Disorder Services</b>				
Inpatient detox	Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered.			Inpatient detox is available to Medi-Cal beneficiaries only to the extent such services result in general acute inpatient services
Outpatient detox	Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered.			
Inpatient substance use disorder services	Benefits are provided for hospital and physician services medically necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and inpatient stays at residential treatment facilities are not covered.			Inpatient substance use services are available to Medi-Cal beneficiaries only to the extent such services result in general acute inpatient services
Outpatient substance use disorder services	The intent of this benefit is to provide medically necessary treatment to stabilize an acute substance abuse condition			
Outpatient drug-free treatment				
Substance use disorder screening				
Peer/recovery support services				Recovery services limited to services rendered in conjunction with perinatal service

Y - Yes N - No U - Unknown at this time	State Employee	HMO	Federal Employee	CA Medicaid
	PPO	HMO	PPO	
	Anthem Choice	Kaiser Traditional	BCBS Standard	Medi-Cal
<b>Prescription Drug</b>				
Prescription drug coverage				
Smoking cessation drugs (includes OTC smoking cessation drugs for pregnant women)	\$100 per year and excludes OTC	Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		Products listed in the Medi-Cal contract drug list subject to utilization controls. Outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guide"
Non-cancer clinical trials		N/A; processed in clinic by trial MD		
Pain medication for the terminally ill		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
Naltrexone		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
Narcotic replacement therapy		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		Narcotic Replacement Therapy medications (LAAM and methadone) are not available via prescription; they are only available in a licensed NTP facility
AIDSHV drugs		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
Antipsychotic drugs		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
Blood and blood derivatives		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
Prenatal vitamins	Not covered; except prescriptions for single agent vitamin D, vitamin K and folic acid	Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		Subject to prior authorization, for use during pregnancy
Weight-loss drugs		Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		When approved by a Medi-Cal field consultant as medically necessary
Erectile dysfunction drugs (off-label use only)	50% coinsurance; does not specify off-label use	Up to 100 day supply in Plan pharmacy with exception of drugs limited to 30 day supply		
<b>Rehabilitative and Habilitative Services and Devices</b>				
Physical therapy	24 visits per year additional services 3-day precertification		75 PT/ST/OT combined per year	
Speech therapy	24 visits per year additional services 3-day precertification		75 PT/ST/OT combined per year	Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services
Occupational therapy	24 visits per year additional services 3-day precertification		75 PT/ST/OT combined per year	Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services
Acupuncture	15 visits, combined with chiropractic care		24 visits/year	Up to 2 visits per month in combination with acupuncture, audiology, chiropractic, occupational therapy, psychology and speech therapy services. Services are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition
Cardiac rehabilitation	Up to 40 visits per calendar year			Requires approved TAR. Services billed by a rehabilitative center must have prior authorization with the exception of the initial and biannual rehabilitative evaluations
Personal care services				Beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services
Pulmonary rehabilitation	Up to \$1,500 per calendar year			Medi-Cal does not generally cover pulmonary rehabilitation services; however, pulmonary rehabilitation for acute airway obstruction or sputum induction for diagnostic purposes is limited to six in 30 days, and aerosol inhalation of pentamidine for Pneumocystis carinii pneumonia treatment prophylaxis is limited to one in 30 days
Respiratory care for vent dependent	45 visits per year; combined with home health care; 3 day precertification requirement			Subject to prior authorization except when personally rendered by the physician
Durable medical equipment	Up to \$350 per calendar year 3-day precertification (limited list)	Home based services, with the exception of hospice, must be delivered inside the service area		Must be prescribed by a licensed practitioner. DME commonly used in providing SNG and ICF level of care is not separately billable. Common household items are not covered
Hearing aids	One every 36 months		Covered, hearing aids and related services are available for up to \$2,500, every 3 calendar years for adults; every calendar year for children	Medi-Cal limits the total hearing cost per fiscal year to \$1510. Excluded from the \$1510 cap are those eligible individuals enrolled in EPSDT, PACE, SCAN; Aids health care programs and CCS; pregnant women with other conditions that might complicate the pregnancy and recipients in a LTC facility (NF-AB) (ICFIDD)
Surgically implanted hearing devices	Up to \$350 per calendar year; combined with DME benefit	Those covered under P&O only	Covered, \$5,000 per calendar year for bone-anchored hearing aids for adults and children	
Orthotics	Custom molded and cast shoe inserts, limited to 1 pair per calendar year			
Prostheses	Outpatient prosthetic appliances, including one scalp hair prosthetic up to \$350 per calendar year			
Prosthetic devices for laryngectomy	No coverage for computerized speech generating devices	No coverage for computerized speech generating devices	\$1,250 annual limit for speech generating devices	
Dentures				
<b>Laboratory Services</b>				
Outpatient laboratory services				
Outpatient x-ray services				
Complex imaging services				
<b>Preventive and Wellness Services and Chronic Disease Management</b>				
Adult physical exam				
Adult male screening				
Adult female screening				
Well baby				
Well child (immunizations)		Well child exams are periodic through 23 months		
Nutritional counseling	Covered when used to enable proper use of diabetes self-management equipment or when provided as part of a medically necessary comprehensive outpatient eating disorder program			Related to breastfeeding
Assisted reproductive technology (ART)			Excludes assisted reproductive technology (ART) procedures, including but not limited to in vitro fertilization (IVF)	
Infertility services (non-ART)				Infertility drugs are covered when approved by a Medi-Cal field consultant as medically necessary
Family planning office visit				
Family planning services and supplies				
Hearing exam				
Oxygen		Home based services, with the exception of hospice, must be delivered inside the service area		Listed under pediatric subacute care
Smoking cessation	up to \$100 per calendar year			Limited to rx benefit
<b>Pediatric Services, Including Oral and Vision Care</b>				
EPSDT compliant				
Pediatric concurrent care				
Pediatric Day Health Care (PDHC)				
Pediatric medical				
Pediatric dental				
Pediatric vision		Vision screening and refraction exams only	Excludes orthodontic care for treatment of TMJ	Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery

# APPENDIX B

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## Medicaid ABP Cost Estimation

### Summary

In order to develop the cost estimates for the Medi-Cal and Anthem Choice ABP options, Mercer:

- Estimated the size and demographic characteristics of the Medi-Cal newly eligible optional expansion population likely to enroll;
- Developed an estimate of the Medi-Cal PMPM total benefit cost;
- Used the detailed benefit information to identify meaningful coverage differences that would contribute to cost differentials between the bookend coverage options and priced out those differences;
- Reduced the Medi-Cal PMPM by the amount of those differences to arrive at an estimate of the Anthem Choice benefit cost; and
- Projected the PMPM and total costs for the Medi-Cal and Anthem Choice bookend coverage options forward for SFY 2014 through SFY 2020 and calculated the federal and non-federal share of these costs.

### Data

To estimate the cost of covering the Medi-Cal newly eligible optional expansion population for CY 2014 through CY 2020 period, Mercer used the CY 2010 and CY 2011 Medi-Cal FFS claims experience in the non-managed care counties<sup>9</sup>. We also isolated the costs of each one of the benefit differentials between the low “bookend” (Anthem Choice), and the high “bookend” (Medi-Cal) packages using the applicable CPT, HCPCS, ICD-9, DRG and provider type codes to develop PMPM costs separately for each meaningful coverage difference.

The Medi-Cal FFS data do not include claims for adult vision services. DHCS provided Mercer with total vision claim costs for adults ages 21 through 64 incurred in CY 2011. Mercer estimated the number of adults eligible for this benefit in the FFS counties in CY 2011 to develop a PMPM vision cost. In developing this estimate, we increased the resulting vision PMPM cost by 50% as a margin of conservatism, and to account for any EPSDT vision services that might be provided to 19 and 20 year olds in the newly eligible optional expansion population.

Medi-Cal currently covers maternity benefits up to 185% FPL. Therefore, Mercer made the assumption that anyone eligible for pregnancy and maternity-related benefits would receive those benefits as part of an existing state plan coverage group and those costs would not be part of the newly eligible optional expansion population benefit. Mercer removed the cost for these benefits from the dataset.

Mercer then removed the PMPM costs for anti-psychotic drugs, Short-Doyle and Mental Health claim categories, which were priced separately by TAC/HSRI.

The remaining pharmacy costs were reduced by 43% to replicate the current Medi-Cal pharmacy rebates.

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<sup>9</sup> As indicated in Section 4, the behavioral health costs developed by TAC/HSRI used CY 2009 Medi-Cal claims data for all counties.

Mercer projected the PMPM costs forward from CY 2011 to CY 2014 using the age/gender demographic mix of the newly eligible optional expansion population and the average of the most recent three years of Medi-Cal managed care trends. We used these trends because most of the newly eligible optional expansion population will be covered by the existing managed care plans.

## Demographics

The Medi-Cal newly eligible optional expansion population will consist of currently uninsured California residents below 133% of the FPL. The uninsured, in general, are assumed to have a higher rate of disability/acuity than the general population. To determine the level of disability among the currently uninsured California residents below 133% FPL, Mercer used the 2010 CPS data for those uninsured, ages 19 through 64, below 125% of FPL (the closest cut of data available). This dataset has three classifications of individuals:

- Severe Work Disability
- Non-Severe Work Disability
- No Work Disability

This dataset showed 7% of this group had a severe work disability, and an additional 2% had a non-severe work disability. As a margin of conservatism, we classify both the severe and non-severe as a “disabled-like” risk group and assume the total newly eligible optional expansion population has a 9% disability rate.

However, because disabled individuals will have greater health care needs, they will be more likely than non-disabled members to enroll, and enroll sooner. At the same time, otherwise healthy individuals (non-disabled) will be less likely to enroll as quickly. Therefore, the “disabled-like” population will make up a larger percentage of the population that actually enrolls than the percentage they make up of the total potentially eligible population. To approximate this behavior in the CalSIM Enhanced enrollment scenario, and as a margin of conservatism, Mercer assumes that 95% of the eligible disabled population will enroll in Medi-Cal immediately in CY 2014, and by CY 2020, 100% of the disabled population will be enrolled in the Medi-Cal newly eligible optional expansion.

The CalSIM projected eligible and enrolled populations for the SFY 2014 to SFY 2020 period are shown in the table below.

SFY	Eligible Population			Enrolling Population		
	Total	Disabled	Non-Disabled	Total	Disabled	Non-Disabled
2014	1,420,000	127,800	1,292,200	780,000	121,410	658,590
2015	1,420,000	127,800	1,292,200	810,000	121,943	688,058
2016	1,425,000	128,250	1,296,750	860,000	123,441	736,559
2017	1,435,000	129,150	1,305,850	885,000	125,383	759,617
2018	1,445,000	130,050	1,314,950	900,000	127,341	772,659
2019	1,455,000	130,950	1,324,050	910,000	129,313	780,687
2020	1,465,000	131,850	1,333,150	910,000	131,301	778,699

The existing Medi-Cal program covers non-disabled adults ages 19 through 64 in the Adult & Family COA group, and disabled adults ages 19 through 64 in the Medi-Cal Only (not eligible for Medicare) SPD COA group. To estimate the resulting costs of the newly eligible optional expansion population, Mercer blended the PMPM costs of each of these two groups based on their projected proportion of enrollment.

### Relative Health Status of Populations

Generally, health status improves as income increases, resulting in decreasing average health care costs. Conversely, health status declines as income decreases resulting in increasing health care costs. Relative health status also improves for those who are employed, both because employed individuals have higher incomes than the unemployed and because they are healthy enough to work.

Since Medicaid (Medi-Cal) represents the lowest income population, this population group is assumed to have the highest health care risk and utilization levels, with the disabled Medicaid population generating higher costs than the non-disabled Medicaid population. The uninsured population represents a mix of relatively healthier individuals, who view purchasing coverage as uneconomical, and those with existing health conditions representing additional risks that cause health insurers to typically deny coverage or make the premiums unaffordable. This mix has been shown to reflect an overall average health status that is better than the Medicaid population – with lower average health care risk and utilization.

Thus, using the current Medi-Cal costs, from the lowest income population, to project the newly eligible optional expansion costs, from a slightly higher income population, provides a small margin of conservatism to our estimates, as the newly eligible optional expansion population should, on average be slightly healthier than the current comparable Medi-Cal enrolled population.

### Assumptions and Methodology

Mercer used the following assumptions to develop the projected costs for the newly eligible optional expansion population:

- The populations that best reflect the health care risk of those eligible for the newly eligible optional expansion are the current Medi-Cal adults in the Adult & Family COA group and the Disabled Medi-Cal Only (i.e., non-dual eligible) COA group;

- To be conservative, we assumed that Medi-Cal would not implement any premiums or cost sharing as allowed by Medicaid, for this higher income population;
- We assume health care cost and utilization trends for the five year period from CY 2010 to the first year of the expansion, CY 2014, will be approximately equal to the average of the most recent three years of Mercer estimates used in the pricing of Medi-Cal managed care capitation rates (4.25% annually); and
- Designated Public Hospital (DPH) costs were assumed to be reimbursed at non-DPH Medi-Cal FFS levels of reimbursement, not cost-based reimbursement.

The CY 2010 and CY 2011 FFS claim data were extracted by COA and category of service for eight distinct age and gender brackets: females and males ages 19 and 20, 21 to 24, 25 to 44 and 45 to 64. The resulting data were projected forward using the recent Medi-Cal unit cost and utilization trends to develop estimated SFY 2014 to SFY 2020 health care costs for both the Adult & Family and Disabled COAs. These costs by age and gender band were then projected based on the population demographics provided by the UCLA CalSIM model. The resulting costs by age bracket were then combined in the respective ratios of Adult & Family COA and Disabled COA to develop blended rates for each year in the projection period.

The mental health, behavioral health and substance use disorder services benefits priced by TAC/HSRI were then added to the Mercer blended SFY 2014 PMPM cost to produce a final Medi-Cal average cost for the newly eligible optional expansion population. Mercer considers this PMPM cost developed from FFS data to be a conservative estimate of Medi-Cal managed care costs because we believe the efficiencies and savings from managed care more than offset the approximate 8-10% loading for administrative costs and profit/risk/contingencies that would be loaded into the managed care rates.

### Behavioral Health Assumptions from TAC/HSRI

TAC/HSRI developed the following assumptions with technical assistance from DHCS to be used to extrapolate the 2009 utilization data to the newly eligible optional expansion population for the period 2014 through 2020:

Assumption Variable	Assumption Adopted
Overall Medi-Cal coverage newly eligible optional expansion population size	The CalSIM-enhanced outreach and enrollment assumptions were adopted, resulting in a 2014 starting population of 780,000 adults and a 2020 ending enrollee population of 910,000 adults.
Behavioral Health newly eligible optional expansion population	TAC/HSRI prevalence estimates were used to project that 18.64% of the total newly eligible optional expansion population would need mental health services. SAMHSA prevalence estimates were used to project that 10.3% of the total newly eligible optional expansion population would need substance use services.
Services included in the benefit	All current Medi-Cal mental health and substance use services benefits were included in the analyses.
Newly eligible optional expansion population take-up rates	The CalSIM enhanced take-up rate assumptions were used. The take-up rate for 2014 is estimated to be 55%, increasing to 62% in 2017 and leveling off in the subsequent years.

Assumption Variable	Assumption Adopted
Users of services	Not all enrollees that need and qualify for mental health and substance use services will actually ask for and access these services. TAC/HSRI estimates that 67% of people needing mental health services will access such services, while 24% of people needing substance use services will access such services
Distribution of service use	With the exception of inpatient psychiatric hospitalization, the distribution of utilization of both mental health and substance use services in the current Medi-Cal program is assumed to accurately reflect utilization of various service types for the newly eligible optional expansion population. Inpatient utilization in the current Medi-Cal system is heavily weighted towards people with serious mental illness receiving SSI, which is not projected to be true for the newly eligible optional expansion population. Thus, LIHP plan utilization of inpatient utilization, which is assumed to more accurately reflect the newly eligible optional expansion population, has been used to adjust hospitalization downward by 50% (from 8% to 4% expected utilization of MH users).
Adjustment for Medical Cost Inflation	The costs of mental health and substance use services are estimated to increase by 3% per year between 2009 and 2020.
Eligible but not enrolled "Woodwork"	There are a number of people currently eligible for Medi-Cal that are not enrolled. This is often referred to as the "woodwork" population. The utilization and cost estimates in this analysis do not include this potential population, which we would assume to be less expensive than the currently enrolled Medi-Cal population.
County Administrative Costs	For the Medi-Cal Specialty Mental Health Services (SMHS) Waiver an administration cost of 13% was added to the total costs of these services to reflect the current administration costs of this program.

The total projected SFY 2014 cost is \$2.07 billion for the Medi-Cal benefits and \$1.77 billion for the Anthem ABP, resulting in a cost differential of \$299 million. It should be noted that these costs represent only one half of the fiscal year because expansion will not begin until January 1, 2014.

The entire cost of the newly eligible optional expansion in SFY 2014 will be paid by the federal government, with the exception of non-eligible abortion services.

**End Notes**

- Service costs are expressed as state and federal share, but some "state" costs may be borne by counties and local entities.
- By using the Medi-Cal provider reimbursement rates in the CY 2010 and CY 2011 data, Mercer has not modeled the increased reimbursements for primary care providers to the Medicare levels mandated by the ACA for CY 2013 and CY 2014.

**Exhibit 1**  
**DRAFT Newly Eligible Optional Expansion**  
**Alternative Benefit Package Cost Estimation**

EXHIBIT 1	SFY 2014	SFY 2017	SFY 2018	SFY 2019	SFY 2020	CY 2020
<b>Projected Medi-Cal PMPM Cost w/o MH/BH/SUD</b>	\$ 386.75	\$ 440.11	\$ 457.45	\$ 480.13	\$ 503.97	\$ 514.57
<b>Projected MH/BH/SA Services *</b>	\$ 54.17	\$ 61.38	\$ 63.98	\$ 66.70	\$ 69.54	\$ 71.00
<b>Projected Total Medi-Cal PMPM Cost</b>	\$ 440.92	\$ 501.48	\$ 521.43	\$ 546.84	\$ 573.51	\$ 585.57
<b>Projected Total Cost for Expansion</b>	\$2,063,487,834	\$5,325,738,667	\$5,631,487,754	\$5,971,455,991	\$6,262,702,224	\$6,394,399,918
<b>CalSIM Projected Expansion Enrollment</b>	780,000	885,000	900,000	910,000	910,000	910,000
<b>CalSIM Projected Member Months</b>	4,680,000	10,620,000	10,800,000	10,920,000	10,920,000	10,920,000
<b>Benefit Differentials</b>	<b>Incremental Cost</b>	<b>Incremental Total State/Local Share of Benefit Cost</b>				
<b>Long-Term Care</b>	<b>SFY 2014</b>	<b>SFY 2017</b>	<b>SFY 2018</b>	<b>SFY 2019</b>	<b>SFY 2020</b>	<b>CY 2020</b>
Nursing Facility > 100 Days	\$ (12.10)	(3,542,465)	(8,206,835)	(10,312,902)	(14,059,261)	(16,888,132)
HCBS services **	\$ (26.96)	(7,398,843)	(17,064,770)	(21,881,180)	(29,829,939)	(35,832,035)
<b>Ambulatory Patient Services</b>						
Targeted Case Management	\$ (1.47)	(434,902)	(1,008,280)	(1,262,773)	(1,721,499)	(2,067,883)
Home Health Care > 45 visits	\$ (0.01)	(2,960)	(6,826)	(8,759)	(11,941)	(14,344)
<b>Mental Health &amp; Substance Use Disorder Services</b>						
Adult Residential Treatment Services *	\$ (0.31)	(90,780)	(202,164)	(262,626)	(343,434)	(412,537)
Family Mental Health Therapy *	\$ (0.24)	(69,420)	(160,542)	(198,744)	(259,896)	(312,190)
Group Mental Health Therapy *	\$ (0.40)	(117,480)	(267,570)	(326,508)	(445,536)	(535,183)
Medication Support Services *	\$ (7.15)	(2,085,270)	(4,780,584)	(5,877,144)	(7,917,546)	(9,510,639)
Other DD Services Including ABA ***	\$ (3.64)	(999,224)	(2,304,465)	(2,955,780)	(4,029,523)	(4,840,306)
Outpatient Drug-Free Treatment *	\$ (1.20)	(349,770)	(802,710)	(986,622)	(1,336,608)	(1,605,548)
Targeted Case Management *	\$ (4.78)	(1,445,997)	(3,357,044)	(4,177,767)	(5,695,421)	(6,841,399)
<b>Prescription Drugs</b>						
Blood & Blood Derivatives	\$ (0.82)	(229,094)	(528,891)	(675,251)	(920,550)	(1,105,774)
Prenatal Vitamins	\$ (0.04)	(10,752)	(24,979)	(30,988)	(42,245)	(50,745)
Weight Loss Drugs	\$ (0.02)	(6,668)	(15,457)	(19,367)	(26,403)	(31,715)
<b>Pediatric Services</b>						
EPSDT ****	\$ (0.04)	(10,138)	(23,445)	(29,693)	(40,480)	(48,625)
<b>Rehabilitative &amp; Habilitative Services &amp; Devices</b>						
DME > \$350	\$ (2.40)	(676,576)	(1,563,254)	(1,988,374)	(2,710,689)	(3,256,108)
<b>Total Differential Cost</b>	\$ (61.58)	\$ (17,470,339)	\$ (40,317,816)	\$ (50,994,478)	\$ (69,390,971)	\$ (83,353,161)
<b>Projected Anthem PMPM Cost</b>	\$ 379.33	\$ 436.05	\$ 453.63	\$ 474.99	\$ 498.75	\$ 509.24

\*- Figures provided by TAC and HSRI

\*\* - HCBS services, for the purpose of this analysis, include IHSS/Personal Care Services and Adult Day Health Care/Community Based Adult Services (ADHC/CBAS).

All waiver services have been excluded.

\*\*\* - ABA claims were included in this category for therapy related procedural codes that had an associated Autism related diagnosis (299.xx).

All DDS waiver services were excluded. Other non-waiver DDS related services, targeted case management and personal care services are included

\*\*\*\* - This represents an estimate of the additional costs to bring the Anthem Choice option into compliance with current EPSDT requirements.

**Exhibit 2**  
**DRAFT Newly Eligible Optional Expansion**  
**Alternative Benefit Package Cost Estimation**

EXHIBIT 2 (Enhanced Scenario)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	CY 2020
CalSIM Projected Expansion Enrollment*	780,000	810,000	860,000	885,000	900,000	910,000	910,000	910,000
<b>ABP = Medi-Cal</b>								
Projected Expansion PMPM Cost	\$ 440.92	\$ 466.88	\$ 480.23	\$ 501.48	\$ 521.43	\$ 546.84	\$ 573.51	\$ 585.57
Projected Total Annual Cost	\$ 2,063,487,834	\$ 4,538,062,391	\$ 4,956,018,702	\$ 5,325,738,667	\$ 5,631,487,754	\$ 5,971,455,991	\$ 6,262,702,224	\$ 6,394,399,918
FMAP %	100.0%	100.0%	100.0%	97.5%	94.5%	93.5%	91.5%	90.0%
Federal Share of Total Cost	\$ 2,060,483,940	\$ 4,531,230,916	\$ 4,948,108,404	\$ 5,182,999,916	\$ 5,311,662,916	\$ 5,572,597,327	\$ 5,718,728,467	\$ 5,754,959,926
Non-Federal Share of Total Cost	\$ 3,003,894	\$ 6,831,474	\$ 7,910,298	\$ 142,738,752	\$ 319,824,839	\$ 398,858,664	\$ 543,973,757	\$ 639,439,992
<b>ABP = Anthem CHOICE</b>								
Projected Expansion PMPM Cost	\$ 379.33	\$ 414.96	\$ 427.37	\$ 436.05	\$ 453.63	\$ 474.99	\$ 498.75	\$ 509.24
Projected Total Annual Cost	\$ 1,775,278,276	\$ 4,033,434,143	\$ 4,410,476,981	\$ 4,630,851,019	\$ 4,899,176,259	\$ 5,186,925,568	\$ 5,446,337,856	\$ 5,560,868,311
FMAP %	100.0%	100.0%	100.0%	97.5%	94.5%	93.5%	91.5%	90.0%
Federal Share of Total Cost	\$ 1,772,274,382	\$ 4,026,602,668	\$ 4,402,566,683	\$ 4,505,582,606	\$ 4,619,669,236	\$ 4,839,061,382	\$ 4,971,755,070	\$ 5,004,781,480
Non-Federal Share of Total Cost	\$ 3,003,894	\$ 6,831,474	\$ 7,910,298	\$ 125,268,413	\$ 279,507,022	\$ 347,864,186	\$ 474,582,786	\$ 556,086,831
<b>ABP Differential</b>								
Projected Total Annual Cost	\$ 288,209,558	\$ 504,628,248	\$ 545,541,721	\$ 694,887,648	\$ 732,311,496	\$ 784,530,423	\$ 816,364,368	\$ 833,531,607
FMAP %	100.0%	100.0%	100.0%	97.5%	94.5%	93.5%	91.5%	90.0%
Federal Share of Total Cost	\$ 288,209,558	\$ 504,628,248	\$ 545,541,721	\$ 677,417,309	\$ 691,993,680	\$ 733,535,946	\$ 746,973,397	\$ 750,178,446
Non-Federal Share of Total Cost	\$ -	\$ -	\$ -	\$ 17,470,339	\$ 40,317,816	\$ 50,994,478	\$ 69,390,971	\$ 83,353,161

\* - While total potential benefit costs are provided in this analysis based on the CalSIM projections, actual costs may be higher or lower than the estimates represented in this analysis. DHCS is completing an analysis of initial and long-term take-up rates and demographics for the expansion populations.

Notes

The Non-Federal Share amounts for SFY2014-2016 reflect an estimate of projected spending on non-federally eligible abortion services for the expansion population. FY FMAP percentages are calculated using the CY federally prescribed rate.



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