



The 2013-14 Budget: Maximizing Federal Reimbursement For Parolee Mental Health Care

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Summary

Historically, the state has spent tens of millions of dollars annually in General Fund for the California Department of Corrections and Rehabilitation (CDCR) to provide mental health treatment services to mentally ill parolees and to assist inmates with applying for benefits (such as Medi-Cal) prior to release from prison. Our analysis indicates that federal Medicaid reimbursements could be attained for some of the costs of these existing services. Moreover, the amount of federal reimbursements could increase significantly under the federal Patient Protection and Affordable Care Act (ACA) if the Legislature chooses to expand Medi-Cal to provide health coverage to most low-income individuals, as authorized by ACA. Medi-Cal expansion would significantly increase the number of parolees who would qualify for Medi-Cal, thereby allowing the state to draw down federal reimbursements for much of CDCR's costs of providing mental health treatment to them. However, it appears that the state lacks a plan to implement the operational changes that will be necessary to maximize the amount of additional federal funds that could be achieved.

In order to maximize the federal reimbursements that will be available for parolee mental health treatment, especially if the state expands Medi-Cal eligibility, we recommend that CDCR (1) provide increased Medi-Cal application assistance for mentally ill parolees to ensure that all eligible parolees are enrolled, (2) develop a process—in collaboration with the Department of Health Care Services (DHCS)—to claim federal reimbursement for the costs of assisting inmates with benefits applications, and (3) develop a process—in collaboration with DHCS—to claim federal reimbursement for mental health treatment services provided to parolees. If the state took these steps, we estimate it could achieve net General Fund savings of about \$6 million in 2013-14 and \$28 million annually upon full implementation in 2014-15 (assuming the state implements the Medi-Cal expansion).

BACKGROUND

In California, mental health treatment is available through the Medi-Cal Program. In addition, mental health treatment services are available to individuals on state parole supervision through programs provided by CDCR. Below, we describe these programs in more detail and identify how federal health care reform could provide for increased federal reimbursements for CDCR's mental health treatment services.

What Is Medi-Cal?

Medicaid is an optional joint federal-state program that provides health care services to certain low-income populations. In California, the Medicaid Program is administered by DHCS and is known as Medi-Cal. Below, we provide an overview of how Medi-Cal is financed, who is eligible for the program, what benefits they receive, and how the program is administered.

Medi-Cal Costs Split Between the State and Federal Government. In choosing to operate a Medicaid Program, states receive federal funding for a significant share of the program costs. The percentage of program costs funded with federal funds varies by state and is known as the federal medical assistance percentage, (FMAP or “federal match”). The Medi-Cal Program currently receives a 50 percent federal reimbursement for most services provided to beneficiaries, as well as for state and county costs to administer the program (such as the costs of processing Medi-Cal applications). In other words, the program generally receives one dollar of federal funds for each state dollar spent on Medi-Cal beneficiaries and administration.

Medi-Cal Provides Health Care Services to Eligible Individuals. Federal law establishes some minimum requirements for state Medicaid

programs regarding the types of services offered and who is eligible to receive them. Required services include hospital inpatient and outpatient care, nursing home stays, doctor visits, and mental health services. California also offers an array of medical services considered optional under federal law, such as coverage of prescription drugs and durable medical equipment. Medi-Cal services are generally provided through two main systems: fee-for-service (FFS) and managed care. In a FFS system, a health care provider receives an individual payment for each medical service provided. In a managed care system, managed care plans receive a set fee per patient in exchange for providing health care coverage to enrollees. In addition, some public providers that are local government entities (such as county hospitals) are paid for services to Medi-Cal beneficiaries and uninsured individuals under a cost reimbursement methodology known as Certified Public Expenditures (CPE). Under CPEs, public providers make expenditures eligible for federal Medicaid reimbursement and certify to DHCS—through auditable documentation such as cost reports and time studies—that these expenditures were used to support the cost of Medi-Cal-covered services. Based on this certification, the state draws down the federal matching funds.

Currently, Medi-Cal eligibility requires individuals to have a low income and to be in certain categories, such as being in a family with children, being blind or pregnant, being over 65 or under 19 years of age, or having a disability. Individuals who are not lawfully residing in the United States are generally ineligible for Medi-Cal. Low-income, childless adults are also generally ineligible for Medi-Cal. (However, such individuals may be eligible for health care

coverage under Low Income Health Plans [LIHPs]. As we describe in our recent report *The 2013-14 Budget: Examining the State and County Roles in the Medi-Cal Expansion*, LIHPs, which expire in 2014, are a short-term expansion of Medicaid approved by the federal government for California in 2010.) The income threshold used to determine Medi-Cal eligibility varies, but for some groups (such as parents) the income threshold is about 100 percent of the Federal Poverty Level (FPL). (The FPL is the income level at which the federal government considers individuals of families to be impoverished.) In 2012, the FPL was \$11,170 per year for an individual and \$23,050 for a family of four.

Mental Health Services for Medi-Cal Beneficiaries

As indicated above, Medi-Cal offers mental health services to those who are eligible to receive them. Generally speaking, a mental illness is a condition that affects a person's thinking, feeling, mood, daily functioning, and ability to interact with others. On the broad spectrum of mental illnesses, the severity of the illnesses varies in terms of the degree to which each illness impairs a person's ability to perform activities of daily living such as eating, bathing, dressing, and going to work. Milder mental conditions, such as mild depression, are relatively common and can typically be treated by a primary care physician or other qualified health professional. Treatment provided by health care professionals who are not licensed as mental health specialists is sometimes referred to as "nonspecialty mental health care." Most nonspecialty mental health services are provided to Medi-Cal beneficiaries through Medi-Cal managed care or FFS.

In contrast, severe persistent mental illness is less common, and its treatment generally requires specialty mental health care typically provided

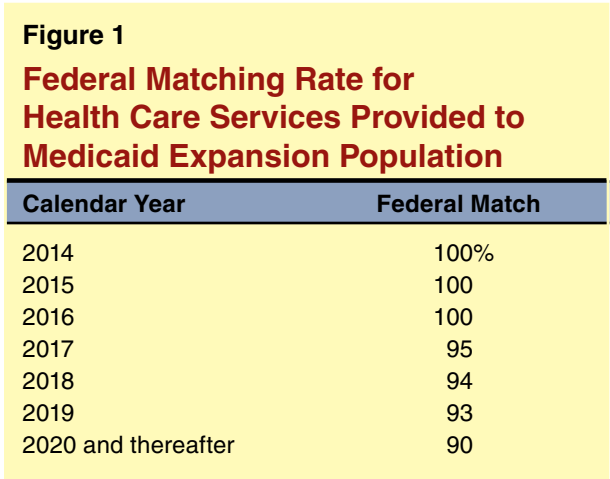
by a licensed mental health professional (such as a psychiatrist, psychiatric nurse, psychologist, or social worker). Most specialty mental health services are provided to Medi-Cal beneficiaries under the Specialty Mental Health Services (SMHS) waiver. (The federal Centers for Medicare and Medicaid Services may waive certain federal rules in order to allow states to modify their Medicaid programs in ways that are generally advantageous to beneficiaries.) This waiver, which was approved in the 1990s, allows counties to take the lead role in the provision of specialty mental health care for Medi-Cal beneficiaries. The SMHS waiver stipulates that counties, through Mental Health Plans (MHPs), will provide the majority of specialty mental health services, as specified in the waiver. These services include psychiatric inpatient hospital services and various outpatient services, such as psychiatric medication management, mental health counseling, case management, day treatment, and crisis management. In some cases, treatment services are delivered by county staff, while in other cases counties utilize contract providers. In order for MHPs to claim federal reimbursement for services provided to Medi-Cal beneficiaries, they must ensure that the services meet several criteria. For example, the services must be (1) provided by Medi-Cal certified providers, (2) received by Medi-Cal enrolled beneficiaries, (3) deemed by a clinician to be medically necessary.

ACA Modifies the Medicaid Program

In 2010, Congress passed and President Obama signed the ACA, which includes a provision allowing states to expand the Medicaid Program beginning in 2014. In addition, the ACA simplifies the Medicaid eligibility determination and enrollment process.

Under ACA, State Can Expand Medi-Cal With Increased Federal Match in 2014. The ACA gives states the option to significantly expand their

Medicaid programs, with the federal government paying for a large majority of the additional costs. Beginning January 1, 2014, federal law gives state Medicaid programs the option to cover most individuals under age 65—including childless adults—with incomes at or below 133 percent of the FPL. As shown in Figure 1, the federal matching rate for coverage of this expansion population will be 100 percent for the first three years, but will decline between 2017 and 2020, with states eventually bearing 10 percent of the additional cost of health care services for the expansion population. The *Governor’s 2013–14 Budget Summary* includes a commitment to expanding Medi-Cal but presents two possible options for doing so—a county-based approach and a state-based approach. (For details on these alternative approaches, please see our recent publication, *The 2013-14 Budget: Examining the State and County Roles in the Medi-Cal Expansion*.) We note, however, that the Legislature has not yet taken action at the time of this analysis to expand the Medi-Cal Program. While policymakers are also still determining how to implement certain changes to Medi-Cal that are required by the ACA in 2014, certain fundamental aspects of the existing program (such as the provision of federally required benefits) will not change.



ACA Simplifies Medicaid Eligibility Determination and Enrollment. Beginning January 1, 2014, the ACA makes changes to the methodology used to calculate income when determining Medicaid Program eligibility for most beneficiaries—excluding certain populations, such as seniors and persons with disabilities. Currently, the methodology used to determine financial eligibility for Medicaid is complex—often involving verification of an applicant’s assets and accounting for a variety of income deductions and exemptions. The ACA generally simplifies the standards used to determine financial eligibility. The two major changes to the methodology are:

- Requiring the use of a new methodology to calculate income, known as Modified Adjusted Gross Income. As part of this change, various deductions to applicant income that are now permissible would end.
- Asset tests will no longer be used to determine eligibility.

In addition, the ACA includes provisions aimed at streamlining the Medi-Cal enrollment process. For example, persons may be determined eligible for Medi-Cal after applying through a website that will be operated by the California Health Benefits Exchange, also known as Covered California. The state is required to use available electronic data sources, such as tax information from the Internal Revenue Service, to determine eligibility prior to asking for additional information from the applicant.

CDCR Provides Mental Health Treatment Services to Parolees

Since 1954, CDCR has operated a mental health treatment program specifically for parolees. This program—the Parole Outpatient Clinic (POC)—provides mental health services for offenders who

have been released from state prison and are under the department's supervision in the community. In addition, the department contracts with private providers for services for severely mentally ill parolees through the Integrated Services for Mentally Ill Parolees (ISMIP) program.

POCs. As of January 2013, the state operated 65 parole offices throughout the state designed to provide space for parolees to meet with their assigned parole agent, as well as participate in treatment programs. At each parole office, CDCR operates a POC, which provides office space for state-employed mental health care professionals (such as psychologists, psychiatrists, and social workers) to deliver outpatient mental health treatment to state parolees. This treatment includes (1) prescribing and monitoring the use of psychiatric medications, (2) regular mental health counseling in group or individual settings, (3) case management (such as assistance with housing and employment needs), and (4) crisis management services on an as-needed basis. While CDCR pays for medications for many POC patients, the Medi-Cal Program pays for POC-prescribed medications for individuals enrolled in Medi-Cal.

The department estimates that POC staff will provide such services to about 17,000 parolees in 2013-14—roughly one-third of the total parolee population. The Governor's 2013-14 budget for CDCR proposes \$44 million from the General Fund for POCs, including \$25 million for 171 staff and ancillary costs and \$19 million for psychiatric medications. This amount is roughly equal to the amount provided in 2012-13.

ISMIP Program. In addition to operating POCs, the department through the ISMIP program contracts with private providers and counties for more comprehensive services for about 300 severely mentally ill parolees. In addition to providing case management and day treatment services, ISMIP providers are responsible for referring parolees to

other supplemental services (such as subsidized housing and substance abuse treatment services) on an as-needed basis. Parolees in the ISMIP program who require psychiatric medications continue to receive medication management services from POC clinicians. The CDCR requires that ISMIP providers maintain certification by the DHCS as Medi-Cal providers. The Governor's budget for 2013-14 proposes \$6 million for the ISMIP program, including \$4.9 million for case management and day treatment services and \$1.1 million for housing subsidies.

Some Parolees Are Eligible for Medi-Cal

Some POC Patients Are Enrolled in Medi-Cal. Neither DHCS nor CDCR tracks whether POC patients are enrolled in Medi-Cal. However, based on data provided by CDCR on the number of parolees whose psychiatric medications are paid for by Medi-Cal, we estimate that about 10 percent of POC patients are currently enrolled in Medi-Cal. It is likely that most of these parolees qualify for Medi-Cal because their mental illnesses are considered disabilities. While these Medi-Cal enrolled parolees are eligible to receive specialty mental health services through county MHPs, typically they do not. Based on conversations with several MHP administrators, most counties do not provide specialty outpatient mental health services to parolees in order to avoid duplicating services that are provided by POCs. However, MHPs do provide services (such as inpatient crisis care) that are unavailable at POCs. They also sometimes provide outpatient services for parolees that have difficulty accessing POC services (such as due to a lack of transportation).

CDCR Assists Some Inmates in Applying for Medi-Cal. The CDCR currently operates a Transitional Case Management Program (TCMP) to assist some inmates with medical, mental health, and developmental disabilities to apply

for benefits (such as Medi-Cal) prior to their release from prison. The purpose of the program is to ensure that these inmates are able to access health care services once they are back in the community. The program has 55 contracted social workers who—working with medical and mental health staff in the state’s 33 state prisons—identify inmates who may qualify for Medi-Cal, assist the inmates in completing applications, and submit the applications to the County Welfare Departments (CWDs) in the counties where the inmates will be released. The DHCS has directed CWDs to take various measures to facilitate the processing of Medi-Cal applications prior to the inmate’s release from prison (such as instituting an expedited review process for inmate applications if the inmate is scheduled for release in fewer than 45 days). Based on data provided by CDCR, we estimate that TCMP staff will submit about 1,500 Medi-Cal applications in 2012-13. The Governor’s budget for 2013-14 proposes \$8.2 million for the TCMP.

Medi-Cal Expansion Would Increase Number of Eligible Parolees

If the Legislature exercises its option under ACA to expand Medi-Cal eligibility to adults up to 133 percent of FPL in 2014, as authorized by ACA, a large majority of parolees would qualify for Medi-Cal following their release from prison. This is because most parolees, including POC and ISMIP patients, fall into the category of low-income childless adults who are currently ineligible for Medi-Cal, but would become eligible under a Medi-Cal expansion. Consequently, the expansion of Medi-Cal would mean that thousands of additional POC and ISMIP patients could be enrolled in Medi-Cal beginning in 2014, allowing the state to receive federal reimbursements for much of the costs of providing psychiatric medications and treatment services to these parolees. Moreover, since these parolees will be newly eligible for Medi-Cal, the federal match for their mental health treatment will initially be 100 percent. Thus, if the state expands Medi-Cal eligibility, the state could draw down additional federal reimbursements.

STATE IS UNPREPARED TO MAXIMIZE FEDERAL FUNDS UNDER EXISTING PROGRAMS AND ACA

As discussed below, we find that the state is not currently maximizing federal reimbursements that are potentially available for parolee mental health programs. Moreover, it appears that the state lacks a plan to implement operational changes that will be necessary to maximize additional federal reimbursements if Medi-Cal is expanded.

State Is Not Maximizing Federal Funds for Existing Programs

Our analysis indicates that federal reimbursements are currently potentially available for (1) benefits application assistance staff, (2) services provided through POCs and ISMIP, and (3) psychiatric medications for Medi-Cal enrolled parolees. However, the state is not drawing down reimbursements for all of these activities and services. Instead, we estimate that the state will draw down only about half of the federal

reimbursements that are potentially available for just the psychiatric medications provided to Medi-Cal enrolled parolees in 2013-14. This is because CDCR does not ensure that all Medi-Cal eligible parolees are enrolled.

In total, we estimate that in 2013-14 the state is losing out on about \$6 million in additional Medicaid reimbursements for existing programs. These are reimbursements that could be available on an ongoing basis whether or not Medi-Cal is expanded. We note that the above estimate is based on two factors which are subject to significant uncertainty. Specifically, CDCR does not know how many POC patients are currently eligible for Medi-Cal, nor does it know what percentage of POC and ISMIP services are covered by Medi-Cal. Thus, the actual amount of potentially available savings could be higher or lower by several million dollars.

CDCR Is Not Getting Reimbursed for Current Application Assistance Efforts. Our analysis indicates that the state is not currently drawing down federal reimbursements that are available for the costs of assisting inmates with Medi-Cal applications. We estimate that about \$2 million of the department's TCMP costs is

spent on such assistance. While the Governor's 2013-14 budget assumes that the TCMP will be entirely supported by the General Fund, it appears that about \$1 million could be offset by federal reimbursements.

State Is Not Getting Reimbursements for Current POC and ISMIP Treatment Services. Our analysis also indicates that a 50 percent federal match is potentially available for the costs of providing certain POC and ISMIP services to Medi-Cal enrolled patients. (Federal funds may also be available for substance abuse treatment services provided to parolees, as we describe in the nearby box.) These services include case management, individual and group therapy, day treatment, crisis intervention, and medication management, as well as administrative activities related to these services. However, the state is currently unable to draw down federal reimbursements for POC services for several reasons.

- First, CDCR does not currently track the amount of time POC staff devote to various activities and thus cannot determine what percentage of their hours are devoted to delivering services that are covered by

Federal Funds Could Also Be Available for Substance Abuse Treatment Services

The Governor's 2013-14 budget proposes \$72 million for substance abuse treatment services for parolees. It is possible that federal reimbursements could also be available for a significant portion of these costs—perhaps as much as tens of millions of dollars—if Medi-Cal eligibility is expanded. However, the amount of available federal reimbursements is subject to significant uncertainty and could vary significantly depending on a couple of factors including (1) what substance abuse treatment services are covered by Medi-Cal beginning in 2014 (which has not yet been determined by Department of Health Care Services) and (2) whether the substance abuse treatment services offered to parolees are consistent with the services covered by Medi-Cal. In addition, some operational changes (such as modifying state contracts with substance abuse treatment providers to require that they draw down Medi-Cal funds) would be required for the state to offset the General Fund costs for substance abuse treatment services.

Medi-Cal. Based on conversations with POC administrators, however, it appears that a large portion of POC staff time is devoted to delivering Medi-Cal covered services.

- Second, only services delivered by Medi-Cal certified clinicians are reimbursable and most POC staff currently lack such certification.
- Third, CDCR does not have a process in place to submit Medi-Cal claims and receive federal reimbursement.

Conversely, the department reports that ISMIP providers should be able to draw down Medi-Cal funding for its Medi-Cal enrolled patients because they are required to maintain Medi-Cal certification. To the extent ISMIP providers do this, they are supposed to pass the reimbursements to CDCR which offsets the General Fund costs of the program. However, the department is aware of only one provider—Santa Clara County—that has been getting Medi-Cal reimbursements. The department is not sure why more ISMIP providers are not getting Medi-Cal reimbursements.

We estimate that in 2013-14 the state's inability to draw down federal funding for POC and ISMIP services provided to existing Medi-Cal enrollees will result in the state spending approximately \$2 million from the General Fund which could otherwise be offset by federal Medicaid reimbursements. The amount of federal reimbursements could be even greater if CDCR is able to ensure that all Medi-Cal eligible parolees are enrolled in 2013-14, as we describe below.

CDCR Does Not Ensure That All Medi-Cal Eligible POC and ISMIP Patients Are Enrolled. The CDCR currently lacks a system for ensuring that all Medi-Cal eligible POC and ISMIP patients are enrolled in Medi-Cal, which limits the state's ability

to claim federal reimbursement for their mental health treatment. Most parolees, including those receiving mental health treatment through the POC and ISMIP programs, do not receive any assistance in applying for Medi-Cal. While CDCR provides prerelease benefits application assistance to some inmates through the TCMP, our analysis indicates that the program does not reach most inmates. During the period from July 2012 through October 2012, TCMP staff were able to offer assistance to only about one out of every ten inmates released from prison. Moreover, staff was able to offer benefits application assistance to only 42 percent of inmates released during that period who had been diagnosed with a mental illness while in prison. Inmates who are not assisted with Medi-Cal applications prior to release are unlikely to receive assistance when they return to their communities.

We estimate that in addition to the approximately 10 percent of POC patients currently enrolled in Medi-Cal, another 10 percent to 15 percent of POC and ISMIP patients are potentially eligible and could be enrolled. The state's inability to ensure enrollment of these individuals into Medi-Cal will result in the state spending approximately \$3 million from the General Fund in 2013-14 which could otherwise be offset by federal Medicaid reimbursements. This includes \$1 million for psychiatric medications and \$2 million for POC and ISMIP services.

State Could Achieve Much Greater Savings Under Medi-Cal Expansion.

The Governor's budget for 2013-14 proposes \$58 million in General Fund for the ISMIP, POC, and TCMP programs. As described above, the amount of federal reimbursements potentially available for these costs is relatively small under current law—about \$6 million annually—because most parolees are currently ineligible for Medi-Cal. However, if the Legislature expands the Medi-Cal

Program, as authorized by ACA, the number of Medi-Cal eligible parolees, as well as the federal match, will increase significantly in 2014. This would allow the state to offset a significant share of current General Fund expenditures for these programs.

Lack of Planning Could Result in Missed Opportunities for State Savings

While our analysis indicates that significant General Fund savings are achievable in 2013-14 and future years, especially if Medi-Cal eligibility is expanded, the state currently lacks a concrete plan for achieving these savings. Based on our conversations with administrators at DHCS and CDCR, staff is aware that General Fund savings are currently available from increased federal reimbursements for parole mental health programs and that an expansion of Medi-Cal eligibility would create opportunities for significant additional General Fund savings. They are also aware that various operational

changes need to be made in order to draw down the federal reimbursements necessary to achieve those savings, but they have indicated that they are only in the preliminary stages of planning to implement those changes. For example, as discussed above, CDCR has not yet implemented a system to track how many POC staff hours are devoted to Medi-Cal reimbursable services, and DHCS has not identified whether federal approval would be required to begin claiming federal reimbursements for such services. On the one hand, it is understandable that the departments have not made great progress in planning for securing additional federal reimbursements for CDCR mental health programs given that Medi-Cal expansion is not yet state law. On the other hand, given that it will likely take the departments some time to coordinate their efforts and implement the necessary operational changes, it is imperative that CDCR and DHCS begin taking steps to do so sooner rather than later.

RECOMMENDATIONS FOR MAXIMIZING FEDERAL REIMBURSEMENTS FOR PAROLEE MENTAL HEALTH PROGRAMS

In order to maximize the federal reimbursements that will be available for parolee mental health treatment, especially if the state expands Medi-Cal eligibility, we recommend that CDCR (1) increase Medi-Cal application assistance for current and prospective POC patients to ensure that all eligible parolees are enrolled, (2) develop a process—in collaboration with DHCS—to claim federal reimbursement for the costs of assisting inmates with benefits applications, and (3) develop a process—in collaboration with DHCS—to claim federal reimbursement for parolee mental health treatment services provided through the POC and ISMIP programs (excluding for psychiatric drugs

for which there is already a claiming process in place). As shown in Figure 2 (see next page) and described in more detail below, if the state took these steps, it could achieve net General Fund savings of \$6 million in 2013-14. We estimate these savings could grow to about \$28 million annually upon full implementation (assuming the state implements the Medi-Cal expansion).

Provide Increased Medi-Cal Application Assistance

We recommend that the Legislature adopt budget trailer bill legislation directing CDCR—in collaboration with DHCS—to expand its prerelease

Figure 2
Potential General Fund Savings From Increased Federal Reimbursements^a

(In Millions)

	2013-14	2014-15
Additional benefits assistance staff	-\$2	-\$2
Increased reimbursements for psychiatric medications	6	13
Claiming reimbursement for benefits assistance staff	2	2
Claiming reimbursements for POC and ISMIP services	—	15
Net General Fund Savings	\$6	\$28

^a Assumes state expands the Medi-cal Program in 2014.
 POC = Parole Outpatient Clinic and ISMIP = Integrated Services for Mentally Ill Parolees.

CWDs will receive applications and enroll eligible inmates into Medi-Cal.

We estimate that several thousand inmates will be referred to POCs upon release in 2013-14. Since CDCR is currently unable to provide benefits application assistance to all of the inmates who are currently potentially

Medi-Cal application assistance to inmates who will be receiving POC and ISMIP services and provide application assistance to current POC and ISMIP patients who may be eligible for Medi-Cal. This will ensure that all eligible POC and ISMIP patients are enrolled into Medi-Cal so that the state can begin drawing down federal reimbursements for the costs of their psychiatric medications. In addition, ensuring that mentally ill parolees accessing POC and ISMIP services are enrolled in Medi-Cal will allow the state to draw down federal reimbursements for POC and ISMIP treatment services.

Additional Benefits Assistance Staff. In our view, CDCR should have prison mental health staff identify all inmates who are likely to require mental health treatment when they are paroled and refer those inmates to staff who can provide them with Medi-Cal application assistance prior to release. This would be similar to the current process used by TCMP staff except that it would incorporate the new simplified Medi-Cal eligibility determination process that the ACA requires states to begin using beginning in 2014. Thus, instead of completing complex, paper-based Medi-Cal applications, TCMP should be able to utilize the new simplified online application system. The CDCR will need to amend its memoranda of understanding (MOU) with DHCS to reflect the new process by which

eligible for Medi-Cal upon release—let alone the additional inmates who will be eligible if eligibility is expanded—the department will likely require additional staff. Based on the current costs of submitting benefits applications, we estimate that the total costs for the additional staff that would be necessary to complete Medi-Cal applications for all prospective POC and ISMIP patients would likely be about \$2 million dollars or less. (As we describe below, the state could potentially draw down federal reimbursements for up to half of these costs.) We note that efficiencies from the new simplified online application system could reduce such additional staffing costs in the future. Moreover, the costs for additional staff would be offset many times over by savings from increased federal reimbursement for parolee mental health care.

The CDCR will also need to ensure that *current* POC and ISMIP patients are enrolled into Medi-Cal in order to maximize available federal funds. As such, the department should develop a plan for assisting current POC and ISMIP patients with Medi-Cal applications. For example, CDCR could require that parole staff (such as parole agents or POC social workers) assist POC and ISMIP patients with Medi-Cal applications as part of their regular duties. Such assistance could

include directly assisting parolees with Medi-Cal applications or referring them to county staff who could assist them in completing Medi-Cal applications.

Increase Reimbursements for Psychiatric Medications. If CDCR is able to ensure that all eligible POC patients are enrolled into Medi-Cal by January 1, 2014, the Legislature could reduce CDCR's POC budget for psychiatric medications by \$7 million in 2013-14. This amount would be offset by a slight increase of about \$1 million in costs for the Medi-Cal Program related to the state share of Medi-Cal costs to provide medications to currently eligible but newly enrolled POC patients. Overall, we estimate the state can achieve \$6 million in net General Fund savings in 2013-14 from reduced expenditures for psychiatric medications for parolees, which could increase to \$13 million in 2014-15.

Develop Process for Claiming Reimbursement for Benefits Assistance Staff

We recommend that the Legislature also adopt budget trailer legislation directing CDCR to implement—in collaboration with DHCS—a process for claiming federal reimbursement for staff that is assisting inmates with Medi-Cal applications. Specifically, CDCR will need to develop a system to track TCMP staff hours that are devoted to assisting inmates with Medi-Cal applications. The CDCR will also need to enter into an MOU with DHCS that outlines a process whereby CDCR submits claims for staff hours devoted to assisting inmates with applications and where DHCS processes the claims and authorizes federal reimbursements for CDCR. This process would likely be similar to the current one used to claim federal reimbursement for the federal court-appointed Receiver's staff that are completing Medi-Cal applications for inmates who receive off-site inpatient medical services. (For more

information on that process, please see our recent publication, *The 2013-14 Budget: Obtaining Federal Funds for Inmate Medical Care—A Status Report.*) Given that the process could be similar to the existing one, we assume that it could be implemented in time to achieve full year savings in 2013-14 of about \$2 million, including \$1 million for existing staff and \$1 million for the staff we recommend adding.

Develop Process for Claiming Reimbursements for POC and ISMIP Services

We recommend that the Legislature also adopt budget trailer legislation directing CDCR and DHCS to take the necessary steps to claim federal reimbursement for POC and ISMIP treatment services, such as day treatment and case management. Specifically, the trailer legislation should direct CDCR to (1) begin tracking POC staff hours that are devoted to Medi-Cal reimbursable services, (2) ensure that its clinicians obtain certification as Medi-Cal providers, and (3) require that ISMIP providers draw down Medi-Cal funding to the extent possible. In addition, the trailer legislation should direct DHCS to identify and seek federal approval of a process by which CDCR can submit claims for POC services.

The DHCS has informed us that there are several possible approaches CDCR could take to submit claims for POC services but all of them pose implementation challenges, and some or all of them may require federal approval. Based on our preliminary conversations with DHCS and other stakeholders, we have identified four possible approaches including (1) having POCs become certified as FFS Medi-Cal providers so that CDCR can submit Medi-Cal claims directly to DHCS, (2) incorporating POCs into county MHPs so that the CDCR can submit Medi-Cal claims through MHPs, (3) having CDCR's

network of POCs certified as a new MHP so that CDCR can submit Medi-Cal claims directly through DHCS, and (4) setting up a CPE program for POCs so that CDCR can submit claims directly to DHCS. However, DHCS has indicated that further analysis is required to identify an optimal approach.

For each of the above options for submitting claims for POC services, we recommend that DHCS report at budget hearings on its feasibility, what contracts and processes would need to be implemented by CDCR and DHCS, and what federal approval would be required. The department should also report on whether there are any additional feasible options. If in the course of budget deliberations, the Legislature is able to identify an approach that is most consistent with its priorities, we recommend the Legislature

adopt budget trailer legislation requiring DHCS and CDCR to develop and submit a plan by September 1, 2013 to implement the preferred approach as well as immediately take steps to implement the plan, including seeking any necessary federal approval. (Alternatively, the Legislature could direct DHCS—in collaboration with CDCR—to develop a plan for legislative consideration that outlines the department’s suggested approach.) If the state begins taking steps to implement the process for drawing down federal funds by September 1, 2013, it should be able to achieve full year savings from increased federal reimbursements for POC and ISMIP services in 2014-15, or about \$15 million. If the state is able to obtain federal approval and implement the process sooner, it is possible that some partial-year savings could be achieved in 2013-14.

LAO Publications

This brief was prepared by Aaron Edwards, and reviewed by Brian Brown. The Legislative Analyst’s Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.

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