ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER JUDY CHU, CHAIR

MONDAY FEBRUARY 24, 2003
STATE CAPITOL, ROOM 437
4:00 PM

ITEMS TO BE HEARD

ITEM 4260 DEPARTMENT OF HEALTH SERVICES- MEDI-CAL

ISSUE 1: MEDI-CAL ACCOUNTING

1. The Departments of Health Services and Finance would be required to change the accounting system for the Medi-Cal Program from an accrual basis to a cash basis. By reverting the accounting system from an accrual basis to a cash basis the state could save $1.128 billion on a one-time basis.

2. In addition, the proposal would include amendments to Section 16531.1 of the Government Code to authorize the Medi-Cal Providers Interim Payment Fund to pay Medi-Cal providers during any portion of the last quarter of any fiscal year in which a General Fund (GF) deficiency exists for the Medi-Cal program.

BACKGROUND:

Currently, the Medi-Cal program is budgeted on an accrual basis. Under accrual basis accounting, expenses and revenues are accounted for when they are incurred or earned. Under cash basis the expenditures and revenues are recognized when they are paid or received. Therefore, funding for Medi-Cal expenses must be included in the budget for the year in which the services were provided to the beneficiaries.

When Medi-Cal began in 1966-67 it was on an accrual accounting basis. In 1971-72, then Governor Ronald Reagan switched the accounting basis to cash. The change in accounting was made, in part, to help address a budget deficit problem similar to what the state confronts today.

Medi-Cal was on a cash basis until 1991-92 when Governor Pete Wilson switched to an accrual basis. The switch by Governor Wilson was for the same reason that Governor Reagan made the switch, to address a significant budget deficit. The switch under Governor Wilson was more comprehensive, revenues and expenditures were switched to accrual based accounting. Revenues and expenditures were increased because of the switch. However, the increased revenues for the GF more than offset the increase in expenditures, which was a result from the changeover.

The Federal Government requires the state to maintain the Medi-Cal program on a cash basis. The state, therefore, has to maintain two sets of books on the Medi-Cal program, one accrual and the other cash.

When the state went to accrual accounting in 1991-92 bond rating agencies were concerned the state was incurring debt without an approved budget when Medi-Cal deficiencies occurred. At that time there were deficiencies nearly every year and they automatically became an obligation that Medi-Cal had to pay. The amendment to the Government Code is addressing the issue of incurring debt through a deficiency in Medi-Cal.

Section 16531.1 of the Government Code created the Medi-Cal Providers Interim Payment Fund for the purposes of paying Medi-Cal providers, providers of drug treatment services for HIV patients and providers of developmentally disabled services, during any portion of a fiscal

year, prior to September 1 of that year, in which a budget has not been enacted. This Section also appropriates up to $1 billion from the GF and up to $1 billion from the Federal Trust Fund, in the form of loans for these purposes. This provision has been employed twice since it was originally adopted. The amendment would expand the purpose of the Fund to include payment of Medi-Cal providers in any fiscal year when a deficiency in GF appropriations exists in the last quarter of that fiscal year. The amendments would also appropriate up to $3.0 billion from the GF and up to $3.0 billion from the Federal Trust Fund, in the form of loans, for the new purpose. The loans would similarly be repaid from the next fiscal year's Medi-Cal appropriation.

COMMENTS:

Department of Health Services/Department of Finance:

1. Does the federal government require the state to account for Medi-Cal expenditures on a cash basis?
2. Would switching accounting from accrual to cash be difficult, time consuming or require significant expenditures of resources?
3. From a technical assistance perspective, does amending Section 16531.1 of the Government Code to expand the purposes of the Medi-Cal Providers Interim Payment Fund, increasing the appropriations authority of the fund for the purposes of Medi-Cal deficiency loans make sense?

Legislative Analyst Office:

1. What is the LAO's assessment of shifting Medi-Cal from an accrual to cash based accounting?

4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 2: MEDI-CAL PROVIDER RATE REDUCTION

The Governor's Mid-Year Adjustment and January 10 budget proposals for fiscal year 2003-04, would reduce provider rates for Medi-Cal providers by 15 percent for three years across the board, exclusive of rates for hospital inpatient and hospital outpatient care, Federally Qualified Health Centers and Rural Health Clinics.

BACKGROUND:

The 2000 Budget Act included Medi-Cal provider rate increases totaling $799.8 million ($402.8 million General Fund.

Provider Rate Increases Funds Appropriated for Budget Act FY 2000/2001

Noninstitutional Providers	Percent Increase	GF Dollars Appropriated	Federal Funds *
Physician Services (includes 40% increase specific to ER physician services)	16.7%	95.3	95.3
CCS physician services (including non-Medi-Cal)	39%	7.8	7.8
Comprehensive perinatal services	11%	2.6	2.6
EPSDT screening (including non-Medi-Cal CHDP)	20%	3.3	3.3
Neonatal intensive care	30%	5.4	5.4
Dental			
General rates	6.8%	17.7	17.7
Medical/Other Services			
Psychologists	30%	3.0	3.0
Physical/Occupational/Speech Therapy/Audiology	30%	2.7	2.7
Respiratory Care	10%	0.06	0.06
Chiropractic Care	130%	0.5	0.5
Mammograms	54%	1.03	1.03
PAP Smear laboratory rates	53%	2.9	2.9
Breast pumps	150%	0.5	0.5
Milk banks	20%	0.02	0.02
Blood banks	70%	0.6	0.6
Wheelchair/Litter Van transportation	20%	4.6	4.6
Hearing aids and dispensing fee	100%	2.8	2.8
Home Health			
Shift nursing rates for EPSDT and Waiver services	10%	8.4	8.4
Home health agencies	10%	1.4	1.4
Institutional Providers			
Small and rural hospitals-outpatient rate supplement	NA	2.0	2.0

Long Term Care			
LTC Wage Pass-through	7.5%	67.0	65.8
LTC annual rate increase	10.1%	161.4	156.8
DP/NF one time increase	NA	10.7	10.7
Adult Day Health Care	4.54%	1.1	1.1
TOTAL		**402.8**	**397.01**

Footnotes:
1. Rate adjustments only (GF appropriations do not reflect the costs associated with expanded benefits).
2. GF appropriations include fee-for-service and managed care where applicable.
3. Rate increase percentages are expressed as averages per service category. Actual increases for specific services will be set by DHS, in consultation with stakeholders, and will vary by procedure within individual service categories. Rate increases do not overlap increases in other categories.
4. * Federal funds presumed to be 50/50. Actual FMAP adjustments included overall FMAP adjustment in the May 2000 Estimate.

09/05/2000
Prepared by the Department of Health Services, MCPD, RDB

The Mid-Year Adjustment proposed to reduce rates by 10 percent effective April 1, 2003. The January 10 budget proposed to reduce provider rates another five percent effective July 1, 2003. Combined, the budget proposes to reduce provider payments by a total of $1.428 billion. Of that, the state would save $702.510 million in GF. In many cases the provider rates would return to the levels that were paid in the middle 1980s. (See the Department of Health Services table below.)

Rates for hospital inpatient care are contracted for by the state with hospitals and are not subject to Department's authority for rate reduction. Hospital outpatient rates are excepted from the rate making authority of the Department because they are subject to a recently settled court case. Rates for Federally Qualified Health Centers are governed by federal statutes and are not subject to the rate making authority of the department.

The administration had proposed a rollback of provider rates for the 2002-2003 fiscal year. However, the Governor signed legislation that repealed the rate reduction. Reimbursement rates for Medi-Cal providers are lower than what they are in other states. The low reimbursement rate limits the number of providers that are available to Medi-Cal beneficiaries. Rolling rates back to the pre-August 2000 level, which in many cases are not much different from the levels in the mid 1980s, will undoubtedly have an impact on access to medical care for Medi-Cal beneficiaries.

Comprehensive Summary of Provider Rate Increases Since 1985

Provider/ Service Type	00/01	99/00	98/99	97/98	96/97	95/96	94/95	93/94	92/93	91/92	90/91	89/90	8	87/88	86/87	85/86
Acupuncturists	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Audiologists	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
CHDP/EPSDT: Primary Care	20.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
CHDP/EPSDT: Other Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Chiropractors	130.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Clinical Laboratories	53.0 (u)	0.0	0.0	0.0	0.0	-3.0	0.0	0.0	-1.0	0.0	0.0	0.0	0.0	-7.2	-6.0	26.3
Clinics: Birthing Centers	0.0	0.0	0.6	0.0	1.8	3.5	1.7	15.6	16.4	0.0	(i)	--	--	--	--	--
Clinics: Free &	0.0	0.0	10.0 &	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0

Community			20.0(j)													
Clinics: Surgical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Dental Services (FFS)	6.8 (v)	0.0	0.0	0.0	0.0	-27.7(a)	0.0	15.9(a)	64.7(a)	38.8(a)	0.0	5.0	0.0	0.0	0.0	5.3
Drug Dispensing Fee: Basic	0.0	7.0	0.0	0.0	0.0	0.0	-12.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Drug Dispensing Fee: Compounding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Drug/Medi-Cal	(g)	(g)	17.0	-31.0	-27.0	-23.0	7.5	-8.2	3.6	3.9	0.0	-0.7	-1.2	5.5	-0.5	0.0
Durable Medical Equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Eye Appliances	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Hearing Aids: Fitting Services	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Hearing Aids: Appliances	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Heroin Detoxification: Outpatient	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Hospital Outpatient Department: Primary Care	16.7 (t)	0.0	10.0 & 20.0(j)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Hospital Outpatient Department: Rooms	0.0	0.0	15.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Incontinence Supplies Dispensing Fee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-20.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Maxillofacial Services	6.8 (v)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	0.0	0.0	4.0
Med Supplies Dispensing Fee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Med Transportation: Air	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(b)	--	--	--	--	--	--	--	--
Med Transportation: Ambulance	0.0	11.7(l)	37.9(k)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Med Transportation: Wheelchair/Litter Van	20.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Nurse Anesthesia: Obstetrical	13.29 (t)	21.8(q)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Nurse Anesthesia: Non Obstetrical	13.29 (t)	10.5(m)	0.0	0.0	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Occupational Therapists	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Optometrists	0.0	18.1(n)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Orthodontic Services	6.8 (v)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	0.0	0.0	4.0
Physical Therapists	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Physicians: CCS/Medi-Cal	39.0 (o)	5.0(o)	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Physicians: Primary Care	16.7 (t)	0.0	10.0 / 20.0(j)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0(d)	0.0	5.3
Physicians: Vaccine Admin. Fee	16.7 (t)	0.0	20.0	0.0	0.0	90.4	--	--	--	--	--	--	--	--	--	--
Physicians: Other Medicine	16.7 (t)	(p)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: Anesthesia, Obstetrical	13.29 (t)	21.8(q)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: Anesthesia, Non Obstetrical	13.29 (t)	10.5(m)	0.0	0.0	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: Gynecology	16.7 (t)	10.5(m) & (r)	0.0	0.0	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: OB Vaginal Delivery	16.7 (t)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.8(c)	18.0	16.0(e)	26.5	5.3
Physicians: OB C-Section	16.7 (t)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-19.6(c)	0.0	0.0	26.5	5.3
Physicians: Abortions	16.7 (t)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: Other	16.7 (t)	10.5(m	0.0	0.0	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	5.3

Surgery		) & (s)														
Physicians: Radiology	16.7 (t)	10.5(m)	0.0	0.0	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: ER Medicine	16.7 (t)	0.0	0.0	25.0(h)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Physicians: ER Surgery	16.7 (t)	10.5(m)	0.0	25.0(h)	0.0	0.0	0.0	0.0	-9.5(f)	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Podiatrists	16.7 (t)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Portable X-Ray Transportation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	50.0	0.0	5.3
Prosthetics/Orthotics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Psychologists	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3
Respiratory Care Practitioners	10.0	0.0	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Short-Doyle/Medi-Cal	(g)	(g)	3.0	2.9	3.6	5.3	3.4	-4.6	3.6	11.9	2.2	8.5	5.0	4.2	2.8	4.9
Speech Therapists	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0

COMMENTS:

Long Term Care

Department of Health Services/Department of Finance:

1. Long term Care rates are set pursuant to a State Plan Amendment (SPA) filed by the Department of Health services with the Center for Medicare and Medicaid Services in Washington. The Department of Health Services has talked with CMS about the rate reduction and was told that a 15 percent rate reduction could be approved. Department of Health Services please describe for the Subcommittee what the Department would need to do in order for a 15 percent rate reduction to be effective July 1, 2003.
2. What is your assessment of the impact of such a significant rate reduction on the closure of facilities?
3. If a significant number of facilities were to close how would access be assured?

Legislative Analyst Office:

1. Relative to other factors like the increasing costs of Workers Compensation Insurance and Liability Insurance, what is your assessment of the effect of such a significant rate reduction on the closure of facilities and access to care?

All other providers

Department of Health Services/Department of Finance/Legislative Analyst Office

2. What is your assessment of the impact of such a significant rate reduction on the availability of providers?
3. Can access be maintained if significant numbers of providers no longer are willing to care for Medi-Cal beneficiaries?
4. What will be the effects of the managed care reductions on access to specialists in the health plans?
5. What will be the effects of the managed care reductions on the viability of the Local Initiative and the County Organized Health Systems?

4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 3: REINSTITUTION OF THE MEDI-CAL QUARTERLY STATUS REPORT

The Governor's Mid-Year Adjustment and the January 10 Budget proposals would permanently reinstate the requirement that all parents on Medi-Cal must file a quarterly report on their financial status as a condition of retaining health coverage in Medi-Cal.

BACKGROUND:

The requirement that individuals file Quarterly Status Reports (QSR) was repealed in 2000. Beginning in January 2001 all parents on Medi-Cal were relieved from filing QSRs and had only to report on their status once a year. The reinstitution was projected to save $5.0 million GF in the current year and $85.0 million in the budget year. The Medi-Cal rolls are projected to decline by 193,000 parents by the end of the Budget Year. (See the Department of Health Services' current draft of the Quarterly Status Report and Implementation Summary in the handout.)

Studies show that excessive reporting requirements pose significant problems for program beneficiaries. Many lose coverage – even though they still qualify - because they are unable to complete the forms, unreliable mail delivery or the paperwork is not processed correctly. The QSRs will achieve savings by erecting barriers to participation for eligible individuals that will be cut from the program.

Reinstitution of the QSR could jeopardize coverage for children. Children are guaranteed 12 months eligibility in the Medi-Cal program. Unintended computer errors could improperly terminate coverage for children when her/his parent's coverage is terminated. In addition, research suggests that providing health coverage to low-income parents helps boost the enrollment of eligible children and increases the likelihood that they will receive well-child care.

Together, the re-imposition of the QSR and the reduction in the income limit for the 1931(b) will cause 486,000 people to lose health care coverage in the budget year. The number of children who might lose health care coverage because of these actions has not been estimated by the Department of Health Services. The end result is uncompensated care at community clinics and hospitals will undoubtedly increase as they provide health care to individuals who previously had health care coverage in Medi-Cal.

COMMENTS:

Department of Health Services/Department of Finance:

1. Please describe the report Medi-Cal beneficiaries will be required to file on a quarterly basis. How difficult will it be to fill out and provide the necessary documentation? What is the time frame for beneficiaries to receive and return the completed report to maintain eligibility?
2. What proportion of those who lose eligibility would be able to successfully re-apply for Medi-Cal? What would be the major impediments to a successful re-application?

3. Will the others become medically indigent and be forced to seek charity care from safety net clinics and hospitals?

Legislative Analyst Office:

1. Has the LAO conducted an independent assessment of requiring adults to file Quarterly Status Reports?
2. Has the LAO attempted to analyze the impact of such a policy change on the availability of health care in safety net clinics and hospitals?

4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 4: RECISSION OF THE 1931(B) MEDI-CAL ELIGIBILITY EXPANSION

The Governor's Mid-Year Adjustment and the January 10 budget proposals would permanently reduce the income limit for the 1931(b) Medi-Cal expansion from 100 percent of the Federal Poverty Level to the CalWORKS income eligibility level, approximately 61 percent of the Federal Poverty Level for individuals and 75 percent for parents. The change would not affect those who are currently enrolled, it only would apply to new applicants. The State would save $235.952 million total funds ($117.976 million General Fund).

BACKGROUND:

The income limit will be reduced from 100% of the federal poverty level to the CalWORKs income eligibility level. In addition, the definition of unemployment (deprivation) will be revised to no longer allow deprivation when the principal wage earner**,** which is working 100 hours or more, has family earned income at or below 100% of the poverty level. As a result, fewer two-parent households will be eligible for the Section 1931(b) program. Parents who meet deprivation requirements but are no longer eligible for Section 1931(b) may be eligible for the Medically Needy program with a share of cost. Children may be eligible for one of the Medi-Cal Percent of Poverty programs or Healthy Families if they have a share of cost in the Medically Needy program.

The reduced income limit will apply only to those who are applying for Medi-Cal; it will not apply to those who are already in the program. If the income limit is reduced, the Department of Health Services estimates 293,000 would be ineligible for Medi-Cal in 2003-2004. The elimination of the QSRs and the reduction in the income limit for the 1931(b) will keep 486,000 off Medi-Cal in the budget year.

The two policy actions could cause the number of uninsured in the state to increase by nearly five percent. That number may be understated, however, as it is probable that some children will lose coverage when his/her parent(s) loses health care coverage from either the reinstatement of the QSRs or the reduction in the income limit under the 1931(b) expansion of Medi-Cal.

For the past few years the number of uninsured has been declining. The adoption of the Healthy Families Program and the expansions in the Medi-Cal program made significant inroads in the number of Californians without health care coverage. The proposed actions will significantly reverse the past success of reducing the number of people without health coverage. Uncompensated care and crowding at community clinics and hospitals will increase as a result.

COMMENTS:

Department of Health Services/Department of Finance

1. What problems will those who would lose eligibility under the proposal confront? Will their income level preclude them from qualifying for other programs in Medi-Cal? Would they become medically indigent?
2. Do you project a loss in enrollment of children as a result of the loss of coverage by the parents?

Legislative Analyst Office

1. What is your assessment of the impact of the loss of Medi-Cal coverage for parents be on children? Will they, too, lose Medi-Cal eligibility?

4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 5: ELIMINATION OF MEDI-CAL OPTIONAL BENEFITS FOR ADULTS

Together the Governor's Mid-Year Adjustments and January 10 budget proposals would permanently eliminate the following optional benefits from the Medi-Cal program for adults above age 21 and not in long term care: dental services, medical supplies, podiatry, acupuncture, chiropractic services, psychology, independent rehabilitation centers and occupational therapy, hospice, non-emergency medical transportation, optometry, optician/laboratory, physical therapy, prosthetics, orthotics, speech/audiology; hearing aids; durable and medical equipment.

BACKGROUND:

Currently the Medi-Cal program offers all 34 optional benefits authorized under federal law. The elimination of the following 18 optional benefits for adults would save the state $361.83 million General Fund in the budget year.

OPTIONAL BENEFITS: TOTAL FUND SAVINGS

Service	Budget Year
Adult Dental Services	$423.602 Million
Medical Supplies	$108.666Million
Podiatry	$8.682Million
Acupuncture	$5.812Million
Chiropractic	$.798million
Psychology	$.458Million
Independent Rehabilitation	$.046Million
Occupational Therapy	$.030Million
Hospice	$27.358 million
Non-Emergency Medical Transport	$62.968 million
Optometry	$18.376 million
Optician/Laboratory	$29.032 million
Physical Therapy	$.060 million
Prosthetics	$4.168 million
Orthotics	$1.280 million
Speech/Audiology	$1.456 million
Hearing Aids	$5.820 million
Durable Medical Equipment	$25.048 million
Total Savings	$723.660 Million

Dental care and medical supplies constitute nearly 70 percent of the savings to the state. For dental care the residents of long-term care facilities would not be affected by the cutback. Many individuals experience severe oral health problems and need the services. The only options for adults without the Medi-Cal coverage will be to seek emergency care in hospital rooms and community clinics. For adults that are clients of the Regional Center system the services would be reimbursed by the Regional Centers, as the benefits are part of the

Lanterman Act entitlement. There would be no federal match, the reimbursement would be 100 percent from the GF.

Medical supplies include, among others, catheters, diabetic test strips and syringes. The proposal would deny these items to adults on Medi-Cal. They each are medically necessary. The denial would subject the Medi-Cal beneficiaries to infections, illnesses and hospital visits to address the health issues that result from not having medically necessary supplies. The health care costs would be shifted from the state and federal government to the counties, clinics and hospitals, as they are the entities that pay or subsidize the health care services provided to the medically indigent.

COMMENTS:

Department of Health Service/Department of Finance

1. Please describe the phrase optional benefits – to whom or what are these benefits optional?
2. What will happen to an adult Medi-Cal beneficiary that relies on catheters when they are no longer available under Medi-Cal? Is it likely that many or some will get infections that will require hospitalization? Are these costs factored into the estimated savings?

Legislative Analyst Office

1. Has the LAO attempted an analysis of the proposed change on its effect on safety net clinics and hospitals?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 6: PROVIDER TAX ON ICF/DD AND DEVELOPMENTAL CENTERS

The Governor's Budget proposes to institute a Quality Assurance Tax on the entire receipts of intermediate care facilities and developmental centers.

BACKGROUND:

The Quality Assurance Tax would be equal to six percent of gross receipts of the facilities. The federal government will match what the state receives from the Quality Assurance Tax. Each facility would have the Quality Assurance Fee returned to it. The net proceeds (federal funds) from the fee assessed on the private facilities would be distributed on a fifty/fifty basis. The net proceeds on the public facilities, Developmental Centers, would be retained one hundred percent by the state. The private facilities would get a rate increase and the state would receive additional revenues. The state would receive $17.815 million General Fund revenue in the Budget Year

COMMENTS:

Department of Health Services/Department of Finance

1. Are the ICF/DDs subject to the 15 percent provider rate reduction?
2. What will the reimbursement increase as a result of the Quality Assurance Fee?
3. What will the net reduction be for the ICF/DDs after combining the rate reduction for providers and the rate increase for the Quality Assurance Fee?

Legislative Analyst Office

1. Do you for see any drawbacks with the proposal?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 7: TRANSITIONAL MEDI-CAL

The budget proposes to eliminate the second year of Transitional Medi-Cal for persons 19 years of age or older if they received the first year of federal Transitional Medi-Cal and met the income requirements.

BACKGROUND:

Effective October 1, 1998, California implemented a second year of Transitional Medi-Cal, pursuant to the Budget Health Trailer Bill, Chapter 310 (AB 2780), Statutes of 1998. The program is a state-only program to encourage parents to seek employment and continue their Medi-Cal benefits until they can secure employer paid benefits. The budget proposes to eliminate the state-only program, leaving the retention of one year of transitional Medi-Cal coverage. On average 1,834 monthly eligibles are expected to be discontinued. The state would save $1.974 million by implementing the discontinuance on October 1, 2003.

COMMENTS:

Department of Health Service/Department of Finance:

2. What is the policy justification for repealing the program?
3. Will these people and the associated families become medically indigent?
4. Do you foresee the loss of the second year of coverage becoming a disincentive for people to move from the Medi-Cal program to private employment and health coverage?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 8: AGED AND DISABLED FEDERAL POVERTY LEVEL PROGRAM

The Governor's Budget proposes to rollback the expansion to cover only those beneficiaries with an income up to SSI/SSP income levels.

BACKGROUND:

The Aged and Disabled Federal Poverty Level Program was established in the Health Budget Trailer Bill in 2000. The program became effective in January 2001. The program expanded zero share-of-cost Medi-Cal eligibility to aged and disabled Medi-Cal beneficiaries with income up to 133 percent of the Federal Poverty Level.

Currently individuals can have income up to $969 under this program and couples can have income of up to $1,332. Individuals will be allowed income of up to $708 and couples will be allowed $1,225. The total annual number of persons that would be affected by the reduction is projected to be 48,302 aged and 20,538 disabled beneficiaries. The state would save $63.8 million GF if the proposal were to be adopted.

COMMENTS:

Department of Health Services/Department of Finance

1. What is the policy justification for repealing the program?
2. Will these people and the associated families become medically indigent?
3. What is the cumulative effect of all of the eligibility proposals, how many people will lose health coverage under Medi-Cal and become medically indigent?