ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES AND ASSEMBLY COMMITTEE ON HEALTH

Assemblymember Judy Chu, Chair
Assemblymember Dario Frommer, Chair

Monday March 17, 2003
State Capitol, Room 4202
6:00 PM

ITEMS TO BE HEARD

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES- MEDI-CAL

ISSUE 1: 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The requirement that individuals file Quarterly Status Reports (QSR) was repealed in 2000.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.)

If the parent fails to return the QSR to the County within the 10-day response period the parent will automatically lose eligibility and the SB 87 re-determination process will not apply. SB 87 (Chapter 1088, Statutes of 2000) requires counties to take three steps prior to discontinuing a person from Medi-Cal: (1) review other case files that the county has access to; (2) attempt to contact the person by the phone; and (3) send a "request for information form" to the person, with a subsequent waiting period to allow time for response. If the parent returns the QSR to the County and the response is unclear the parent does not lose eligibility and the SB 87 re-determination process will apply. In that case the County will need to make a re-determination of eligibility for the parent. Only after the re-determination will the parent lose eligibility if income and/or assets are above program limits, otherwise the parent will retain eligibility.

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 attempted to analyze the impact of such a policy change on the availability of health care in safety net clinics and hospitals?

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ISSUE 2: RECISSION OF THE 1931(B) MEDI-CAL ELIGIBILITY EXPANSION

The Governor's Mid-Year Adjustments 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 between 61 and 75 percent for individuals that qualify as Medically Needy. 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. The 100 hour deprivation rule will also only apply to new applicants. If the income limit and the deprivation rule were adopted, the Department of Health Services estimates 293,000 would be ineligible for Medi-Cal in 2003-2004. Most parents will lose eligibility because of the 100 hour deprivation rule rather than the reduced eligibility income level. 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. Department please explain why more Medi-Cal beneficiaries will lose eligibility as a result of the deprivation standard change than because of the income eligibility reduction.
2. 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?
3. 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?

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ISSUE 3: 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. The state would save $63.8 GF dollars.

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. Are these people and the associated families likely to become medically indigent?
2. 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?

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ISSUE 4: 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:

1. Are these people and the associated families likely to become medically indigent?
2. 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?

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ISSUE 5: COUNTY ADMINISTRATIVE OVERSIGHT

BACKGROUND:

The Governor's Budget proposes to fully fund the county cost of administering the Medi-Cal Program, it would increase funding for county administration by $54.9 million ($27.4 million General Fund) in the current year and $97.2 million ($48.6 million General Fund in the Budget Year). Also, the proposal would require counties to meet rigorous performance standards as a condition of receiving the increased funding.

The budget proposes to fully fund the county cost of administering the Medi-Cal program in the budget year. By fully funding the administrative costs the budget expects to save $388 million ($194 million General Fund) in program costs resulting from caseload due to counties completing re-determinations. The re-determinations would be conducted pursuant to re-imposing the QSR, lowering the income eligibility level for the 1931(b) program and elimination of the 2nd year of Transitional Medi-Cal and Aged and Disabled Federal Poverty Level Program.

The state has not provided full funding of the Medi-Cal administrative function for the last two years. For the 2002-2003, county administrative funding was cut by one percent. The counties were not able to support staff for Medi-Cal cases, the caseload has increased and the county staff to has declined. In addition, some counties have begun layoff procedures to further reduce staff. As a result of the reduced staffing counties are not able to meet statutory performance requirements. Annual re-determinations have not been completed on time, increasing the Medi-Cal caseload. Further, some counties are not able to complete the initial Medi-Cal eligibility determinations within the 45 day requirement.

The budget proposes to fully fund the county Medi-Cal administrative costs, establish rigorous performance standards (see below) and add staff to monitor the counties performance record. The budget proposal links full funding with performance standards to give counties the incentive to meet the performance standards and enable them to continue the work they do on behalf of the state. If the counties did not meet the performance standards for eligibility determinations and re-determinations, the department may, at its sole discretion, reduce the allocation of funds in the subsequent year by two percent.

Performance Standards

- Meet the 45 day requirement to complete eligibility determinations:
  - 90% of all applications not specified below without significant applicant errors must be completed within 45 days.
  - 99% of all applications not specified below without significant applicant errors must be completed within 60 days.
  - 90% of applications with applicant errors must be completed within 60 days, exclusive of the time the applicant has the application for correction of applicant errors.
  - 99% of the applications with applicant errors must be completed within 75 days, exclusive of the time the applicant has the application for correction of applicant errors.
  - 90% of the applications for disability must be completed within 90 days.

  - 99% of the applications for disability must be completed within 105 days.
  - 90% of the newborn referral requests and the applications for pregnancy must be completed within 5 days
  - 99% of the newborn referral requests and the applications for pregnancy must be completed within 10 days.
- Perform timely annual re-determinations:
  - 90% of the annual re-determinations must be done by the end of the13th month after initial application or anniversary date
  - 99% of the annual re-determinations must be done by the end of the14th month after initial application or anniversary date

The California Welfare Directors Association states the budget does not fully reimburse the costs because the budget proposal does not provide funding for the years for which there were no cost of living increases. The foregone cost of living increases the counties have not received total $ 400 million ($230 million General Fund). Also, the county funding was reduced by a veto of $58 million ($29 million General Fund) in the current year. The counties believe fully funding county Medi-Cal eligibility would require the additional $458 million.

CWDA indicates that it is supportive of performance standards and it has recommendations to "flesh out" the Administration's proposal. Specifically, the recommendations would be aimed at: conforming to federal requirements: clarifying expectations so they are balanced and achievable within the statutory and fiscal context; and specifically outlining the review process for sampling, auditing, due process and corrective action (see handout memo to chair).

COMMENTS:

Department of Health Services please review for the Subcommittee the last three-year funding history of the county cost of administering the Medi-Cal Program. Do you agree with County Welfare Directors Association that the cost of administering the program has been under-funded for the last three years?

Department of Health Services, are there any fiscal benefits to the state or the counties if the Medi-Cal determinations are done late and re-determinations are done early? What if the order is late Medi-Cal determinations and early re-determinations?

LAO, you recommend the rejection of the proposed augmentation and the adoption of the performance and workload or productivity standards. Please review your recommendations and reasoning.

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ISSUE 6: CRAIG LAWSUIT

BACKGROUND:

The Craig Lawsuit challenged the state's implementation of SB 87 (Chapter 1088, Statutes of 2000). The legislation requires counties to take three steps prior to discontinuing a person from Medi-Cal: review other case files that the county has access to; attempt to contact the person by the phone; and send a "request for information form" to the person, with a subsequent waiting period to allow time for response. The process had been applied to most Medi-Cal cases but it had not been applied to individuals who were receiving Medi-Cal through the SSI disability system and subsequently lost that eligibility. The court determined that the statute applied to them and ordered Department of Health Services (DHS) to continue Medi-Cal benefits for most individuals discontinued from SSI/SSP until the DHS can provide the court with the a plan for doing ex-parte eligibility determination. The Department submitted a plan to the Court last December and a hearing has been scheduled for March 27, 2003 for the judge to announce whether the State's plan is acceptable. The Department estimates it will require $94 million GF in the Budget Year, an increase of $7.5 million GF from the current year, to provide Medi-Cal services to the affected beneficiaries.

The budget also contains one-time funding of $4.024 million and ongoing funding of $4.124 million for county administration in the budget year. The California Welfare Directors Association thinks the state has underestimated the time and costs associated with each case and may have underestimated the number of cases that counties will be required to process.

COMMENTS:

Department of Health Services please provide the Subcommittee with an overview of the Craig lawsuit and budget costs associated with it?

Department of Health Services do you concur with CWDA's assessment of the under-funding?

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ISSUE 7: ICF/DD AND DEVELOPMENTAL CENTER QUALITY ASSURANCE FEE

The Governor's Budget proposes to institute a six percent Quality Assurance Fee 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 GF 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

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