

**AGENDA**  
**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1**  
**ON HEALTH AND HUMAN SERVICES**

**Assemblymember Hector De La Torre, Chair**

**MONDAY, APRIL 11, 2005**  
**STATE CAPITOL, ROOM 447**  
**4:00 PM**

**ITEMS TO BE HEARD**

<b>ITEM</b>	<b>DESCRIPTION</b>	<b>PAGE</b>
<b>4260</b>	<b>Department of Health Services – Medi-Cal</b>	<b>2</b>
Issue 1	Dental Benefit Modification	2
Issue 2	Beneficiary Cost Sharing	4
Issue 3	Easing Enrollment for Children	6
Issue 4	Establish and Monitor County Performance Standards	8
Issue 5	Safety Net Hospital Financing	11
Issue 6	Intermediate Care Facilities Staffing	13
Issue 7	Disproportionate Share Hospital Program Staffing	15
Issue 8	Staffing for Medi-Cal Administrative Activities and Targeted Case Management Programs	16
Issue 9	Quality Improvement Fee	16
Issue 10	Long Term Care Integration	18
Issue 11	PACE	22
Issue 12	Medicare Modernization Act	24
Issue 13	Disease Management	29
<b>4170</b>	<b>Department of Aging</b>	<b>32</b>
Issue 1	HICAP Funding For Implementation of Drug Medicaid Changes	32

## ITEMS TO BE HEARD

### ITEM 4260            DEPARTMENT OF HEALTH SERVICES

#### ISSUE 1: DENTAL BENEFIT MODIFICATION

Commencing in the 2005-2006 Fiscal Year, the budget proposes to limit Adult Dental Services to \$1,000 per rolling 12-month period. The budget projects savings of \$48.2 million (\$24.6 million General Fund) in 2005-06. An implementation date of August 1, 2005 is assumed. This proposal requires trailer bill legislation to enact. There are nearly 3 million adults in the Medi-Cal program. Approximately 95,000 Medi-Cal beneficiaries would be subject to the cap.

Many of the affected Medi-Cal beneficiaries may be enrolled in California's Regional Center system which provides services to eligible individuals with developmental disabilities. It is very likely the Regional Center system would incur additional General Fund expenditures to provide dental services which fall above the \$1,000 cap.

#### HISTORY OF MEDI-CAL DENTAL PROGRAM CHANGES August 2000 through January 2004

Date	Program Change(s)
August 2000	Rate increase on selected procedures; exams every 6 months; cleanings every 6 months
December 2002	Adults reduced to 1 exam per lifetime per provider and cleanings every 12 months
July 2003	Elimination of posterior lab-processed crowns for adults; periodontal subgingival curettage and root planning rate reduced to \$118 (except for residents of Skilled Nursing Facilities or Intermediate Care Facilities).
October 2003	Radiographic documentation required for 4 or more fillings on claims.
January 2004	Denti-Cal allows "alternative filling" material in teeth (same rate as silver fillings).

#### Department of Health Services

Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered optional. Generally, covered dental benefits for children and adults include: diagnostic and preventive services such as examinations and cleanings; restorative services such as fillings; and oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

The \$1,000 limit would not apply in the following circumstances:

- Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions;
- Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and
- Services that are federally mandated under Code 42 of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

It is not clear what specific procedures are exempt from the cap, as well as what dental services would fall above a \$1,000 cap. For example, dentures cost \$900 but other related dental work associated with this procedure would likely fall above the cap, such as related gum work or necessary medications, or root canal work related to the denture. The Department has provided a list of 13 Medi-Cal dental services with fees that exceed \$1000 and four services with an exact fee of \$1000. In addition they have provided a number of other dental treatment sequences that would probably exceed \$1000 annually.

The budget proposes the Medi-Cal adult dental \$1,000 cap because the private sector benefit plans have such a limitation. Medi-Cal, however, is dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market and has eliminated or restricted services to enrollees due to budgetary constraints over the years.

Expenditures for each of the nearly 3 million beneficiaries will need to be tracked in order to determine when a beneficiary has or will exceed the cap. The proposal includes a request for \$4 million, \$1 million General Fund to develop a tracking system. The details of the tracking system proposal are lacking.

Many issues need to be considered if a cap is to be implemented. Among the issues needing consideration are: possible sunset date, rate adjustment factors, and the need for more preventive dental services. Also, adequate access to dental services needs to be a part of the discussion as Medi-Cal dental reimbursement rates are extremely low and placing a cap in statute without consideration for out-year implications could be counter-productive.

The Department of Health Services proposes to implement the proposal through all county letters, provider bulletins, or similar instructions. Thereafter, the Department may adopt regulations. Additionally, DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using "all county" letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 2: BENEFICIARY COST SHARING**

The Department of Health Services is authorized to collect insurance premiums. The proposal would add 3.5 positions to the Department and the initiative would cost \$2.282 million, \$650,000 General Fund. The proposal would increase Local Assistance payments by a total of \$12.394 million, \$6.197 million General Fund.

The 2005-2006 Budget proposes to establish monthly premiums for certain families, children, elderly individuals, and persons with disabilities. Effective January 1, 2007, Medi-Cal enrollees with incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage. The 100 percent of poverty threshold represents \$1,306 per month for a family of three, \$812 a month for a senior, or disabled individual, and \$1,437 a month for a couple receiving SSI/SSP. Exempted from the premium requirement are share-of-cost beneficiaries, 1931 (b) families enrolled in CalWORKS, infants under one year of age, American Indians, and Alaskan Natives.

Premium payments, with certain exceptions, would be \$4 per month for each person under age 21 and \$10 per month for other adults, with a monthly cap of \$27 per month per family. Counties would determine premium level, if any, and the Department of Health Services would contract with a vendor to conduct premium collections month.

A family of three with a monthly earned income of \$1,306 per month would pay \$24 per month for coverage or \$288 annually, representing almost 2% of total family income. Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If a dropped individual wanted to re-enroll, he or she would be required to pay back premiums owed from the previous six months in which they were enrolled.

The budget proposal will have an adverse effect on 1931 (b) families. First, the proposal would change how the existing earned income deduction will be applied for the purpose of determining premiums. This will make more 1931 (b) families subject to premiums because, for the purposes of premiums, it will raise the family income level. Second, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These recipients are generally individuals who have left CalWORKS. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Cal services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and remain eligible for Medi-Cal, if they met the 100% FPL income limitation at the time of enrollment. However if a 1931 (b) family

loses its eligibility for failure to pay premiums, the family would not be eligible to re-enroll in Medi-Cal, even if it paid back premiums, unless it was at 100 percent of poverty or below.

Approximately 550,000 people would be required to pay a premium, including 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level. In the first year the Department of Health Services projects approximately 20 percent of these individuals or about 94,630 individuals will fail to pay and become dis-enrolled. This would exacerbate the increasing ranks of the uninsured in California. The Department of Health Services assumes the dual eligibles (Medicare and Medi-Cal eligible) will not drop off because Medi-Cal pays Medicare premiums for them. If the assumptions of the Administration are inaccurate the number of beneficiaries who lose coverage will be significantly higher.

The budget projects the premiums will produce state GF savings of from \$15 million to \$23 million annually (0.1 to 0.2% of total GF expenditures for Medi-Cal). Approximately 50% of the savings would come from premium collections (net of costs) and the other 50% from savings from not having to provide services to individuals who failed to pay premiums but were otherwise eligible for continued Medi-Cal coverage. Of note, the Administration assumes that although 20% of individuals subject to premiums would drop off the Medi-Cal rolls, the projected savings would only be 2-5% of the cost of covering individuals subject to premiums, because the vast majority of care needed by those who drop off the rolls will ultimately be delivered by Medi-Cal. The Administration projects Local Assistance and State Operations expenditures of \$6.85 million in 2005-2006. That would increase to \$10.0 million in 2006-2007.

The proposal will result in a churning of enrollees and increased administrative processing costs. Individuals who lose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. This is not consistent with the Administration goals of decreasing the number of uninsured, particularly children, in the state and increasing program efficiency. Also, the proposal conflicts with current Medi-Cal policy of annual reenrollment of children aims to provide continuous coverage

The budget does not include expenditure projections for: county re-determinations; county re-enrollments; county premium re-calculation; county MEDS linkage to the vendor; and health plans options processing. Other county costs not included in the Administration's proposal are those that will be incurred in adjusting premium levels of families as income, family size, etc. change. Also, Medi-Cal re-determinations increase county costs which have not been addressed in the proposal.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 3: EASING ENROLLMENT FOR CHILDREN**

The proposed budget purpose is to improve the Medi-Cal eligibility determination process for children that apply through the Single Point of Entry (SPE) application. The SPE would become a centralized, one-stop center to make preliminary eligibility determinations for Medi-Cal applications submitted through SPE. Final eligibility determination for children-only Medi-Cal applications would shift from the counties to the State.

The net costs to the state for this proposal in 2005-06 are projected to be \$6.8 million (\$2.1 million General Fund). This includes the cost for 19.5 new state positions, as well as vendor contract expenditures and information system changes. The Administration projects savings of \$9 million (\$7 million General Fund) will be generated annually from the proposal when fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal.

<b>FY 2005-06</b>	<b>Policy Change #</b>	<b>DHS TF</b>	<b>DHS GF</b>	<b>DHS FFP</b>	<b>MRMIB GF</b>
<b>Local Assistance</b>					
Program Savings	PC 13	-\$210,000	-\$105,000	-\$105,000	
County Administration Savings	CA 19	\$2,182,000	-\$1,091,000	-\$1,091,000	
SPE Contract Costs	OA 39	\$1,150,000	\$0	\$1,150,000	\$1,150,000
<b>Total Local Assistance</b>		<b>\$1,242,000</b>	<b>-\$1,196,000</b>	<b>-\$46,000</b>	<b>\$1,150,000</b>
<b>Support Cost</b>	19.5 PYs	<b>\$6,909,000</b>	<b>\$2,172,000</b>	<b>\$4,737,000</b>	
<b>Net Impact</b>		<b>\$5,667,000</b>	<b>\$976,000</b>	<b>\$4,691,000</b>	<b>\$1,150,000</b>

Department of Health Services

Currently, joint applications for the Medi-Cal Program and the Healthy Families Program are submitted to a "Single Point of Entry" where they are initially processed by the Healthy Families Program vendor. If a child appears to be eligible for Healthy Families, the vendor determines eligibility and processes the application. However, if the child appears to be eligible for no-cost Medi-Cal, then the application is forwarded to the county welfare office where the child resides for a Medi-Cal determination by an eligibility worker. Pursuant to Federal law, Medi-Cal eligibility must be determined by either a county or the state. The county is currently responsible for Medi-Cal eligibility

determinations, sending out notices to applicants or beneficiaries regarding that determination, as well as handling questions concerning the determination or appeals regarding eligibility denials.

The budget proposal would change the processing of children's applications by authorizing a vendor to process Medi-Cal application for children received through SPE. Once processed, the vendor would send the application to the state for "certification". The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management. The Department of Health Services assumes that about 85,000 applications would be processed in this manner.

The savings proposed in the budget stem primarily from children being removed from Medi-Cal. Additional information is necessary for more complete understanding of how the Single Point of Entry will work. Specifically, issues such as information systems processing changes, coordination between the HFP vendor, state, and counties, and related matters need clarification.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 4: ESTABLISH AND MONITOR COUNTY PERFORMANCE STANDARDS**

The Governor's Budget provides resources (2.5 positions and \$297,000, \$148,000 General Fund) for the establishment of performance standards in the Medi-Cal/Healthy Families Bridge Program. Also, the Governor's Budget provides resources, (\$995,000 total funds and \$312,000 General Fund) for county performance standard verification, contract monitoring staff, and follow-up services to monitor counties and impose sanctions for not meeting performance standards. Currently, counties submit reports to the Department of Health Services annually to certify if they met all of the performance standards. There is no verification of the self-reported certifications from the counties.

The proposal would include 2.5 staff positions. One position would focus on procuring the contract in 2005-2006 and to monitor the contractor's performance thereafter. One position would be to oversee the procurement of the contract. One-half of a position would be to perform legal work relating to the implementation of County Performance standards.

In addition there would be Local Assistance of \$600,000 in total funds, \$300,000 General Fund for 2005-2006 and \$2.4 million total funds, \$1.2 million General Fund, for 2006-2007 for a three year contract for a contractor to monitor performance standards compliance. There would be \$742,500 total funds, \$372,250 General Fund, in external contracts for the Information Technology and Services Division to hire contract staff to produce management data reports. Finally, the program would generate Local assistance expenditures in the Medi-Cal and Healthy Families Programs, \$1.5 million for the Medi-Cal Bridge and \$3.1 million total funds, \$1.1 million, for the shift of children from Medi-Cal to Healthy Families.

Counties are required by federal and State law to complete initial eligibility determinations within 45 days of application and complete annual re-determinations to determine if the applicant continues to be eligible. Currently some counties are not completing the initial Medi-Cal eligibility determinations within the 45-day requirement or the annual re-determination. Effective July 1, 2003, the State adopted statutory performance standards for completion of these determinations in 2003. Failure to comply with the performance standards could result in a 2% reduction in the county administration funding. These same standards would be adopted for the bridge.

The Legislature enacted the county performance standards in 2003, in conjunction with increased funding for counties to perform initial eligibility determinations and federally required annual re-determinations, as well as manage cases as needed throughout the year. The performance measurement system was implemented in 2004, requiring corrective action plans for counties that fail to meet any of the five required performance standards. Counties that enter into corrective action plans and do not make progress face the 2% penalty.

The Legislature also approved the creation of nine new state staff at the Department of Health Services to validate county-reported performance data and provide technical assistance to counties as needed. The positions were, however, never filled, and ultimately were eliminated in order to comply with overall state budget reductions. Other Departmental staff absorbed the workload associated with gathering data reports and monitoring performance standards.

The budget proposal would permit the Department to hire a contractor. The contractor would be authorized to:

- Receive and analyze performance standard reports from counties;
- Validate the performance standard reports;
  - ✓ Select counties for case review based upon the self-reports
  - ✓ Select Counties for case reviews based upon trend data or other information that indicates that counties may not be in compliance with the performance standards;
  - ✓ Select counties for case reviews on a random selection basis to determine if counties are meeting the performance standards;
- Require corrective action plans when any such county case review indicates that a county is not meeting the performance standards;
- Provide technical assistance to counties to help improve operations and understanding of program requirements;
- Share best practices among the counties to become more effective and efficient in meeting the performance standards;
- Attend county corrective action meetings, as needed; and
- Provide documentation to, and make recommendations to, the Department for reduction of a county's administration fees by two percent for counties that do not meet one or more of the performance standards.

The County Welfare Directors Association believes the duty of monitoring county performance should remain at the state level. Counties worked with state staff and advocates to implement the performance standards, which have now gone through a full cycle of reporting, corrective action, and re-reporting. The few counties that entered into corrective action plans in early 2004 were able to improve their performance over the past year, showing that the system is working.

The Welfare Directors note that the Department of Health Services already operates a Program Review Section, which conducts periodic, ongoing reviews of county performance as well as ad hoc reviews as needed, such as counties are reviewed on case error rates, as well as implementation of newly enacted programs and compliance with court settlement agreements. In addition the Welfare Directors Association have identified tools the state could provide the counties to assist families in bridging from Medi-Cal to HFP. The tools include:

- ✓ Update all relevant forms and provide instructions to counties: The application forms as well as the annual re-determination forms which are presently used do not ask parents for consent to share information between programs. As such, the overwhelming majority of parents whose children are not eligible for no cost Medi-Cal must be contacted. In turn, the counties contend that no standard instructions have been provided to counties for how this parental consent is to be obtained and documented (i.e., to show the state “performance”).
- ✓ Streamline County Packaging of Materials: Once parental consent is given to share information across programs, counties must copy the annual re-determination form and “notice of action” form, complete a transmittal form, package the documents together, and mail them to the HFP administrative vendor. The HFP vendor then mails an application to the individual because the HFP vendor will not accept the annual re-determination form as an application for the HFP. As such, the counties are seeking to have the state re-examine these existing procedures to streamline the process.

For placeholder trailer bill language it is recommended to: adopt the Administration’s three proposed performance standards for the bridge as proposed, except clarify that the performance standards will not commence until 60-days after the revised applicable forms are available; add language to require the State to develop procedures in collaboration with the counties and stakeholder groups for developing implementation instructions for the bridge by no later than September 1, 2005; add language to require the state to issue by no later than September 1, 2005 a revised annual re-determination form that includes a section for parental consent to be provided; add language to require the state to streamline methods of providing the necessary information for Healthy Families to make an eligibility determination; and delete language that enables a contractor to perform county monitoring activities in lieu of state staff.

The funding for the effort is proposed as follows: approve four Associate Governmental Program Analyst positions for expenditures of \$400,000 (\$200,000 General Fund), including benefits and operating expenditures, and delete the remaining funding intended to fund a half-time Staff Counsel III position and vendor contract for monitoring. These two positions can be used to address both the revised forms and streamlining needs identified above, as well as for overall county performance monitoring purposes.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 5: SAFETY NET HOSPITAL FINANCING**

The Department proposes to add 12 staff positions in the 2005-2006 for work on the Hospital Financing Redesign (HFR) component of Medi-Cal Redesign. The proposed expenditures are \$1.49 million total funds, \$686,000 General Fund.

The Medi-Cal system, currently used to reimburse hospitals for the care they provide, must be changed. The status quo is not possible because the current system is funded by a mechanism that the federal government considers unacceptable. Center for Medicare and Medicaid Services (CMS) has indicated it will not approve any waiver that uses "unacceptable" IGTs. Specifically, CMS will not approve any waiver that contains an Intergovernmental Transfer (IGT) that has the effect of increasing the Federal Medical Assistance Percentage over 50 percent, or where either the State or a county "recycles" a portion of the IGT or federal funds back to the general fund in excess of the cost of providing healthcare to Medi-Cal beneficiaries. To address this problem, California is proposing to change its reimbursement methodology to a cost-based system using Certified Public Expenditures (CPE).

A new reimbursement system is necessary to accommodate the change from the current reimbursement system to a CPE-based system. This new system will apply to the 21 public hospitals, and will require a new system for interim rate setting, claiming, and monitoring. Interim rates will be established for each of the 21 public hospitals based on the most current filed and audited cost reports, and other financial data available from the hospitals. The rates will be reviewed and updated on at least an annual basis. Payments made to hospitals based on CPEs represents only a portion of the revenue each hospital will receive to cover costs under the HFR waiver. The remaining supplemental payments will be based on the spending limits as outlined in the HFR waiver and will require the Department to monitor all payments to each hospital to ensure compliance.

The selected components of the Hospital Financing Redesign proposal will:

- Be a demonstration waiver that will serve as the reimbursement mechanism for hospitals over the next five years;
- Continue the state program to contract with hospitals for Medi-Cal patients;
- Expand Medi-Cal to incorporate, by waiver, the public indigent care services of the University of California and many counties throughout the state;

- Include a broader base of services to include hospital outpatient services, ancillary services , as well as services provided to Medi-Cal and indigent beneficiaries in public clinics;
- Replace some Intergovernmental Transfers with Certified Public Expenditures;
- Modify the establishment of the federal limit on payments (upper payment limit) to take into account all inpatient hospital services whether delivered on a fee-for-service or managed care basis. and
- Provide opportunities for increased federal reimbursement.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 6: INTERMEDIATE CARE FACILITIES STAFFING**

The Intermediate Care Facility for Persons with Developmental Disabilities – Continuous Nursing (ICF/DD-CN) was established by AB 359 (Aroner, Chapter 845, Statutes of 1999). The program is a pilot that requires the Department to explore more flexible models of health care facility licensure to provide continuous skilled nursing care to medically fragile developmentally disabled individuals in the least restrictive setting. The budget proposes to extend four limited-term positions that are currently scheduled to expire January 1, 2006. The positions would be extended to January 1, 2008, the sunset date of AB 359.

In 1971, the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) was established in California, the ICF/MR program has been further classified into subgroups. Two of these subgroups, Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) and Intermediate Care Facility for the Developmentally Disabled –Nursing (ICF/DD-N), provide beneficiaries with community placement in a 4 to 15 bed facility. AB 359 establishes a third ICF/DD category that will provide continuous (24-hour) skilled nursing care to medically fragile developmentally disabled infants, children and adults in a residential community setting.

The pilot program was established and began enrolling beneficiaries in April 2002. To date the program has not been in place long enough with enough providers to assess the effect of the program on the health, safety and quality of life of the individuals and the cost effectiveness of the care. The extension of the pilot program until 2008 would allow sufficient time for the program to be fully evaluated and steps taken to include the program for the Medicaid State Plan or transition of the beneficiaries to alternative placements.

ICF/DD-CN Pilot Project consumers differ from other ICF consumers in that they have a specific set of clinical conditions requiring continuous, 24-hour nursing observation and intervention. The difference between CN pilot project consumers and consumers in other ICF's is not really related to differences in specific disability types so much as differences in the combination of disabilities and co-morbidities which cause a consumer to require 24-hour, continuous nursing care, versus intermittent but recurring personal care, habilitation, developmental, and/or supportive health services.

The following defines the minimum clinical criteria necessary for authorizing ICF/DD-CN services:

- Consumer's condition has stabilized to the point that acute care is not medically necessary; **and**
- Consumer's condition warrants twenty-four hour nursing care by a licensed nurse which would be inclusive of nursing assessment, interventions with documented outcomes; **and**
- Any one of the following items:
  - i. A tracheotomy with dependence on mechanical ventilator;
  - ii. Dependence on a tracheotomy that requires nursing intervention such as medication administration, suctioning, cleaning inner cannula, changing tracheotomy ties or tube care;
  - iii. Continuous or daily intravenous administration of therapeutic agents, hydration, or total parenteral nutrition via peripheral or central line;
  - iv. Peritoneal or hemodialysis;
  - v. Decubitus ulcer care stage three and above or skin care that requires frequent nursing observation and intervention with substantiating documentation;
  - vi. Chronic instability of medical condition occurring daily or more often and requiring skilled nursing assessment and subsequent nursing intervention, **or**
- Administration of two treatment procedures listed below:
  - i. Nasal or oral suctioning at least every eight hours and room-air mist or oxygen any part of the day;
  - ii. Tube feeding either continuous drip or bolus every shift
  - iii. Five days per week of inpatient physical, occupational, or speech therapy, singly or in combination, provided directly by or under the direct supervision of a licensed therapist.

The four positions proposed to be extended are responsible for the implementation, monitoring and evaluation of the pilot program.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES**

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**ISSUE 7: DISPROPORTIONATE SHARE HOSPITAL OVERSIGHT**

The budget proposes to add two fulltime, permanent positions in the Medi-Cal Operations Division (MCOB) of the Department of Health Services. In addition, the budget proposes to add two limited term positions for 18 months in the Medi-Cal Policy Division.

The two positions in the MCOB would be in the Construction/Renovation Reimbursement Program. The program consists of 32 hospitals that are eligible for reimbursement for bond debt service related to an Medi-Cal eligible project. The program budget for the current year is approximately \$129 million. The program was designed to assist hospitals that serve a disproportionate share of the Medicaid and uninsured population, in renovating, replacing or retrofitting facilities in order to better serve the community. The state's share of the debt service is directly related to the percentage of the hospital's inpatient Medicaid. A portion of the calculation used in the methodology for an individual's hospital reimbursement utilizes the percentage of the hospital's inpatient Medicaid to total days. The percentage is then applied to the hospitals debt service payments, in order to determine the State's portion of the debt service obligation.

The staffing augmentation is to address new workload and existing workload that has not been completed. The program involves debt-service payments that are subject to dispute, overpayment and litigation. Staff from other programs has been assigned to address various audit and legal issues of disputed payments when available. The dependence on temporary staff has caused delays of up to a year for settlement.

The two limited term positions in the Medi-Cal Policy Division to address changes required by the Federal Health Insurance Portability and Accountability Act, confirm findings of the Office of Inspector General from the Federal Department of Health and Human Services regarding total Medi-Cal expenses and develop a method to obtain the information, and work off the disproportionate share backlog of payments to qualifying hospitals.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES**

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**ISSUE 8: STAFFING FOR MEDI-CAL ADMINISTRATIVE ACTIVITIES AND TARGETED CASE MANAGEMENT**

The Governor's Budget provides resources to address the increased workload within the Medi-Cal Administrative Activities (MAA) and the auditing requirements in the Targeted Case Management (TCM) program. The funding is through the Local Governmental Agencies (LGA) reimbursement contract and matched with federal funds, \$938,000, \$469,000 in reimbursements from Local Government Agencies and \$469,000 in federal funds. No general funds are required.

Local governmental agencies (LGA's) and counties contract with the Department of Health Services for reimbursement of federal funds for the costs of providing services for which federal funds are available. These contracts finance local outreach; facilitating Medi-Cal applications; Medi-Cal non-emergency, non-medical transportation; contracting for Medi-Cal services; program planning and policy development; MAA coordination and claims administration; MAA implementation training; and TCM.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES**

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**ISSUE 9: QUALITY IMPROVEMENT FEES**

The Legislative Analyst Office noted in its analysis of the budget that \$294 million in revenues from the quality improvement fees had inadvertently been omitted from the budget.

The schedule of estimated state revenues for the Governor's budget plan reflects an assumption of \$120 million in collections of the nursing home fees in the current fiscal year and an additional \$257 million in the budget year. However, the LAO reviewed the state revenue projections and determined that the revenues from the quality improvement fees for ICF-DDs and Medi-Cal managed care plans had not been included in the schedule of revenues for the Governor's budget plan. That means that General Fund revenues are currently understated in the Governor's budget plan by a combined total of \$294 million for the current and budget years.

The LAO states federal Medicaid law permits states to impose quality improvement fees on certain health care service providers and, in turn, offset the increased cost to the providers from the fee through increased reimbursements. The Legislature has approved and the state has fully implemented with federal approval a quality improvement fee for Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs). The state is currently in the process of seeking federal approval to implement a separate quality improvement fee on Medi-Cal managed care plans as well as another fee affecting nursing homes which serve Medi-Cal patients.

Implementation of such fees can be a lengthy process because it generally involves seeking federal approval of a Medicaid State Plan amendment, a federal waiver of Medicaid law, or both. As a result, implementation of the fee for Medi-Cal managed care plans has previously been delayed, and under the Governor's 2005-06 budget plan would be further delayed until July 2005. The LAO suggests that it is a reasonable assumption that the new fee finally will be implemented on that projected date, and that it is appropriate that the budget plan presented by the Governor assumes that the associated revenues will be deposited in the General Fund during 2005-06. The LAO further notes that the Bush administration has recently proposed to limit these types of fees and change how they are applied.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES****ISSUE 10: LONG TERM CARE INTEGRATION**

A cornerstone of the Administration's Medi-Cal Redesign effort is the expanded use of managed care delivery systems. The Administration is proposing to increase access to care and improve health outcomes through expansion of Medi-Cal managed care plan options. This would be accomplished by expanding the geographic areas in which managed care is available and the population groups within Medi-Cal who are enrolled in managed care.

The Administration proposes to implement a new program—the Acute and Long-Term Care Integration Program (ALTCI) through trailer bill legislation. As proposed in the trailer bill legislation, the program would be an expansion of the Medi-Cal Managed Care Program, and not simply a pilot project for three county areas (Contra Costa, Orange and San Diego. Today, managed care is available to Medi-Cal beneficiaries in 22 counties.

The language provides the Department of Health Services complete discretion as to how the ALTCI would operate including any federal waivers or any state plan amendment it choose to make, and it provides that they can implement, interpret, or make specific any aspect of the program by means of all county letters, all plan letters, or provider bulletins, or similar instructions.

When Medi-Cal Redesign is fully implemented, managed care plans will be available to Medi-Cal beneficiaries in 35 counties. Families and children in 13 additional counties will enroll in managed care plans and seniors and persons with disabilities will enroll in managed care plans in all counties in which managed care is available (seniors and persons with disabilities are currently required to enroll in the existing 8 counties served by a County Organized Health System (COHS)). One component of the Medi-Cal managed care proposal includes establishing Acute and Long Term Care Integration health plans in three counties.

Several counties throughout California have been actively engaged in Long Term Care Integration (LTCI) planning and development of integrated local service systems. The Legislature authorized LTCI grants as a result of state and local interest in creating more efficient delivery of medical, social and supportive services. The first state funded LTCI grants were awarded July 1999. Grants supported the establishment of local stakeholder groups followed by feasibility reviews that included evaluating the availability of local community LTCI services, and service gap analysis. A total of \$2,658,021 has been awarded to 16 counties between 1999 and 2004. Many early grantees generated significant local interest for integrated systems but lacked sufficient resources and expertise to support the development of LTCI projects. A state-level approach is needed to allow for consistent criteria including performance standards and

measures for all participating health plans, which will improve oversight options and will also improve probability for federal approval. Both Contra Costa and San Diego counties have sustained ongoing planning and development activities and succeeded in earning the first Implementation Grant awards totaling \$897,507 for the 2004-2005 Budget Year.

ALTCI plans will provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities and will incorporate primary, acute and long term care services, including home and community-based services and providers in their networks. Integration of medical and social supports across the full scope of Medi-Cal benefits and Medicare benefits (for those who are eligible) will provide the consumer the option of enrolling in one health plan instead of seeking out multiple programs and services to meet various health and social service needs. Integration of medical and social supports also provides the State the opportunity to streamline the funding and administration of multiple programs and to reduce overlapping services while improving efficiency. The ALTCI plan standards will be designed specifically around the health, social and supportive service needs of seniors and adults with disabilities.

Integration of Medi-Cal and Medicare funding and services will occur at the health plan level. The State has no role in the administration of Medicare funding. ALTCI health plans must be approved as Medicare Plans (referred to as Medicare Advantage Plans) that include the new Medicare prescription drug coverage. The state will be working with potential ALTCI plans and with the federal Centers for Medicare & Medicaid Services (CMS) to determine the appropriate federal agreements to provide ALTCI consumers with the most efficient coverage of drugs under an integrated Medi-Cal and Medicare system. By requiring ALTCI plans to also be Medicare plans, the State provides the opportunity to ensure the best use of the member's federal Medicare benefit. ALTCI plans will be reimbursed through a capitated payment from the State for Medi-Cal services and a capitated payment from the federal Centers for Medicare and Medicaid Services (CMS) for Medicare services for eligible members. The Medi-Cal rate setting methodology will be carefully structured to assure appropriate reimbursement and incentives for health plan success in meeting the goals of the ALTCI model.

Coverage under the integrated plans will be comprehensive and will expand on the successes of traditional Medi-Cal managed care models. The following table displays the expanded coverage:

Traditional Managed Care Coverage	ALTCI Coverage
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits	Medi-Cal Scope of Benefits
	Expanded Care Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Care Management will have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services
	Mental Health Services
	Home and Community-Base Services (home modifications, personal emergency response systems, nutrition, others necessary to avoid or delay inpatient nursing facility care.)

Integrated Medi-Cal and Medi-Cal/Medicare plans provide new opportunities to address the unique health care needs of seniors and adult persons with disabilities who are generally high-cost and high frequency users of health care. ALTCI health plan comprehensive coverage will be designed to help individuals maintain independence and avoid the need for inpatient nursing facility care whenever possible. The intended goal of these health plans will be to keep people healthy and actively involved in their homes and communities for as long as possible. Additionally, participating health plans will be designed to assist those currently in nursing facilities to pursue community living and supports in an independent living environment.

The ALTCI model will be implemented in three counties to facilitate modifications on a smaller scale should they become necessary and to validate the model before it is implemented statewide. The ALTCI proposal also includes the development and testing of a Long Term Care Diversion and Assessment Protocol to assess and divert individuals from costly long-term nursing facility care.

The United Domestic Workers of America have raised a number of questions about the Acute and Long Term Care Integration Program. They include:

1. Is it contemplated that the managed care provider would be required or have the option of offering IHSS services?
2. What role would independent providers and contractors have in this situation?
3. Would ALTCI access the revenue now supporting IHSS?
4. Would counties still be required to put up 35 per cent of the non-federal costs?
5. What role would county social workers have in ALTCI? Would the managed care provider provide case management services in partial substitution for what social workers now do and would be doing under the quality assurance program now being developed?
6. Current law requires that clients be able to choose their own providers. How would this be maintained if ALTCI were adopted, particularly under the proposed "default" enrollment of IHSS clients?
7. How would DHS ensure that all clients are served, without being placed on waiting lists?
8. DHS indicates it would finance ALTCI plans through "actuarially determined rates that cover the full array of services." Yet, the state has not conducted any rate studies of IHSS costs as required in 42 U.S.C. §1396a (a) (30) A). In determining rates, would DHS continue existing requirements for provider rate studies, which require the participation of all stakeholders, under this redesign?
9. How would existing contractual arrangements be preserved in San Diego, Orange and Contra Costa County?
10. What assurances can DHS provide that San Diego, Orange and Contra Costa counties would have sufficient experience to serve the combined 37,000 IHSS clients and their caregivers, and that none would be placed on waiting lists, in violation of federal law?

11. What is there that applying managed care to IHSS services will save money when compared to the existing delivery systems, including homemaker, public authorities and consortia, the contract mode?

The budget contains \$928,000 in Other County Administration for up to two implementation grants of up to \$500,000. The combined total of the grants cannot exceed \$928,000.

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**ITEM 4260**                      **DEPARTMENT OF HEALTH SERVICES**

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<b>ISSUE 11: PACE</b>
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PACE, Program of All-inclusive Care for the Elderly (PACE), serves seniors in need of nursing home care. With broad range and intense coordination of services provided by PACE, these seniors are able to remain at home and in their communities. PACE provides comprehensive medical and long-term care services, with the program's interdisciplinary team fully coordinating these services. Two-thirds of the program's funding comes from the federal government, through Medicare and Medicaid capitation payments. PACE:

- ✓ Addresses consumers desire to remain in the community as long as possible, the heart of the Olmstead decision.
- ✓ Serves population in need – dual eligibles who are nursing home certifiable (NHC).
- ✓ Successfully integrates acute and long-term care for improved outcomes and provides consumers with a single interdisciplinary team for care coordination.
- ✓ Provides savings to the Medi-Cal program when compared to a comparable population.
- ✓ Provides an infrastructure for community-based geriatric services.

PACE providers and the National PACE Association have successfully worked with the Centers for Medicare and Medicaid Services (CMS) and State Medicaid agencies to implement PACE nationally. The National PACE Association is a leader in developing resources to support States and providers interested in implementing PACE. For

example, the National PACE Association is spearheading an effort to adapt PACE to rural areas.

California has been a pioneer in PACE development, beginning with On Lok Senior Health Services in San Francisco in the early 1970s and later with PACE replication sites. In 1986, Congress authorized a federal demonstration program – PACE – to replicate the successful model of care developed by On Lok. Seeing PACE’s proven high quality and cost-effectiveness, Congress set up PACE as a permanent provider under Medicare and Medicaid in The Balanced Budget Act of 1997. In 1998, AB 2583 (Shelley) expanded the number of authorized sites in California from five to ten. In 2002, AB 798 (Shelley) was chaptered to make the PACE program a permanent optional benefit under the Medi-Cal program. Yet only four PACE programs now operate in California:

- On Lok in San Francisco
- Center for Elders Independence in Oakland
- Sutter Senior Care in Sacramento and
- AltaMed Health Services Corporation in Los Angeles.

Together, these programs have 13 PACE Centers in different low-income communities, serving over 1,700 seniors. Downey Regional Medical Center is currently finalizing a PACE application with the Department of Health Services, Office of Long-Term Care (DHS-OLTC) to implement a PACE program. Community Eldercare of San Diego, an affiliate of St. Paul’s Senior Homes and Services, and other California providers want to develop PACE programs or expand their PACE programs.

#### **Current Concerns:**

**Staffing limitations at the DHS-OLTC-- organizations interested in developing PACE and existing programs seeking to expand are being told they cannot.**

Nonprofit organizations who have invested resources to develop a PACE program are delayed and have no assurance that their applications will be processed and approved. Current PACE providers are unable to expand service areas; thereby impacting the efficiency of their operations and their ability to grow their census and serve more seniors in need. In one community, a local entity is willing to fund the development of a PACE center on behalf of the PACE program but moving forward without some assurance carries significant financial risks. Furthermore, many local entities previously interested in establishing a PACE program have been discouraged in pursuing this line of business due to the lack of resources available to process applications. PACE has been criticized as not being a “scalable” program. However, many more seniors could be enrolled in the PACE program if DHS would expand current sites and establish new sites in the State.

In 2001, with bi-partisan support, both houses and the budget conference committee approved a budget item authorizing \$100,000 for Departmental staff. Unfortunately, this amount was blue-penciled from the budget. In 2002, with bi-partisan support, both houses and the budget conference committee approved a budget item authorizing \$100,000 General Fund for DHS staff. In September 2002, Governor Davis signed the budget including this budget item. DHS was not able to fill these positions prior to across-the-board staff reductions.

**Although PACE is a leader in acute and long-term care integration, PACE is not specifically included in the Governor's Medi-Cal Redesign Proposal.**

PACE, an innovator in integrated care, is an important option for seniors with serious medical conditions and disabilities who wish to remain in the community. The integration of PACE into larger managed care efforts is critical to continuing the success of a proven model. In addition, lessons learned from PACE can benefit the development of larger systems. For example, On Lok, with funding from the California Endowment, is working with federal and state regulators, PACE and other integrated providers and consumer groups on a project to streamline the regulatory oversight for PACE and other integrated providers. As part of this effort, a task force is exploring what quality indicators are important for seniors and persons with disabilities.

## **ITEM 4260            DEPARTMENT OF HEALTH SERVICES**

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### **ISSUE 12: MEDICARE MODERNIZATION ACT**

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) became law on December 8, 2003. The MMA makes significant changes to the federal Medicare Program. The scope of the Act is broad and it will be years before all of its provisions are implemented and its effects understood. The implications of the Federal Medicare Part D drug program will be significant for the dual eligibles – beneficiaries who are eligible for both Medicare and Medi-Cal benefits. In addition to the Medicare Part D prescription drug benefit, the MMA also includes a number of other benefit changes.

The dual eligibles are individuals who are entitled to Medicare and who are eligible for some form of Medi-Cal benefits. There are approximately 1.1 million dual eligibles in the Medi-Cal Program. Dual eligibles tend to be in fair or poor health due to chronic illnesses and conditions. Because dual eligibles are eligible for Medicare, they are the Medi-Cal recipients most significantly affected by Part D.

The Governor's budget plan would reduce General Fund expenditures for the Medi-Cal Program by about \$747 million (\$1.5 billion all funds) in the budget year in recognition of the savings to the state from no longer providing a drug benefit to the dual eligibles under Medi-Cal. These savings would be partially offset by a new payment that the state will have to make to the federal government known as a "phased-down state contribution" or, more commonly, as a "clawback". This clawback payment is estimated to be \$646 million General Fund in the budget year. As a result, the General Fund effect upon the Medi-Cal Program from the new Part D drug benefit is projected to result in net savings of about \$100 million General Fund in 2005-06. The estimate of net savings is misleading when other factors relating to implementation of Part D have been taken into account.

The new Part D drug benefit will result in savings of about \$100 million General Fund in 2005-06, but will probably be a losing proposition for the Medi-Cal Program beyond the budget year. This is partly due to the so-called clawback provision written into the new federal law, and the specific way this provision is being interpreted and implemented by CMS. The clawback provision and other important changes resulting from MMA probably mean that, after a short-lived one- to two-year gain, the Medi-Cal Program will end up experiencing large net financial losses for at least several years afterward.

The LAO estimates that the combined effect of the reduction in drug expenditures, the clawback payments, and the loss of drug rebates associated with the dual eligibles will result in cumulative additional General Fund costs to the state through 2008-09 of about \$758 million. The following table provides the LAO estimates of the fiscal effect that the MMA will have on Medi-Cal Program finances over the next four years.

<b>Figure 10</b>				
<b>Fiscal Impact of New Medicare Drug Benefit</b>				
<b>As Reflected in the Governor's Budget Plan<sup>a</sup></b>				
<i>(In Millions)</i>				
	<b>2005-06</b>			
	<b>(Half-</b>	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>
	<b>year)</b>			
Reduced Drug Costs	-\$747	-\$1,617	-\$1,818	-\$2,043
Clawback	646	1,428	1,574	1,737
Reduced drug rebates	—	273	620	705
<b>Annual Impact</b>	<b>-\$101</b>	<b>\$84</b>	<b>\$376</b>	<b>\$399</b>
<b>Cumulative Impact</b>		<b>-\$17</b>	<b>\$359</b>	<b>\$758</b>
A 2006-07, 2007-08, and 2008-09 figures are LAO estimates.				

Legislative Analyst Office

As pointed out above, dual eligibles are the Medi-Cal beneficiaries that are most directly affected by the implementation of Medicare Part D. The LAO notes that the new program has some potential pitfalls for dual eligibles whose drug coverage would be shifted from Medi-Cal to Medicare. In some cases, these individuals may not be able to get the same drugs under Medicare that they now get under Medi-Cal, with unknown medical consequences. As a result, the state faces the difficult choice of whether to continue their state-supported drug benefits without any further financial support from the federal government.

Factors related to Medicare Part D implementation that could increase cost pressures on the state are summarized in Figure 11.

<b>Figure 11</b>	
<b>How the Medicare Part D Benefit Could Be Costly to Medi-Cal</b>	
<b>Annual Cost</b>	
<b>Wrap-Around</b> Under existing state law, the state provides wrap-around coverage.	Unknown, potentially low hundreds of millions of dollars.
<b>Clawback Effect</b> Provision requires the state to pay the federal government back most of the state's savings from no longer providing drug coverage to dual eligibles.	\$646 million in 2005-06.
<b>Reduced Drug Rebates</b> The state's drug rebates will be reduced because fewer drugs will be purchased.	\$273 million beginning in 2006-07, and larger amounts thereafter.
<b>Supplemental State Rebates</b> The state's ability to negotiate supplemental drug rebates with pharmaceutical manufacturers may be negatively affected when the volume of drugs that the state purchases decreases.	Unknown, potentially up to tens of millions of dollars.
<b>County Administration</b> Creates additional workload in county welfare offices by requiring them to do eligibility determinations for Medicare Part D low-income assistance.	Unknown.
<b>Woodwork Effect</b> May result in increased Medi-Cal caseloads because county welfare offices will have to screen people applying for low-income Medicare Part D assistance for some Medi-Cal low-income assistance programs.	Unknown, probably relatively small.

Legislative Analyst Office

However, MMA does not allow California or other states to keep all of these savings. The measure includes a clawback provision that requires states to pay back most of their estimated savings to the Medicare program to help pay for the Part D benefit.

States are required to pay the federal government 90 percent of their estimated savings in calendar year 2006. During the following nine years the clawback percentage is reduced by 1.66 percent per year until it reaches 75 percent, then remains set at that level.

Beginning in January 2006, California is required to make a monthly clawback payment that is to be deposited into a federal government account. The amount of each state's monthly payment is determined by a complex formula with several components, including the amount the state spent on drugs covered by Part D for dual eligibles in calendar year 2003 on a per-person basis and the rebates received by a state from drug manufacturers.

The CMS has issued final regulations that will determine how the clawback formula will be applied to each state. The DHS concluded that the regulation adopted by CMS unduly disadvantages California by overstating the true net costs it had incurred in the past for providing prescription drugs to dual eligibles—a key component of the federal clawback formula. The DHS found that the proposed clawback formula inaccurately calculates the rebates collected from drug suppliers for 2003 by using the dollar amount of rebates collected in 2003. The department indicates a more appropriate calculation, which would have taken into account rebates collected in 2004 that would reduce the state's clawback payments by \$91 million a year. Although the regulations have been finalized, the CMS has not yet determined the amount of the state clawback payment. The deadline for the CMS to announce state clawback payments is October 15, 2005.

A point noted earlier is that DHS' budget proposal assumes that the rebates the state receives from drug manufacturers will decrease by about \$273 million in 2006-07 as a result of the implementation of the Part D benefit and dual eligibles receiving their drugs under Medicare instead of Medi-Cal. That \$273 million decline in rebates represents only the partial-year effect of Part D implementation. The estimate for the full annualized loss of Medi-Cal rebate revenues could be more than \$620 million in 2007-08.

In addition to the direct reduction in rebates, the implementation of Part D could reduce the state's bargaining power with drug manufacturers for drug rebates under the Medi-Cal Program. The anticipated decrease of more than 50 percent in the amount of drug purchases being made under the fee-for-service component of Medi-Cal as a result of dual eligibles shifting from Medi-Cal drug coverage to Medicare drug coverage could weaken DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions of dollars annually.

Certain state agencies and groups of medical providers who provide services to Medicare beneficiaries have historically built the costs of drug coverage into their operations. For example, the cost of providing prescription drugs is embedded in the rates that the state now pays to certain Medi-Cal managed care providers, and in funding for developmental centers operated by the Department of Developmental

Services (DDS) and state hospitals operated by the Department of Mental Health (DMH).

The implementation of Medicare Part D means that the drug costs in these programs will decrease as drug costs for Medicare patients shifts to the new Part D program. The LAO notes the budgets for these other programs have not been adjusted in the Governor's budget plan to reflect these potential savings. Their rates and funding levels could be adjusted to reflect this anticipated decrease in their drug costs. The LAO estimates that fully recognizing these adjustments for the startup of Medicare Part D drug coverage could collectively result in significant General Fund savings as much as \$100 million in 2005-06, and as much as \$200 million annually by 2006-07.

## **ITEM 4260 DEPARTMENT OF HEALTH SERVICES**

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### **ISSUE 13: DISEASE MANAGEMENT**

The Legislative Analyst Office notes that disease management is a set of interventions, such as using patient education programs to promote preventative self-care, designed to improve the health of individuals with chronic conditions (lasting a year or longer) such as diabetes, chronic heart failure, and asthma. More than 30 other states have implemented various types of Disease Management (DM) programs since at least 1995. Based on indications that the implementation of such programs can reduce patient utilization of high-cost services, such as emergency rooms and hospitals, the Legislature provided nearly \$100,000 General Fund for three staff as part of the *2003-04 Budget Act*. Related budget implementation legislation, Chapter 230, Statutes of 2003 (AB 1762, Committee on Budget), required DHS to apply for a federal waiver to initiate DM pilot projects within the Medi-Cal Program.

The table below shows the range of potential savings that could be achieved in Medi-Cal fee-for-service expenditures for several medical conditions that are commonly targeted for DM services. We estimate, for example, that a 1 percent reduction in costs for five chronic conditions often targeted for disease management services could result in annual savings of \$15 million (\$7 million General Fund). A 10 percent reduction in costs for these same five diseases could result in estimated savings of \$153 million (\$76 million General Fund).

<b>Figure 12</b>				
<b>Expenditures and Potential Savings on Conditions Commonly Targeted by Disease Management Programs</b>				
<i>Fiscal Year 2003 (In Millions)</i>				
<b>Disease</b>	<b>Cost to Treat Condition</b>	<b>Potential Savings From Reductions in Costs</b>		
		<b>1 percent</b>	<b>5 percent</b>	<b>10 percent</b>
Asthma/respiratory infections	\$510	\$5	\$26	\$51
Diabetes	458	5	23	46
Renal function failures	247	2	12	25
Chronic obstructive pulmonary disease	181	2	9	18
Depression	137	1	7	14
<b>Totals</b>	<b>\$1,533</b>	<b>\$15</b>	<b>\$77</b>	<b>\$153</b>

Legislative Analyst Office

The Governor's proposed budget includes \$4 million in 2005-06 (\$2 million from the General Fund) for two contracts to establish disease management services. This funding is in addition to the three staff previously provided for implementation of the pilot project. The Governor's budget plan does not assume any Medi-Cal savings from the implementation of the pilot program in 2005-06. According to the LAO, the Department of Health Services has indicated that this is because it is not yet certain that the pilot projects will result in savings. Notably, some Medicaid programs in other states have encountered difficulties in trying to quantify the savings, if any, that have resulted from their DM program.

The Department has been working with an existing contractor to define the general categories of patients likely to benefit from DM services. This determination is based on the type and severity of a Medi-Cal beneficiary's disease and historical hospital utilization related to that disease. Based on this review, DHS has concluded that the population that best meets these criteria is aged persons as well as blind and disabled persons over 21 years of age who receive care from fee-for-service health care providers. The state's DM program will focus on Medi-Cal beneficiaries who are not also enrolled in the Medicare program, given that the federal government, rather than the state, now bears most of the costs for medical services for persons with dual enrollment in Medi-Cal and Medicare.

The LAO notes the department intended to release by fall 2005 a Request For Proposal (RFP) to identify a vendor or two to provide medication management services, coordinated care management, risk assessments, and development of outcome measures necessary for the operation of a DM program. The RFP is to be structured to guarantee savings to the state, or at least to ensure that the program results in no additional costs to DHS. If a vendor does not achieve an agreed-upon level of savings, the state will not pay some or all of the fees owed to the vendor. The department has not announced a specific date or the award of the contract.

The Department is seeking a waiver from the federal government that will enable it to focus the provision of DM services on this specific population, and now assumes it will receive approval of the waiver by May 2005. The pilot project is expected to begin July 1, 2005 and to continue for three years.

One component of the redesign of Medi-Cal proposed by the administration in the *2005-06 Governor's Budget* is to broaden the enrollment of aged, blind, and disabled Medi-Cal beneficiaries in managed care. Thus, the redesign could potentially affect some of the same fee-for-service beneficiaries that are being targeted for DM services. To the extent that managed care plans choose to offer DM services as a means to hold down medical costs, there exists in theory the possibility that the state could pay twice for DM services for the same beneficiaries—once through payments to a managed care plan and again through payments to a DM services contractor who is participating in the state's pilot projects.

The LAO notes that for this reason, it will be important to coordinate the expansion of DM services and the expansion of managed care to ensure that no such overlap occurs. However, the Department has not yet provided the Legislature any information regarding the potential fiscal and programmatic interactions between the redesign of Medi-Cal and the DM pilot program. Absent such information, the Legislature does not have any way to assess whether such an overlap in services will be avoided.

The Legislative Analyst Office recommends the Legislature approve the \$4 million (\$2 million General Fund) requested by the administration in the 2005-06 budget proposal. This will enable DHS to continue with implementation of the pilot program. Also, the LAO recommends that the Legislature direct DHS to report at budget hearings on the potential fiscal and programmatic interaction between the DM pilot project and the proposed Medi-Cal Redesign. The department should explain how it will ensure that it does not pay twice for the same DM services for aged, blind, and disabled Medi-Cal beneficiaries who would be shifted into managed care.

**ITEM 4170 DEPARTMENT OF AGING****ISSUE 1: HICAP FUNDING FOR IMPLEMENTATION OF DRUG MEDICAID CHANGES**

The Department of Aging's HICAP program will have difficulty helping California's 4.1 million Medicare recipients enroll in the new federal drug program.

**BACKGROUND**

The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA), became law on December 8, 2003. The MMA makes significant changes to the federal Medicare program. The scope of the legislation is so broad that it may be years before all of its initiatives are fully implemented and its overall ramifications are completely understood. The measure will have a number of significant fiscal effects, positive and negative, on various state programs.

The MMA created the new Part D prescription benefit. Medicare will begin to pay for outpatient prescription drugs through private plans as of January 1, 2006. Medicare beneficiaries entitled to Part A or enrolled in Part B are eligible to enroll in part D and receive the new prescription drug benefit. For most Medicare beneficiaries, the initial open enrollment period will run from November 15, 2005 through May 15, 2006. Medicare beneficiaries who prefer not to have prescription drug coverage can choose not to sign up for the new benefit. Signups for drug coverage will be permitted after the May date. However, beneficiaries who choose to pass on enrolling during this initial period may face a late enrollment penalty.

The federal Centers for Medicare and Medicaid Services (CMS) and Social Security Administration (SSA) will soon launch a major media campaign to encourage Medicare beneficiaries to enroll in Medicare Part D prescription drug benefits. Beginning in November 2005, approximately 4.1 million California Medicare beneficiaries will make enrollment decisions for the Part D benefit. As a result, demand for local Health Insurance Counseling and Advocacy Program (HICAP) services is expected to dramatically increase.

Over 1.1 million individuals that are "dual-eligible", who are entitled to Medicare Part A and/or Part B and who are also eligible for some form of Medicaid benefit, will have only one month, from Nov 15 to Dec 15, to choose a Part D plan. Otherwise they are enrolled automatically in a randomly chosen plan, which may or may not cover the medications they need.

The CDA received \$765,000 in additional federal funds for HICAP in the current year. The Administration has requested additional funding for Part D consumer education, but the amount of addition federal funds that will be provided is unknown. The CDA and

HICAP will face a tremendous need for individual consumer counseling on Part D in 2005-06.

HICAP is a volunteer-supported program that provides consumers with information about Medicare, related health care coverage, and long-term care insurance. In 2004, HICAP fielded 90,000 consumer phone calls, 40,000 of which resulted in insurance counseling appointments. This figure is expected to increase substantially in the last few months of 2005 when 4.1 million Californians receive MMA enrollment information.

Although a total of \$900 million in federal funds were provided by Congress for MMA advertising, outreach, education, and other implementation efforts, only \$31.7 million was provided for local HICAP efforts across the nation in Federal Fiscal Year 2005. Of that amount, California received only \$765,000, and this funding has already been spent in the current year. Much of the federal funding is used by the federal Centers for Medicare and Medicaid Services (CMS) to operate a toll-free telephone line to answer consumer questions. However, in many cases consumers calling this line are redirected to local HICAP offices for individual counseling.

The budget proposes to use \$93,000 in existing federal funds to establish 1.0 permanent position to develop training and program standards for the HICAP, which will provide consumer information on the federal Medicare Modernization Act. Although the CDA previously contracted with consultants for these types of activities, it now indicates the need for ongoing specialized expertise and closer management oversight. Total funding for HICAP is \$6.8 million in the current year and \$6.0 million in the budget year. Funding in 2005-06 does not reflect any additional federal funds for MMA consumer education.

The Department of Aging has submitted a request to the federal government for additional federal funds for HICAP.

#### **STAFF COMMENT**

The Subcommittee should consider whether the existing HICAP program would be able to address the needs of 4.1 million MediCare recipients that will need guidance to select the appropriate drug coverage that meets their needs.