AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER PATTY BERG, CHAIR

MONDAY, APRIL 14, 2008
STATE CAPITOL, ROOM 127
4:00 P.M.

2400 DEPARTMENT OF MANAGED HEALTH CARE

The Department of Managed Health Care (DMHC) was established in 2000, when the licensure and regulation of the managed health care industry was removed from the Department of Corporations and placed in a new, stand-alone, department. The mission of DMHC is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These 94 Health Care Plans provide health insurance coverage to approximately 64 percent of all Californians. Recent statutory changes also make DMHC responsible for the oversight of 240 Risk Bearing Organizations (RBOs), who actually deliver or manage a large proportion of the health care services provided to consumers. Within the Department, the Office of the Patient Advocate helps educate consumers about their HMO rights and responsibilities.

The Governor proposes $44.3 million (all special fund) in total expenditures and 297.3 positions for the department – an increase of $121,000 compared with the current year and no net change in positions.

Health Plan Oversight Staff Increase. The budget proposes to extend 2.0 limited-term positions for another two years at a cost of $196,000 to address workload related to the review of required health plan filing submissions.

The Office of Health Plan Oversight reviews new license applications and regulatory filings. In 2006-07 the Legislature approved 9 permanent and 2 limited-term positions to improve processing times for licenses and material modifications of existing plans. As a result of this staffing increase, review times have decreased. For example, material modifications of existing plans dropped from 116 days in 2003 to 67 days in 2007. The department indicates that it needs to continue the limited-term staff in order to maintain these shorter review times. No issues have been raised regarding this proposal.

ISSUE 1: REGULATORY AND ENFORCEMENT EFFORTS—INFORMATIONAL

The department plays a key role in making sure that millions of Californians who receive health care through managed health care plans receive quality care, the appropriate scope of coverage, and fair and expeditious dispute resolution.

Update on Regulatory Activity

On March 5, 2008, the Office of Administrative Law (OAL) rejected, on procedural grounds, DMHC regulations related to timely access to health care services. The DMHC also has submitted new draft regulations related to unfair billing patterns (balance billing) – these are narrower than the draft regulations under discussion over the past year that also addressed reasonable and customary payment and other related issues.

Effect on Future Budget Needs. Both of these draft regulations project they would not have a fiscal impact on the department, although it would seem they could affect the volume of certain complaints and dispute resolution requests.

Enforcement Update

Post-Claims Underwriting. Post-claims underwriting is the practice of canceling coverage (usually after some significant claim is made) based on an alleged past error or omission on the application for coverage. Since 2006, DMHC has been investigating health plans that issue individual policies as part of a non-routine survey. DMHC met with five plans during March 2008 to provide an overview of deficiencies detected during this survey process as required by law. DMHC is developing a corrective action plan to remedy past violations. It is anticipated that a public report will be issued by June 2008 that will discuss plan deficiencies and proposed remedial actions. During 2007-08, approximately 3 personnel-years of staff have been dedicated to the ongoing enforcement and survey activities. Although DMHC indicates that it has sufficient resources to conduct these activities through the end of the current fiscal year, the department is in the process of assessing the workload attributed to future post-claims underwriting activities.

Discount Health Plans. Since 2004, DMHC has opened 54 cases involving discount entities and has taken 7 actions to prevent fraudulent or unlicensed plan activities. To date, one discount health plan has been licensed and five other license applications are being reviewed at this time. During February 2008, DMHC circulated draft regulations to interested parties. DMHC is currently evaluating comments received to date. DMHC will make necessary adjustments in response to comments, and anticipates adopting the regulation package this year. During 2007-08, approximately one personnel-year of staff has been dedicated to the ongoing enforcement, licensing, and rulemaking activities. Although DMHC has sufficient resources to conduct these activities through the end of the current fiscal year, DMHC is in the process of assessing the workload attributed to future licensing activities. The licensing activities may increase substantially when final regulations (e.g., application forms and standards) are adopted in the future.

STAFF COMMENTS

DMHC should briefly update the subcommittee on its current rulemaking and enforcement efforts discussed above and their potential workload impacts.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: QUARTERLY STATUS REPORTS

The Governor's Budget proposes to eliminate annual continuous eligibility for children and semi-annual reporting for parents, and, instead, require families to submit status reports on a quarterly basis (three times during their eligibility year plus the federally-required annual eligibility redetermination). Failure to file a quarterly status report (QSR) would result in disenrollment without any actual redetermination of eligibility. Disenrollment also would occur if a filed QSR indicates that the family (or the children in the family) no longer qualify for Medi-Cal because their income has increased beyond the eligibility limits (also assets for parents) or they have left the state. These January budget proposal estimated combined General Fund savings of $97.4 million in 2008-09 from these changes.

The January budget proposal has the following two components (savings shown are General Fund; there also would be an equal reduction in federal matching funds):

1. $83.5 million savings from elimination of continuous annual eligibility for children and making them subject to QSRs.

2. $13.9 million savings from requiring quarterly, rather than semiannual status reports from parents.

The savings estimate primarily results from the disenrollment of an estimated 157,400 children from Medi-Cal, generally for the failure of their families to return a QSR. This level of disenrollment assumes that 37 percent of the affected families will fail to return a quarterly status report and be dropped from the rolls. The Governor's proposal requires: (1) statutory changes; (2) emergency regulation authority; (3) changes to county eligibility systems; (4) increased county administrative workload; and (5) a Medi-Cal State Plan Amendment.

Excluded Medi-Cal Categories. The QSR proposal would not affect: (1) women who are pregnant and enrolled in the Medi-Cal eligibility "pregnancy" aid codes (however, women who are enrolled in the 1931 (b) family eligibility category and then become pregnant would be affected by this proposal); (2) CalWORKS-linked families (who must meet CalWORKS reporting requirements); and (3) persons in aged, blind or disabled eligibility categories.

2008-09 Savings Now Less. These savings and caseload reduction estimates assumed March 2008 enactment of legislation and that savings would start July 1, due to the time needed to prepare mailings and receive responses. The department now indicates that it is assuming a July 1 enactment date with a lower savings amount in 2008-09 since savings would not begin until November 2008.

The QSR Process. Under the budget proposal, families participating in Medi-Cal only (non-cash aid) would be required to complete quarterly status reports every three months even if there is no change in the families' circumstance. Medi-Cal coverage would be discontinued if the form is not returned within 60 days.

The specific steps are as follows:

1. The county must send a "notice of action" to a family's home if the QSR has not been returned after 20 days.

2. If no changes, the family checks on box, signs the form and returns it in a self addressed envelope. If there is a change, the family describes the change and provided documentation of the change (1 check stub for income).

3. The family then has 10 additional days to return the QSR.

4. After the 10 days, eligibility is put in a "hold" status for 30 days so that special approval is needed to obtain services.

5. If the family submits the QSR during this process, eligibility is restored as well as enrollment in their health plan with no break in eligibility and no new application.

6. Disenrollment occurs if the QSR has not been filed when the 30-day hold period expires or when the beneficiary is determined no longer to be eligible.

Families and children, who respond to the QSR with inaccurate or incomplete information, are subject to a mandatory Medi-Cal eligibility review. Generally, this requires that in instances when Medi-Cal eligibility has been terminated on one basis, a review must be conducted to determine if the individual is eligible for Medi-Cal in a separate category or to determine if other information available to the county can be used to verify eligibility for Medi-Cal in a separate category or to determine if other information available to the county can be used to verify eligibility for Medi-Cal. Therefore, some of the returned QSRs will need to be re-evaluated by County Welfare Departments, including an "ex parte" review of any other case files the county has on the child or family, attempted telephone contact, and a Medi-Cal form 355.

Background—Existing Annual Enrollment for Children. California is currently among 15 states that provide annual eligibility for children. Currently, children determined eligible for Medi-Cal are enrolled for coverage for one year (i.e., until an annual re-determination form is submitted). The annual redetermination form is a comprehensive document and requires County Welfare Department review and approval. Annual enrollment for children has been in operation for over 7 years.

Background—Existing "Semi-Annual" Eligibility for Parents. Currently, parents determined eligible for Medi-Cal must submit a semi-annual status report to continue enrollment after six months. At the one-year anniversary of enrollment, parents must submit a comprehensive annual redetermination form to continue enrollment. Families are also required to report any changes in income, assets, and related items within ten days during their enrollment period. Semi-annual reporting for parents has been in place for over 5 years (plus about two-years of annual eligibility).

QSRs Will Increase "Churning"

The department's projected caseload reduction from the imposition of QSRs results simply from assumed rates of non-filing. The majority of non-filers, however, actually would continue to meet Medi-Cal eligibility requirements. Consequently, many who would be dropped from the rolls will reapply when they need services. For example, many public and other hospitals have county eligibility workers on site to facilitate enrollment of eligible persons who show up at the emergency department. It is anticipated that a significant number of those who are disenrolled will re-enroll in a relatively short time. Moreover, under federal law, Medi-Cal has 90-day retroactive eligibility, so that even when covered services are provided to person who is not currently enrolled, Medi-Cal must pay for those services if the person enrolls within 90 days. The disenrollment/re-enrollment cycle is referred to as "churning."

Churning is Expensive and Detrimental

A 2005 report entitled *How Much Does Churning in Medi-Cal Cost?* examined the stability of children's enrollment in both Medi-Cal Fee-for-Service and Medi-Cal Managed Care. Specifically, the study analyzed Medi-Cal data on children who are disenrolled and subsequently reenrolled, and the costs to the state of processing and re-processing applications for the same eligible children. The report found that about 20 percent of the children in the study were disenrolled at least once in the course of the three years of data analysis, but subsequently regained Medi-Cal coverage. Most of the children disenrolled from Medi-Cal and subsequently re-enrolled, did so *within four months.* The fact that the breaks in Medi-Cal coverage were relatively short suggests that children probably remain eligible and lost coverage for other reasons, such as failure to return paperwork. Based on information provided by the Administration, the study identified about $200 in costs per child (in 2005) for processing children into Medi-Cal and subsequently into Medi-Cal Managed Care. This means that California spent over $120 million to re-process eligible children over a three-year period or about $30 million annually.

CWDA Analysis of Current Semi-Annual Reporting. Additional information recently has been provided by the County Welfare Director's Association (CWDA) regarding the mid-year status reports currently filled out by parents receiving Medi-Cal, and what happens to individuals whose eligibility is discontinued due to an incomplete report or failure to return the report at all. CWDA worked with three of the four county SAWS consortia, representing approximately 85 percent of the statewide caseload, to analyze longitudinal data on adults whose cases were discontinued due to these factors. Their analysis found that of the 34,194 adults whose cases were discontinued in May 2007 due to either an incomplete or missing mid-year status report:

- 22,393 or 70 percent of the adults were back on Medi-Cal by mid-February 2008; and

- Ninety percent of those 22,393 cases had actually returned to Medi-Cal *within the first 90 days* after being discontinued.

These findings are consistent with longstanding anecdotal information from counties – that “most cases” come back onto Medi-Cal within a short period of time – and that they do so because they were not actually ineligible at the time they were discontinued from the program, but they just failed to submit a complete mid-year status report on time. These data also are consistent with research on “churning” within California’s Medi-Cal and Healthy Families programs and also on the impact of paperwork and reporting requirements in other states’ programs.

Budget Provides No County Administration Funding for "Churning." Clearly, administration of the QSR process and of the resulting additional eligibility determinations due to churning will impose a cost on counties. Nothing has been budgeted for this cost, which the LAO estimated at #23.1 million (GF). The department, however, argues that it has indirectly funded QSR administration and churning costs by not applying an additional reduction to county administration funding for the QSR caseload reduction. However, the budget does not include an actual estimate of these costs or the caseload administrative savings that would be available to cover those costs. Furthermore, the budget eliminates normal county funding for cost-of-doing business increases, overall caseload growth and makes an additional 2.5% cut to county administration.

BACK TO THE FUTURE: REDUCED ENROLLMENT BUT HIGHER COSTS

The basis of the department's savings estimate is an "unwinding" of some of the caseload increases that occurred in 2001-02 as a result of the following policy changes:

- Expansion of the entry income level for 1931(b) family eligibility to 100% of poverty became effective March 1, 2000--increased number of parents enrolled.
- Continuous eligibility for children became effective January 2001.
- Elimination of QSRs for parents became effective January 2001.
- The SB 87 *ex parte* redetermination process for families leaving CalWORKS became effective January 2001.

Specifically, the department went back to its estimates of the caseload increases due to continuous eligibility and elimination of QSRs in 2001-02 and essentially reversed them to generate its current caseload savings estimate. However, the department's savings estimate overlooks what happened to the average cost-per-eligible during this caseload expansion. Figures 1 and 2 below show what happened to caseload and to costs during this expansion (using data directly from the 2002 and 2003 May Medi-Cal Estimates).

Figure 1

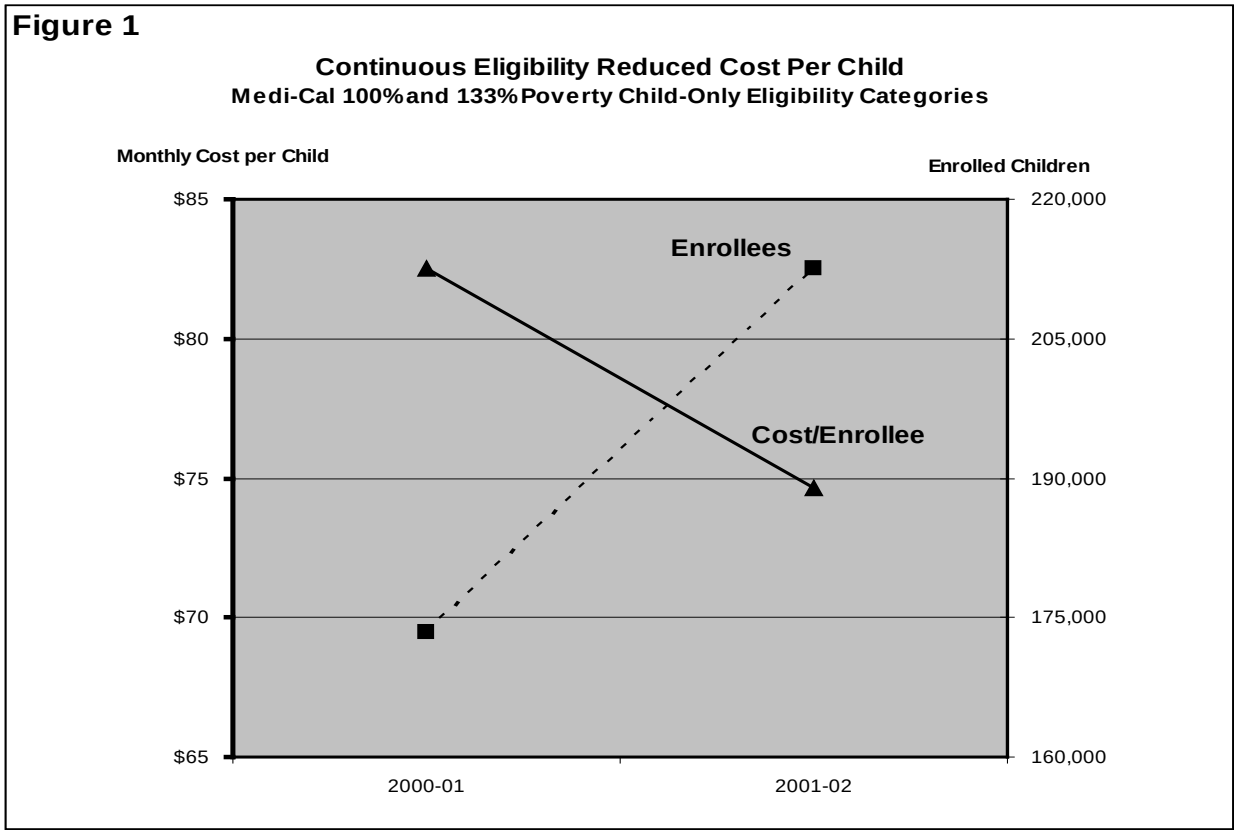
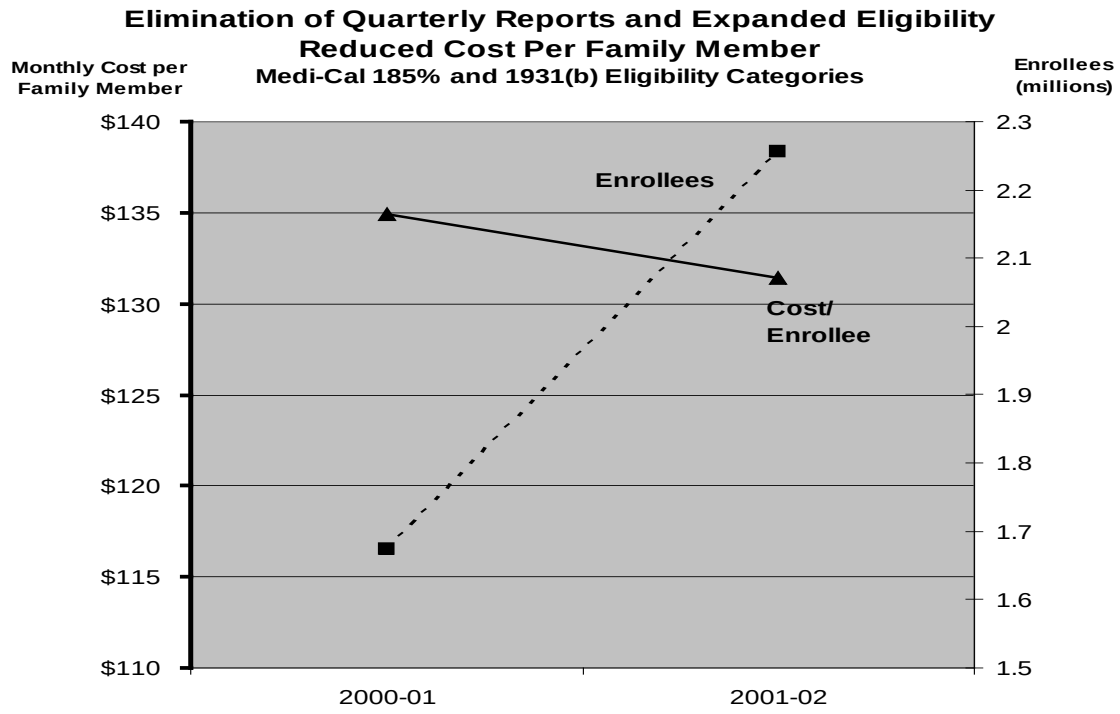


Figure 2



Continuous Eligibility Reduces Cost-Per-Eligible. Figures 1 and 2 clearly illustrate that the caseload increases in 2001-02 were accompanied by reductions in the monthly cost-per-enrollee for both children and families. The basic reason for this is simple: Reduced churning. Much of the caseload increase represented "fill-in" months during which enrollees were generally healthy and cost little. Also, continuity of enrollment allowed longer periods of enrollment in managed care—avoiding some of the use of expensive emergency room and other episodic services that occurs more frequently when enrollees churn in and out of coverage. Overall monthly costs per enrollee decreased by 9.5 percent for the child-only groups and by 2.6 percent for the family groups in 2001-02. However, the fee-for-service cost component dropped much more dramatically—by 21.9 percent and 10.2 percent, respectively.

Unwinding the Cost Reduction Negates the Caseload Savings

In order to complete the department's estimating methodology, the caseload reductions from re-instating QSRs should be offset by increasing the cost per eligible month for the remaining caseload—unwinding the cost reduction that accompanied the 2001-02 caseload expansion. This calculation results in a General Fund cost increase of $90.7 million (on a full-year basis). This amount is similar to the budget caseload savings of $97 million (full year). All of these calculations are somewhat speculative since they assume that what happens in 2008-09 will be similar to what happened in 2001-02 (only in reverse). However, it is clear that reinstating QSRs is unlikely to result in any significant state savings and would put additional burdens on county welfare departments when their normal funding is being cut.

Other Approaches May Be Worth A Look

Certainly, during any period, whether 6 months or a year, some children and families enrolled in Medi-Cal no longer qualify for—and may no longer need or use—Medi-Cal. For example, a parent may get a better job that both pays more and has good family health coverage, or a family may move out of the state. However, there are alternative approaches that should be explored to identify these enrollees without simply throwing eligible children and families off the rolls if they fail to return a form. Examples include the following:

1. Using the Medi-Cal third-party liability system to identify enrollees who appear to have obtained regular health coverage. These enrollees could be contacted and asked if they have gotten a new job and if their income has changed.

2. Using the federal PARIS system to identify enrollees who have moved out of state.

3. Performing additional data matches with EDD and other state data systems to identify enrollees who may no longer qualify for or need Medi-Cal so that they can be contacted on a selective basis.

STAFF COMMENTS

1. DHCS should address the issues of churning costs and county administrative costs.

2. DHCS should also respond to the feasibility of the other potential approaches to caseload.

3. CWDA should address the administrative costs of churning.

ISSUE 2: LAO ALTERNATIVE: CENTRALIZE ELIGIBILITY DETERMINATIONS

The LAO's alternative budget includes a proposal to centralize some types of Medi-Cal eligibility determinations at the state, rather than the county, level. LAO estimates that this would save $75 million annually, beginning in 2009-10. LAO originally presented this option in their *Analysis of the 2003-04 Budget Bill.*

In the 2003-04 *Analysis*, LAO raised the possibility of shifting the task of processing Medi-Cal applications from the counties to the state on a gradual basis to avoid disruption of these functions. For example, DHCS could begin such a transfer of responsibility by processing all Medi-Cal applications currently coming into the "single point of entry," operated in conjunction with the Managed Risk Medical Insurance Board (MRMIB).

Single Point of Entry Increases Cost and Can Delay Medi-Cal Determinations

LAO's 2003-04 *Analysis* pointed out that in 1999, the state implemented what is known as a "single point of entry" to process all Healthy Families applications and Medi-Cal applications for children and pregnant women (for whom there are simply income tests). The purpose of this process was to improve coordination between the Medi-Cal and Healthy Families programs. Applicants who qualify have one application to fill out and one place to send it. They don't have to figure out first exactly which program they qualify for. The single point of entry provides a uniform, centralized process for receiving, processing, and tracking applications for enrollment in one of the programs.

While this approach has simplified enrollment for potential eligibles, the manner in which it has been implemented has increased the cost of Medi-Cal determinations and can delay the process. This is because applications have to go through a two-step process. First, they are submitted to the single point-of-entry for an initial eligibility determination. Those applications initially determined to be eligible for Medi-Cal are next forwarded to the applicants' counties of origin, where county eligibility workers continue to make final eligibility determinations for Medi-Cal beneficiaries. In contrast, applications for individuals initially determined to be eligible for the Healthy Families Program or AIM are processed directly by the state. The state pays a contractor for each application that it forwards to the county for further processing. The state cost of this process was estimated to be nearly $1.4 million in 2003-04. This two-step process can also delay the processing of applications and granting of Medi-Cal eligibility because of the addition of the contractor's processing time and the time it takes to mail the applications to the counties.

Under the LAO's unified approach, the state would funnel application data into a centralized computer system and state employees would make final determinations of eligibility rather than continuing the present practice of forwarding Medi-Cal applications to the counties for further action. Establishment of a state-level system for Medi-Cal eligibility would open the way for a simpler and quicker processing of applications using the Internet-based system called *Health-e-App*. In this limited centralization, applicants could still apply directly to their county welfare department, and counties would still perform the more complex eligibility determinations for families, the elderly and disabled, and for long-term care.

- ***Advantages Cited by LAO.*** Under a complete centralized approach, DHCS could achieve administrative efficiencies, such as reduced computer programming costs from changes in Medi-Cal eligibility codes. Instead of 58 counties making the programming changes, only the state would make the modifications. That would reduce the cost per eligible for Medi-Cal eligibility determinations to a level more in line with those of the Healthy Families Program. While the exact level of these savings is unknown, they could be significant. For example, a $50 drop in the cost of each eligibility determination would save about $150 million in General Fund support. Conducting eligibility determinations at the state level would also ensure greater uniformity in processing applications.

- ***Disadvantages Cited by LAO.*** Transferring this responsibility from the counties to the state would be a difficult and complex task that would temporarily require an increase in state resources.

CWDA Critique of LAO Proposal. CWDA contends that the current LAO recommendations are based on a flawed, outdated and incomplete analysis that failed to consider the past impacts of Medi-Cal administrative underfunding, the outcomes of federal and state reviews of the program, the complexity of Medi-Cal eligibility determinations, workload increases associated with these determinations, and other factors.

According to CWDA, some of the problems with the 2003-04 LAO analysis include the following:

CWDA Claims that Savings Are Overstated. While the LAO admits that any savings from this proposal would not be achieved until future years, its estimated level of savings is highly optimistic. First, the LAO compares Medi-Cal costs with the cost of California's Healthy Families program, but the two programs are not comparable. Healthy Families costs far less per case because it is far simpler than Medi-Cal, which has more than 120 separate aid codes, regulations that have not been updated in 15 years, and includes confusing, and sometimes contradictory, rules. While Healthy Families provides coverage only for children, Medi-Cal covers children, families, pregnant women, and individuals who are aged, blind and disabled. Further, the Healthy Families contractor is able to use the budget and income calculations performed by county Medi-Cal staff, so part of the contractor's work is actually done by the counties.

At the time it first proposed this shift in 2003-04, CWDA notes that the LAO also recognized that the transfer would be complex, would need to be phased in over time, and would require a temporary *increase* in resources. None of this is mentioned in the "alternative budget" proposal.

STAFF COMMENTS

1. MRMIB and DHCS—please describe the current operation of the single point of entry with respect to the Medi-Cal and the Healthy Families Programs and how the single point of entry interacts with the county welfare departments.

2. LAO, DHCS and MRMIB—What would be the savings from centralizing eligibility determination for children and pregnant women at the single point of entry? How much would this speed up Medi-Cal determinations for those applicants?

3. CWDA—what specific types of problems would result, in your view, from allowing state employees to make Medi-Cal eligibility determinations for children and pregnant women at the single point of entry?

ISSUE 3: MEDICARE PART B PREMIUMS FOR SHARE-OF-COST ENROLLEES

The Governor proposes to eliminate Medi-Cal payment of the Medicare Part B Premium for individuals who are enrolled in Medi-Cal with a share-of-cost *and* who do not meet their share-of-cost in any month. Specifically, the DHCS would no longer pay the Part B premium of about $100 per month for individuals enrolled in Medi-Cal with a "share-of-cost" who qualify for Medicare but do *not* meet their monthly share-of-cost requirement under the Medi-Cal Program. There is no federal requirement to pay Part B premiums for these individuals, and the federal government does not contribute to this payment (since the payment is for federal Medicare coverage).

There are about 57,000 individuals, primarily aged, blind or disabled who would be affected by this proposal. These individuals would either need to pay the Part B Premium on their own to maintain the Medicare outpatient services coverage, *or* pay out-of-pocket for outpatient medical services until they meet their share-of-cost requirement in Medi-Cal. If an individual meets their Medi-Cal share-of-cost requirement, Medi-Cal then pays for any excess medical costs in that month and would pay the person's Part B Premium the *following* month.

DHCS estimates savings of $66.5 million (all General Fund) in 2008-09 with an implementation date of July 1, 2008. The proposal requires trailer bill legislation. LAO also included this savings in their alternative budget.

Background on Medicare Part B Premiums (Outpatient Services). Currently, California participates in a "buy in" agreement with the federal government whereby Medi-Cal pays the federal Medicare Part A (inpatient) *and* Part B premiums (outpatient) for all Medi-Cal enrollees who qualify for the federal Medicare Program. This "buy-in" reduces Medi-Cal costs because the federal government then pays the total cost for all Medicare-covered services. With respect to the Part B Premium Program, Medi-Cal automatically pays Part B premiums for all Medi-Cal enrollees who have Medicare Part B entitlement in the following groups:

- Full-scope Medi-Cal recipients, who are currently both Medicare Part B entitled and Medi-Cal eligible with no share-of-cost.

- Medicare Savings Program individuals, who are not on Medi-Cal, but who qualify for Medicare premium payments under federal income and asset rules.

- Medi-Cal "share-of-cost" individuals who are Medicare entitled but whose adjusted income exceeds the Medi-Cal income limit for no share of cost. This is a "state-only" program. There is no federal requirement for the payment of Medicare premiums for this group of individuals. (This is the group that is proposed for elimination by the DHCS if they do not meet their monthly share-of-cost. Generally, Medi-Cal share-of-cost individuals have income levels that are too high to qualify for full-scope Medi-Cal services at no cost to them; therefore, they need to spend out-of-pocket for some of their health care costs before Medi-Cal starts paying.)

DHCS contends that Medi-Cal does not realize net General Fund savings through the payment of Part B Premiums for share-of-cost individuals. The DHCS states that these individuals have an average share-of-cost of *over* $500 per month (i.e., the person has to spend this much on medical expenses before Medi-Cal pays) and the average outpatient cost for this population is less than $300 per month, so Medi-Cal pays nothing. Fiscally, there is no reason for the state to pay $100 monthly premium for no state benefit. Under the budget proposal, if an individual meets their share-of-cost, the state would then pay the Part B Premium for the month following the first month that they meet the share-of cost and then continue until they don't meet their share-of-cost. The DHCS believes this approach is cost-beneficial because outpatient costs which would be "owed" by Medi-Cal would be shifted to the Medicare Program. According to DHCS data, about 16 percent of the existing share-of-cost individuals actually meet their share-of-cost each month.

It should be noted that the DHCS has not provided any details as to how their proposal would functionally operate if adopted by the Legislature.

STAFF COMMENTS

1. The Subcommittee may want to consider an approach whereby the state continues to pay an individual's Part B Premium if their share-of-cost is *under* $500. For example, individuals with a $200 monthly share-of-cost have monthly incomes of $820 ($9,840 annually). As such, a monthly Part B Premium represents a considerable cost for these aged and disabled individuals, as does paying their share-of-cost. This safety net approach would reduce the Administration's savings by roughly $4.6 million (General Fund) but would help ensure that very low income, aged and disabled individuals are assisted.

2. DHCS should explain how its proposal would work and discuss the feasibility and advisability of the "safety net" approach discussed above.

3. Maintaining Part B coverage also assists providers. First, providers sometimes write off the share-of-cost amounts for low-income patients who would have a lot of difficulty paying it. Part B coverage provides a payment source. Furthermore, providers receive 80 percent of the full Medicare rate for Medicare-covered Part B services (the 20-percent patient copay is waived for persons on Medi-Cal) whereas they would receive generally much lower payments from Medi-Cal for amounts above the share-of-cost.

4270 CALIFORNIA MEDICAL ASSISTANCE COMMISSION

The California Medical Assistance Commission (CMAC) negotiates hospital contracts on behalf of the Medi-Cal Program and it negotiates Medi-Cal managed care rates for the Geographic Managed Care delivery models that operate in San Diego and Sacramento Counties.

The Governor's Budget for 2008-09 requests $2.6 million ($1.3 million General Fund)—a reduction of $244,000 ($154 General Fund), compared with the current year. The reduced request is due to an unallocated Budget-Balancing Reduction. Commission staffing would remain at 22.4 personnel-years.

No issues have been raised regarding the CMAC budget request.

ISSUE 1: HOSPITAL CONTRACTING UPDATE

The Governor's Budget does not propose any reduction to Medi-Cal rates paid to hospitals that contract with CMAC. (The budget does propose reductions in supplemental Safety Net Care Pool and DSH-Replacement funding for designated public hospitals and for private and nondesignated public hospitals, respectively, however.) CMAC indicates that the contract rates that it negotiates save the General Fund between $600 and $700 million annually compared with the cost-based payments that those hospitals otherwise would receive.

CMAC estimates that their contract rates are between 60 percent and 70 percent of the cost-based rates. This percentage discount would be reduced to between 67 percent and 77 percent after the 10-percent reduction to non-contract hospital rates takes effect in July. According to CMAC and DHCS, the average increase in contract hospital rates in 2006-07 was 6.73 percent versus an increase of 9.76 percent for non-contract hospital cost-based rates.

Hospital consolidation has made contracting more difficult. As in any marketplace, the incentive for hospitals to contract for discount rates is competition. Medi-Cal authorization for inpatient most non-emergency inpatient services is limited to contract hospitals in areas that have them. However, when there are few hospitals (or hospital systems) in an area, there may be little incentive to contract since Medi-Cal must provide accessible inpatient care regardless of whether an area has contract hospitals.

STAFF COMMENTS

1. CMAC should provide a brief update of the status of its hospital contracts and the current contracting environment in terms of prospects for future discounts.

2. CMAC—to what extent will the 10-percent reduction in rates to non-contract hospitals encourage hospitals to continue contracting?

4280 MANAGED RISK MEDICAL INSURANCE BOARD

The Managed Risk Medical Insurance Board (MRMIB) administers programs that provide health care coverage through private health plans to certain groups that otherwise would be uninsured. The MRMIB administers the: (1) Healthy Families Program (HFP); (2) Access for Infants and Mothers (AIM) Program; and (3) Major Risk Medical Insurance Program (MRMIP).

The budget proposes total expenditures of almost $1.4 billion ($432.3 million General Fund, $846.2 million Federal Trust Fund and $115.1 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. Table 1 shows program funding as estimated for 2007-08 and proposed for 2008-09 excluding the effect of the Governor's Budget-Balancing Reductions.

Table 1

Summary of Expenditures (dollars in thousands)	2007-08	2008-09	$ Change	% Change
Program Source				
Major Risk Medical Insurance Program (including state support)	$40,089	$35,999	-$4,090	1.0
Access for Infants & Mother (with state support)	$135,563	$154,692	$19,129	14.1
Healthy Families Program (with state support)	$1,099,469	$1,200,055	$100,586	9.1
County Health Initiative Program	$2,777	$2,874	$97	3.5
Totals Expenditures	**$1,277,898**	**$1,393,620**	**$115,722**	**9.1**
General Fund	$396,040	$432,338	$36,298	9.2
Federal Funds	$770,423	$846,213	$75,790	9.8
Other Funds	$111,435	$115,069	$3,634	3.3
Total Funds	**$1,277,898**	**$1,393,620**	**$115,722**	**9.0**

The Governor has proposed reductions to the HFP totaling $121.7 million ($43.2 million General Fund and $78.5 million federal funds) as shown in Table 2 below. These savings assumed a July 1, 2008 implementation date.

Table 2

Governor's Proposed Reductions to Healthy Families Program

Healthy Families Program	Governor's Proposed 2008-09 Reduction (General Fund)	Governor's Proposed 2008-09 Reduction (Total Funds)
Reduce rates paid to participating health plans by 5%	-$22,400,000	-$63,100,000
Benefit limit for dental coverage ($1,000 annually)	-$6,300,000	-$17,700,000
Increase premiums families pay for coverage	-$11,100,000	-$31,300,000
Increase co-payments for certain services	-$3,400,000	-9,600,000
Total Reduction to Program	**-$43,200,000**	**-$121,700,000**

Loss of Enhanced Federal Match. The state receives almost 2 dollars of federal State Children's Health Insurance Program—SCHIP-- match for every dollar of state funds spent in the HFP (within the limits of the state's federal allotments). Consequently, each dollar of General Fund savings results in about $3 of program spending reduction. Likewise, family premium contributions (see below) are taken "off the top," so that out of every $3 dollars of additional family contribution, the state benefit is $1 and the federal savings is $2.

Healthy Families Program Eligibility. The HFP provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are in families with incomes above the Medi-Cal limits and who meet citizenship or immigration status requirements. Eligibility is determined on an annual basis, and children must not have been covered under an employer plan (generally as a dependent) for at least three months (unless coverage is no longer offered or employment with that employer ends).

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available. In addition, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans.

Premiums. Families pay a monthly premium and copayments. The amount paid varies according to a family's income and the health plan selected. The HFP offers subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer or reoccurring credit card payment.

ISSUE 1: GOVERNOR'S PROPOSED HFP REDUCTIONS

The Governor's Budget includes the following HFP Budget-Balancing Reductions, all of which require statutory change, emergency regulations and often a state plan amendment:

General Reduction in HFP Plan Rates

The Governor proposes to reduce by 5 percent the rates paid to plans participating in HFP. The budget estimates a total savings of $63.1 million ($40.7 million federal S-CHIP) from this rate reduction, assuming July 1, 2008 implementation. This proposed reduction would affect all types of plans (health, dental and vision). Generally, MRMIB negotiates contracts annually and presently contracts with 23 health plans, 6 dental plans, and 3 vision plans to achieve statewide coverage. The 5-percent reduction is from the rates in effect on July 1 2007. Plan rates, including health, dental and vision, are normally negotiated between January and March and approved by the MRMIB Board in March of each year for the upcoming budget year. Also, HFP enrollees historically have an open enrollment period in April and May to change plans. This proposal requires: (1) a statutory change; (2) emergency regulation authority; (3) contracts to be re-negotiated with the plans; and (4) a State Plan Amendment which requires federal approval. This proposal interacts with the limit to dental coverage, and the proposal to increase copayments, discussed below.

How Will Health Plans React? Some plans, particularly in well-served competitive areas of the state may choose to simply absorb the rate reduction. Others may revise provider networks to restrict access to higher-cost providers. Currently, MRMIB indicates that there are seven counties with only one HFP health plan available. If any of those plans drop out due to the rate reduction, then MRMIB would have to find another plan to continue offering coverage. There also are eleven counties with only 2 HFP plans.

Premium Increases

Table 3 below shows current premiums and the Governor's proposed Increases, which would require Trailer Bill language. A total reduction of $31.3 million ($11.1 million General Fund and $20.2 million federal SCHIP funds) is assumed from this proposal with an effective date of July 1, 2008.

Table 3

Governor's Healthy Families Program—Proposed Premium Increases

HFP Subscriber Family Income %	Existing Monthly Premium Payment	Governor's Premium Payment	Increase Per Month	Annualized Increase (12 months)
100 to 150 percent	$7 per child Maximum per family of $14	No change	--	--
151 to 200 percent	$9 per child Maximum per family of $27	$16 per child Maximum per family of $48	$7 child $21 family	$84 child $252 family
200 to 250 percent	$15 per child Maximum per family of $45	$19 per child Maximum per family of $57	$4 child $12 family	$48 child $144 family

Although the premium increases would be substantial in percentage terms, the budget does not assume any resulting enrollment decline despite the fact that experience with premium increases in other states has resulted in some decline due to failure to continue payments and a reduction in applications. Also, as noted above, $2 of every $3 extra dollars paid by families will be offset by reduced federal match.

Premiums for subscribers with incomes over 200 percent of poverty were increased as of July 1, 2005 (from $9 to the present $15 per child). No other subscriber categories have had premium increases since inception of the program in 1998.

Copayment Increase

The Governor proposes to increase HFP co-payments from $5 to $7.50 for *non-preventive* services for children in families with incomes *over* 150 percent of poverty (i.e., from 151 to 250 percent). A total savings of $9.6 million ($3.4 million General Fund and $6.2 million federal funds) is estimated from this action, which requires a statutory change, assuming July 1, 2008 implementation.

The increased copays are paid to the managed care plans and providers, not the state. The state savings results from an assumed 1.25 percent reduction in the utilization of services--such as doctor and dentist visits and prescriptions—as a result of the higher copays. The state (and federal) savings show up as an additional 1.25 percent additional reduction in rates paid to health plans to reflect the reduction in utilization. This reduction in plan rates would be in addition to the 5 percent general rate cut, so that the total cut in plan rates would be 6.25 percent.

The co-payment proposal would require MRMIB to designate the income level of each family to their health plan and other providers, so that they can charge the appropriate copayment amount

Dental Coverage Limit

The Governor proposes an annual limit of $1,000 per child for HFP dental coverage for a total reduction of $17.7 million ($6.3 million General Fund and $11.4 million federal S-CHIP funds), assuming July 1, 2008 implementation. This proposal would limit the annual dental coverage provided to subscribers, reducing dental plan costs, which MRMIB would translate into plan rate reductions (on top of the general 5 percent rate Reduction and the reduction resulting from increased copayments).

According MRMIB and their contracted actuary, establishing this dental limit would result in a 12 percent savings in dental benefits compared with the current year. Under the $1,000 cap, subscribers with significant dental needs would likely need to spread services over more than one year if feasible in order to avoid the cap. MRMIB's actuary estimates that 5 percent of the HFP subscribers would reach the $1,000 annual limit.

Presently, the MRMIB contracts with 6 dental plans for HFP dental care services at capitated rates. HFP does not provide orthodontia unless it is determined to be medically necessary, in which case it is provided under the California Children's Services (CCS) Program.

STAFF COMMENTS

MRMIB, please respond to the following:

1. If legislation authorizing the Governor's budget reductions is not enacted until July 1, how much savings could still be achieved in 2008-09?

2. How is MRMIB preparing for the possibility of the budget reductions and dealing with the uncertainty about their adoption and, if adopted, their timing? What has happened to negotiations with health and dental plans?

3. Does MRMIB foresee the possibility of significant access problems as a result of the proposed rate cuts? What tools does MRMIB have to ensure access throughout the state?

LAO, please respond:

1. LAO has withheld recommendation on the reductions pending the outcome of plan contract negotiations. However, that schedule does not seem workable if MRMIB must have legislative approval prior to final negotiations with plans.

ISSUE 2: LAO ALTERNATIVE BUDGET PROPOSALS

In their alternative budget, LAO includes all of the Governor's Budget-Balancing Reductions discussed above. However, as noted above, LAO also withholds recommendation on the reductions pending the outcome of plan contract negotiations.

LAO also adopts the following two proposals as part of the alternative budget plan:

1. Eliminate payments for certified application assistance—General Fund savings of $9.6 million, including both the assistor payments and caseload savings due to a loss of application assistance (18,140 children).

2. Further delay implementation of SB 437, which will provide for testing of self-certification of income in Medi-Cal and HFP (General Fund savings of $2.7 million for HFP and an additional savings of $18.5 million in Medi-Cal).

LAO indicates that their rationale for these proposed additional reductions was that these reductions would not reduce existing health care services.

STAFF COMMENTS

1. LAO should describe their additional alternative budget reductions and the impacts of those reductions.

2. MRMIB should respond to the LAO's additional alternatives.