

AGENDA
SUBCOMMITTEE No. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER JERRY HILL, CHAIR

MONDAY, APRIL 20, 2009
STATE CAPITOL, ROOM 127
4:00 P.M.

4260 DEPARTMENT OF HEALTH CARE SERVICES

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4260 DEPARTMENT OF HEALTH CARE SERVICES

CONSENT ITEMS**ISSUE 1: COUNTY ORGANIZED HEALTH SYSTEM EXPANSIONS*****Proposal:***

The 2009-10 Budget Act Assumes a \$16 million GF cost. The Administration believes that state statute may not be totally clear on whether a county can affiliate with a non-contiguous County Organized Health System (COHS), which would be the case for Merced County which intends to affiliate with the Central Coast Alliance for Health (which serves Santa Cruz and Monterey). Therefore, the Administration has put forward proposed trailer bill that clarifies the statute to this effect.

Background:

California began enrolling Medi-Cal recipients in managed care via enactment of the Knox-Keene Health Care Service Plan Act in the early 1970s that authorized the state to license health maintenance organizations (HMOs) for enrollment of Medi-Cal beneficiaries.

Not until the early 1990s, however, did California focus on shifting large numbers of beneficiaries into managed care. The state's expansion of Medi-Cal managed care was precipitated by many of the same factors that led to increased managed care penetration in commercial health care markets: rapidly increasing health care costs and lack of access to primary health care services. Today, approximately 50 percent of Medi-Cal beneficiaries are enrolled in some form of managed care.

There are three main Medi-Cal managed care models in California: County Organized Health Systems (COHS), Geographic Managed Care (GMC), and the Two-Plan Model. There are also a limited number of prepaid health plans and primary care case management programs that enroll Medi-Cal recipients on a voluntary basis. A small number of state-approved special managed care projects also exist primarily to serve seniors and individuals with AIDS.

Medi-Cal beneficiaries are enrolled in managed care according to the model of managed care in their given county. With the exception of those beneficiaries living in areas with a COHS, enrollment in a managed care plan is a process independent from general enrollment into the Medi-Cal program. A state subcontractor, Maximus, is responsible for both informing Medi-Cal beneficiaries about the managed care process and administering enrollment.

In 1982, state legislation was enacted to create three COHSs in California. Such a system allows a county to operate a managed care program. Enrollment in a COHS is

mandatory for almost the entire Medi-Cal population, and occurs concurrently with enrollment in the Medi-Cal program. Santa Barbara, Monterey, and San Mateo counties were the first selected to design and implement COHSs. The Monterey COHS ultimately was not viable. In 1990 Congress authorized three additional COHSs: Santa Cruz, Solano, and Orange Counties. Under both federal and state law, a COHS must be an independent public entity that meets Knox-Keene requirements, but does not need a Knox-Keene license. Counties are paid a set amount per member each month, known as a capitated rate. Most services covered under traditional Medi-Cal fee-for-service (FFS) are covered in the COHS. It is possible for a county to make a special arrangement with DHCS for some services, such as nursing home care, to remain FFS. The Solano County COHS has expanded to include Napa County within its system, and the Santa Cruz County COHS now includes Monterey County, and is call the Central Coast Alliance for Health. Additional counties in the state are interested in developing a COHS, however, in order for a county to establish a COHS, the county must receive both state and federal approval. Federal law also limits the total enrollment in COHSs to 16 percent of the total Medi-Cal population. Currently there are five COHS and federal legislation passed and was signed into law last year approving of adding Merced and Ventura Counties to California's system of COHS. According to DHCS, Merced County officials indicate that they are not yet prepared to establish their own COHS and therefore intend to affiliate with the Central Coast Alliance for Health, which is noncontiguous to Merced County.

Budget Impact:

Finance estimates that this will result in one-time costs of \$16 million GF (2009-10) for lagging FFS claims coming in during the transition to managed care. Finance assumes that there will be long-term savings due to the cost-effective nature of managed care.

Staff Recommendation: Approve/Consent

**ISSUE 2: EXPANDED ACCESS TO PRIMARY CARE PROGRAM
(SPRING FINANCE LETTER)*****Proposal:***

DHCS is proposing to move \$200,000 in Prop 99 funds from state operations to local assistance in order to pay the community clinics for their increasing administrative costs of processing claims for uncompensated care that they provide as participants in the Expanded Access to Primary Care Program (EAPC).

Background:

The (EAPC) provides a limited amount of funds to community clinics for providing primary care services to individuals whose family income is below 200% of the federal poverty level and who have no other health care coverage or means to pay. The EAPC Local Assistance Proposition 99 funds were reduced by \$3.2 million in 2008-09, resulting in a reduction in funds to pay claims for clinic services. DHCS also reports dramatic increases in uncompensated care due to job layoffs and subsequent loss of health insurance coverage, as well as an increase in administrative costs to process claims from the clinics. All together, these developments have led to a significant loss in Local Assistance funding available for uncompensated care.

Budget Impact:

DHCS states that this transfer of funds will assist the state in complying with corrective actions in response to a Federal Office of the Inspector General audit, thereby minimizing potential federal penalties. Otherwise, there is no budget impact.

Staff Recommendation: Approve/Consent

**ISSUE 3: CALIFORNIA DISCOUNT PRESCRIPTION DRUG PROGRAM
– DELAYED IMPLEMENTATION (SPRING FINANCE LETTER)*****Proposal:***

The Administration proposes to delay implementation of the California Discount Prescription Drug Program until at least 2010-2011 due to state fiscal constraints.

Background:

Chapter 619, Statutes of 2006 (AB 2911, Nunez) created the California Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians by offering drug discounts. The general structure of the program is for the state to negotiate with drug manufacturers for *voluntary* rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program would be targeted at uninsured California residents with incomes below 300 percent of the federal poverty level, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income, share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug. Enrollment would occur primarily at pharmacies, which would retain the \$10 enrollment fee to cover their expense.

The cost of the program has two components. First, there is the administrative and fiscal intermediary cost of negotiating discounts and for developing, operating and maintaining a discount claiming and payment system. Second, there is the cost of "float." Pharmacies would give immediate discounts to participants and be compensated by the state for those discounts. The state, in turn, would recover the discounts from the participating manufacturers, but with a lag—hence the need for the General Fund to finance the up-front cost of discounts.

Implementation of this program was delayed in both of the past two budgets, 2007-08 and 2008-09, due to state fiscal constraints. DHCS also contends that pharmacies, pharmacy benefit management companies, and drug manufacturers have taken steps in recent years to help improve access to prescription drugs for low-income individuals.

Clearly, drug costs are a significant problem for many people, and the new program would provide some assistance. However, it is not clear how much of a discount the state could obtain or whether it would result in prices lower than can be found in the open market at some pharmacies or that are available through existing drug discount programs offered by the drug manufacturers to low-income uninsured persons.

Budget Impact:

No funding was budgeted for implementing this program in 2009-10, and therefore there are no costs or savings associated with deferring its implementation. Nevertheless, the cost of implementing the program was estimated last year to be \$5.8 million directly, requiring an additional approximately \$8.5 million for the "float" described above. However, through last year's trailer bill, the Legislature implemented a change to the financing which would require that the General Fund be repaid the program start-up costs, using some of the rebate funding over several years.

Staff Recommendation: Approve/Consent

ITEMS TO BE HEARD

ISSUE 1: MAXIMUM ALLOWABLE INGREDIENT COSTS – GENERIC DRUGS

Proposal:

The 2009-10 Budget Act assumes \$1 million GF savings for one month of implementation (\$12m GF annually in future years). The Administration is proposing to establish a new Maximum Allowable Ingredient Cost (MAIC) that would allow DHCS to set MAIC using either: the Average Manufacturer Price (AMP), the wholesaler acquisition cost, or to contract with a vendor to establish MAIC prices. DHCS states that the benefits include:

- Establishes a maximum reimbursement process that has been inactive in Medi-Cal for a long period.
- Will maintain or increase savings should the payment reduction currently in place get eliminated.
- Increases the use of generic drugs, thus responding to the criticism by providers and others that Medi-Cal doesn't use enough generic medication.
- Statute must be changed in order to use other processes to establish a MAIC.

Pharmacies would see a decrease in reimbursement of some generic drugs. However, pharmacy providers have stated that they lose money on many brand name drugs, but not on generics (with or without an MAIC). DHCS therefore argues that a shift away from some branded drugs to generics with MAICs can be expected to financially benefit pharmaceutical providers.

Background:

Through the Medi-Cal program, pharmacies receive two fees: 1) one for ingredient costs, calculated as average wholesale price (AWP) minus 17 percent; and 2) a dispensing fee of \$7.25. The MAIC is an upper payment limit for the ingredient component of generic drugs. Medi-Cal has been criticized by providers and other entities for not utilizing generic drugs more for cost savings. According to DHCS, in order to have savings associated with generic drugs, Medi-Cal needs to have an active Federal Upper Limit (FUL) and/or MAIC program. The state's efforts to implement a MAIC have had a rather complex history, as described below.

Originally, the state utilized a MAIC that was defined in regulations as AWP minus 5 percent, providing the manufacturer could supply a sufficient quantity of the drug. However, no statute required manufacturers to supply the information necessary for DHCS to establish MAIC prices.

In 2004, a new MAIC definition was established based on wholesale selling price. This methodology would use all generic equivalent products to calculate a weighted average that would become the MAIC. This methodology was stopped when Congress established a FUL on generic drugs.

In 2007, state statute was changed to make MAIC equal to the mean of the AMP of generic drugs plus a percent markup to represent the average purchase price paid by retail pharmacies in California. In October 2007, the Center for Medicare and Medicaid Services (CMS) issued regulations regarding the calculation of FUL and AMP. In December 2007, the federal court issued a temporary injunction barring CMS from implementing the FUL changes and sharing AMP prices with state Medicaid programs. Federal legislation was passed to delay implementation of the FUL prices and AMP until October 2009. California's current Medi-Cal MAIC depends on use of AMP, as reported by CMS, and therefore cannot implement MAIC in this way.

Budget Impact:

Finance estimates a one month savings of \$2 million TF (\$1 million GF) with a June 1, 2010 implementation, and \$12m GF savings annually thereafter.

Establishment of the MAIC will reduce payment for many generic drugs thereby increasing the use of generic drugs. According to DHCS, the extent of the savings will depend on the differences between the current reimbursement and the new MAIC, and in those situations where the brand name drug is preferred, the difference between the net cost (cost after rebates) of the brand name drug and the net cost of the generic drugs, plus the drug utilization patterns after the MAIC is established.

The savings generated by MAICs is partially dependent on the existence of the five percent payment reduction enacted by AB 1183 (the 2008 budget trailer bill), which has been stopped temporarily by a court injunction. The payment reduction affects the net costs of the drugs, therefore the net cost comparisons (e.g. MAIC generic compared to a brand name drug net) will vary with the amount of payment reduction.

Comments and Questions:

The Subcommittee has asked DHCS to discuss the following:

1. Please fully explain generic drug pricing and this proposal.
2. Please explain the interaction between this proposal and the AB 1183 rate cut.

Staff Recommendation: Leave open to work with DHCS and advocates on Trailer Bill Language (TBL).

ISSUE 2: GENETICALLY HANDICAPPED PERSONS PROGRAM***Proposal:***

The 2009-10 Budget Act assumes savings of \$790,000 GF for this proposal. In order to control costs and minimize crowd-out in the Genetically Handicapped Persons Program (GHPP), the Administration has put forward the following two proposals:

- 1. Private premium assistance.** The Administration proposes to authorize DHCS to purchase private insurance for eligible individuals when it's cost effective. Beginning Aug. 1, 2009, GHPP would help clients, who do not qualify for Medi-Cal, Medicare or employer-sponsored insurance, enroll in commercial insurance programs. This program would pay the premium payments for an insurance policy that will reimburse a client's full range of health care services. The program also would reimburse a GHPP client for his or her COBRA payments.
- 2. Six-month waiting period.** The Administration proposes to establish incentives to retain private coverage. Proposed trailer bill language stipulates that a person cannot have had employer-sponsored coverage for at least 6 months in order to qualify for GHPP, unless they have lost coverage for specified reasons, all of which are reasons that have been no fault of the individual. Should an individual lose employer-sponsored coverage, he or she would be required to enroll in GHPP within 15 days, in order to avoid being subject to the 6-month waiting period.

Background:

The GHPP provides comprehensive health care coverage for people with qualifying genetic disease including: blood diseases; Cystic Fibrosis; brain and nerve diseases; protein, carbohydrates, and copper metabolism diseases; and Von Hippel-Lindau Disease (VHL).

The GHPP provides complete services to its clients including those not related to the treatment of the GHPP eligible medical condition. The approval of these services is subject to individual review based on medical need. The GHPP services include the following: Special Care Center Services, hospital stay, outpatient medical care, pharmaceutical services, surgeries, nutrition products and medical foods, durable medical equipment, and other services.

Currently, the program has approximately 1,700 beneficiaries, 25 percent of whom are in Medi-Cal. 400 state-only beneficiaries who have hemophilia account for 85 percent of the treatment costs of the program due to the high cost of treating hemophilia.

The program experienced a significant increase in costs over the last couple of years. Specifically, FY 07-08 program costs were \$17 million over budget. Based on anecdotal evidence, DHCS believes rising costs can be attributed in part to "crowd out" occurring, whereby individuals are dropping private coverage and opting to enroll in GHPP instead. However, it should also be noted that this is a very small program and therefore it can experience wide variations in costs from year to year given the random

occurrence of more expensive cases, especially given the very expensive treatment required for hemophilia.

The proposed premium payment assistance policy is modeled after policies in place as part of the state's Health Insurance Premium Payment Program (HIPP), a program that has been in operation for over ten years and, according to DHCS, has been cost effective.

The Hemophilia Council of California objects to the requirement in trailer bill that an individual must enroll in GHPP within 15 days after losing employer-sponsored coverage in order to avoid the six-month waiting period, and would like to see this extended to 45 days. It might be difficult for an individual who has just lost his or her job and health insurance to know and remember to enroll in GHPP within only 15 days, amongst all the other concerns and tasks that must be attended to in such situations. Moreover, denying an individual with hemophilia access to health care for six months could lead to significant financial hardship and potentially devastating health consequences for that person. People with hemophilia must infuse blood clotting factor several times per week or risk internal bleeding, joint damage, or other significant health problems.

Budget Impact:

The proposed premium payment policies are expected to result in \$66,000 GF cost (for premiums) and \$842,000 GF in savings (resulting in a net gain of \$776,000). The Administration estimates that the savings will increase substantially in future years as more individuals remain in private coverage rather than enrolling in GHPP. The six month waiting period is expected to result in \$14,000 GF savings in 2009-10, and annually.

Comments and Questions:

The Subcommittee has asked DHCS to describe the overall GHPP budget and cost drivers, and present any evidence of crowd-out.

Staff Recommendation: Leave open to work on TBL.

ISSUE 3: GENETICALLY HANDICAPPED PERSONS PROGRAM

Proposal:

The 2009-10 Budget Act assumes increased revenue of \$1.4 million GF annually as a result of this proposed fee increase. Current GHPP enrollment fees are based on a sliding scale. Beginning July 1, 2009, DHCS proposes to increase the fees from 1 percent to 1.5 percent of Adjusted Gross Income (AGI) for families between 200 and 300 percent of the federal poverty level (FPL), and 3% of AGI for families over 300% FPL.

Background:

As discussed under the previous issue, the Administration believes that GHPP costs need to be better controlled. To this end, the Administration also has proposed an increase in enrollment fees. The enrollment fees have never been increased since their inception in 1992. The Hemophilia Council of California is neutral on this proposal.

The following chart provides some examples of existing and future enrollment fees for a family of four based on this proposed change (Note: for a family of four, 200 percent of the FPL is \$42,400; 300 percent is \$63,600) :

Adjusted Gross Income	Current Annual Fee	New Annual Fee	Annual Increase	Current Monthly Fee	New Monthly Fee	Monthly Increase
\$20,000	\$0	\$0	\$0	\$0	\$0	\$0
\$50,000	\$240	\$750	\$510	\$20	\$63	\$43
\$75,000	\$840	\$2,250	\$1,410	\$70	\$188	\$118
\$100,000	\$1,320	\$3,000	\$1,680	\$110	\$250	\$140

Staff Recommendation: Approve proposal.

ISSUE 4: ELECTRONIC ASSET VERIFICATION***Proposal:***

DHCS is requesting \$125,000 GF (\$250,000 TF) to contract with a service vendor to provide a secure, web-based means for counties to electronically request asset information from Financial Institutions (FIs) to supplement verification for Aged, Blind or Disabled (ABD) individuals in order to be in compliance with related federal requirements. The proposed trailer bill language exempts DHCS from the Public Contract Code in order to expedite this process. DHCS also is requesting one new position (\$51,000 GF) associated with this proposal.

Background:

Federal legislation (HR 2642) includes the "Asset Verification through Access to Information Held by Financial Institutions" policy that requires states to electronically verify the assets of Medi-Cal applicants and beneficiaries whose Medi-Cal eligibility is based on being ABD through electronic requests sent to FIs, whenever the State determines that such requests are needed in order to determine or re-determine the individual's eligibility. Federal regulations on this policy require a few states, including California, to implement this policy by October of 2009.

HR 2642 also requires that each applicant or beneficiary whose eligibility is on the basis of being ABD, and any other person whose assets are required by law to be disclosed to determine the eligibility of that applicant or beneficiary, to provide authorization for the State to obtain from any FI any financial record held by the FI with respect to the applicant or recipient whenever the State determines the record is needed in connection with an eligibility determination.

According to guidance from the Centers for Medicare and Medicaid Services (CMS), noncompliant states would have Federal Financial Participation (FFP) withheld for ABD individuals whose assets were not verified through the required electronic asset verification. CMS could impose sanctions for any delays in implementing the electronic verification in California by October 2009, and the longer it takes for DHCS to electronically verify assets of the ABD population, the greater potential for a CMS sanction. CMS has indicated that, to avoid the penalty from noncompliance with the timeline for electronic asset verification, states would be required to show "good faith" efforts for implementation, submit a corrective action plan within 60 days, and implement the third party verification within 12 months. In order to remain within the timeframe required by HR 2642, DHCS will implement the asset verification procedures through release of an All County Welfare Directors Letter (ACWDL).

The Medi-Cal Eligibility Division (MCED) has requested \$250,000 to contract with a service vendor to provide a secure, web-based means for counties to request asset information from FIs to supplement verification for ABD individuals in order to be in compliance with the new federal requirements. DHCS requests exemption from the provisions of the Public Contract Code and Department of General Services (DGS) review to obtain the direct service contractor in FY 2009-10. Even with the exemption,

DHCS may not be able to comply with the aggressive timeline to have the vendor ready by October 2009. However, according to DHCS, the exemption will show a good faith effort and DHCS will be able to submit a corrective action plan without losing FFP. By receiving the exemption and procuring a direct service contractor in FY 2009-10 to provide the means to request assets information for the ABD population, DHCS will be in compliance with the good faith effort and will not have FFP withheld.

Without exemption from the provisions of the Public Contract Code and DGS review to obtain the direct service contractor, California will be at least three years out of compliance with the mandates of HR 2642 due to the lengthy contract process in which DHCS must write the Request for Proposal (RFP), obtain proposals from vendors, conduct a lengthy review of the proposals, award a contract, and allow time for appeals prior to beginning work with the vendor.

Budget Impact:

DHCS is requesting a one-time appropriation of \$250,000 (\$125,000 GF) to contract with a vendor and one AGPA position to work with the contractor (approximately \$51,000 GF).

Comments and Questions:

The Subcommittee has requested that DHCS answer the following questions:

1. Are there other state agencies that already, or are planning to, utilize this type of technology, from which DHCS could benefit rather than reinventing the wheel?
2. What does it mean to be exempted from the Public Contract Code but still engage in a competitive bidding process?
3. How much federal funding do we stand to lose in penalties?
4. Please clarify how long this process would take without an exemption from the Public Contract Code, and for what reasons.

Staff Recommendation: Leave open to work on TBL.

ISSUE 5: SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPRING FINANCE LETTER)***Proposal:***

DHCS is requesting \$2,756,000 GF dollars to backfill for the loss of federal funding as a result of federally denied claims (i.e., denied at a higher match) for Skilled Professional Medical Personnel (SPMP).

Background:

The Department's Audits and Investigations' Medical Review Branch (MRB) employs nurses, physicians and pharmacists whose work is an integral part of the Medi-Cal Anti-Fraud program. The federal Medicaid program provides states with a 75:25 federal-state match as an incentive to hire SPMP for this purpose. Recently, the federal Centers for Medicare and Medicaid Services (CMS) has denied some of California's claims in this area stating that some of what MRB considers valid SPMP work is administrative and therefore can only be reimbursed with a 50:50 match. The department contested the CMS findings and is in the process of appealing a portion of the disallowed claims. DHCS anticipates possibly knowing the outcome of its appeal by mid-May.

According to DHCS, since the CMS review and denial of claims, the department has implemented improved SPMP tracking and oversight procedures to eliminate further disallowances.

DHCS states that if the state does not backfill this loss of federal funds, the department will be forced to reallocate its current funds thereby severely compromising its ability to perform its anti-fraud efforts.

Budget Impact:

This represents a one-time \$2,756,000 GF appropriation.

Comments and Questions:

The Subcommittee has asked DHCS to respond to the following:

1. What will the impact be on anti-fraud efforts if the state does not backfill this loss of federal dollars?
2. What are some examples of activities that SPMP have engaged in that CMS views as administrative?
3. Could these activities be handled by administrative staff?

Staff Recommendation: Leave open to await outcome of the State's appeal to CMS.

ISSUE 6: NON-EMERGENCY MEDICAL TRANSPORTATION BROKER***LAO Proposal:***

In the *2009-10 Budget Analysis Series Health*, the Legislative Analyst's Office (LAO) recommends that the state contract with a transportation broker, on a two-year pilot basis, to manage its Medi-Cal non-emergency medical transportation (NEMT), in order to improve efficiency and reduce costs.

Background:

The federal Medicaid program requires states to provide necessary medical transportation to and from health care providers for Medicaid recipients. In California, Medi-Cal provides NEMT only to patients who have a documented medical condition that prevents them from traveling via ordinary means of transportation. As such, Medi-Cal requires the transportation provider to submit a treatment authorization request (TAR) to Medi-Cal for approval, denial or modification. The TAR must include documentation from a health care provider confirming the medical necessity for the transportation. The LAO analyzed California's NEMT program and concludes that it could be more efficient and more cost-effective due to the following issues:

1. The TAR process is overly cumbersome. TARS are typically evaluated after the transportation has been provided.
2. Most transportation goes to dialysis patients. This results from the cumbersome TAR process, given that dialysis patients can get a one-year TAR approved.
3. The TAR review process requires excessive staff resources. Medi-Cal receives 300,000 NEMT TARs annually.
4. Unequal access to NEMT services exists geographically.

Several other states utilize transportation brokers for their NEMT services. A broker operates like a managed care plan just for NEMT services, contracting on a per member per month basis. Brokers: screen NEMT companies; subcontract with vendors to establish a network of service providers; and establish a single point of contact for patients to call when they need transportation services. The LAO identifies the following advantages of using a broker:

1. Creates a consistent contact point for patients;
2. Improves service delivery;
3. Eliminates the expensive and cumbersome TAR process; and
4. Manages state costs by utilizing a capitated monthly premium.

The LAO also points out that the main disadvantage of using a broker is the same disadvantage that always exists with managed care arrangements which is the financial incentive for the broker to minimize access to the services.

DHCS states that the department has explored NEMT brokers on more than one occasion and found that, after discussions with potential brokers, both the brokers and DHCS have concluded that such an arrangement does not make sense in California.

Budget Impact:

NEMT is available to Medi-Cal patients in both managed care and fee-for-service (FFS). The LAO estimates that Medi-Cal provides approximately \$50 million GF in NEMT services to FFS patients. The LAO reports that other states' experiences suggest that savings could be achieved between 15 and 35 percent of the cost of these services, thereby ranging from \$7 to \$15 million annually in California. They also estimate approximately \$1 million GF savings in administrative costs.

Comments and Questions:

The Subcommittee has asked DHCS to respond to this proposal and share with the Subcommittee what their experiences have been in exploring the use of a broker.

ISSUE 7: DHCS REGULATIONS

LAO Proposal: In the *2009-10 Budget Analysis Series Health*, the LAO explores the status of DHCS regulations specifically within the context of counties performing their Medi-Cal eligibility determinations function. As the LAO points out, regulations are often necessary, and required, to define and clarify statute. DHCS has come to rely heavily on All County Welfare Director's Letters (ACWDLs) which can provide guidance to counties and can be completed in much less time than regulations, as they are not subject to the same development and review process. According to LAO, most other departments follow-up on initial documents (that are comparable to ACWDLs) with formal regulations. DHCS, however, has failed to do so. LAO points out several problems with DHCS's over-reliance on ACWDLs, including:

1. Counties often find them unclear;
2. Confusion results from multiple letters regarding the same issue;
3. This confusion diminishes efficiency at the local level; and
4. It impedes the state's ability to effectively manage the county eligibility function.

The Subcommittee has asked DHCS to provide an overview of the outstanding regulations and their respective timelines, and to provide general comments in reaction to this issue including what the department's approach to regulations will be in the future.