ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Dave Jones, Chair

MONDAY, APRIL 26, 2010
STATE CAPITOL, ROOM 444
1:30 PM

4260 DEPARTMENT OF HEALTH CARE SERVICES

OVERVIEW OF MEDI-CAL

Purpose
The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. Generally, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures. However, federal American Recovery & Reinvestment Act of 2009 provides an enhanced federal match of 61.59 percent (from October 2008 to December 30, 2010).

Medi-Cal is at least three programs in one: 1) a source of traditional health insurance coverage for low-income children and some of their parents; 2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and 3) a wrap-around coverage for low-income Medicare recipients ("dual" eligibles who receive Medicare and Medi-Cal services).

Medi-Cal Eligibilty and Enrollment
Generally, recipients fall into four eligibility categories as follows: 1) aged, blind or disabled; 2) low-income families with children; 3) children only; and 4) pregnant women. Men and women who are not elderly and do not have children or a disability cannot qualify for Medi-Cal regardless of how low their income is. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures, or combinations of these. Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others at the state's option.

The Medi-Cal Program also has several "special programs" that provide limited services for certain populations**.** These include: 1) Emergency Medical Services Program which provides emergency medical services to undocumented individuals; 2) the Family PACT Program which provides reproductive health care services; 3) the Breast and Cervical Cancer Program which provides services related to cancer for women up to 200 percent of poverty; 4) the Disabled Working Program which allows certain disabled working individuals to pay a premium to buy into the Medi-Cal Program; and 5) the Tuberculosis Program which provides treatment for TB. These programs are limited in their eligibility and in the services that are funded under them.

Estimated Medi-Cal enrollment for the current year is about 7.3 million people and for 20010-11 it is 7.5 million people. Medi-Cal provides health insurance coverage to about 19 percent of California's population, or almost one in every five people (assuming a population of 38.8 million). Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty ($18,310 for a family of three). The projected Medi-Cal eligible caseload is summarized in the table below.

Eligibility Category	Projected Caseload for 2010-11
Families/Children	
CalWORKS	1,467,600
Working Families (1931(b) Program)	3.100,000
Pregnant Women	35,900
Children (100% and 133% Programs)	294,500
Aged/Disabled	
Aged	712,700
Blind	23,300
Disabled	1,128,400
Medically Indigent	232,500
Other Various Categories	461,600
Undocumented Persons	67,600
TOTAL	**7,524,100**

Summary of Proposed Medi-Cal Budget

The Governor proposes total expenditures of $40.3 billion ($12.9 billion General Fund, $25 billion federal Title XIX Medicaid funds, and $2.4 million in other funds) for local assistance in the Medi-Cal Program in 2010-11. This reflects a proposed *decrease* of $8.8 billion (total funds) as compared to the revised 2009-10 budget.

This reflects a *net* General Fund increase of $678.2 million, or an increase of about 5.5 percent above the revised current-year level as shown in the chart below.

MEDI-CAL FUNDING/EXPENDITURES SUMMARY
(Dollars in Thousands)

Program or Fund	2009-10 Revised	2010-11 Proposed	Difference	Percent Change
Local Assistance				
Benefits	$45,752,600	$37,020,500	-$8,732,100	-19.1
County Administration (Eligibility Processing)	$3,116,100	$3,007,400	-$108,700	-3.5
Fiscal Intermediaries (Claims Processing)	$309,900	$302,600	-$7,200	-2.3
TOTAL LOCAL ASSISTANCE	**$49,178,500**	**$40,330,500**	**-$8,848,000**	**-18.0**
General Fund	$12,232,900	$12,911,100	$678,200	5.5
Federal Funds	$33,653,300	$25,017,300	-$8,636,000	-25.7
Other Funds	$3,292,500	$2,402,100	-$890,400	-27.0
TOTAL FUNDS	**$49,178,700**	**$40,330,400**	**-$8,848,200**	

GOVERNOR'S FEDERAL FUND ASSUMPTIONS FOR MEDI-CAL

There are several components to the Governor's January budget related to the receipt of federal funds under Medicaid (Medi-Cal Program). These federal fund assumptions for Medi-Cal, along with several others, are tied to the Governor's "trigger" proposal, discussed in more detail later in this agenda. Each of the federal fund assumptions is described below. Receipt of these federal funds saves General Fund support. In some instances as noted, the receipt of new additional federal funds will require the State to identify an appropriate State match in order to draw the funds and offset General Fund support.

A) Receipt of federal ARRA funds through December 31, 2010

The federal ARRA enacted by President Obama in 2009 provided increased federal funding for States from October 2008 through December 31, 2010 (27 months). California is to receive a 61.59 percent federal medical assistance percentage (FMAP), or 11.59 percent above our standard level of 50 percent.

This enhanced funding reduces General Fund expenditures in a corresponding manner. Certain local fund commitments, such as County Realignment expenditures, are also reduced.

B) Assume extension of federal ARRA to June 30, 2011

The Governor's budget assumes the federal government will pass legislation to extend the ARRA for another 6 months to June 30, 2011. The DHCS budget assumes about $1.5 billion in federal funds for this extension which would be used to offset General Fund support in the Medi-Cal Program and other departments. There have been several proposals for federal extension, most recently the Senate included an extension in H.R. 4213 (American Workers, State and Business Relief Act) on March 10. The Governor's "trigger" calculation assumes a total of $2.1 billion (federal funds) for this extension which includes other federal ARRA funds in addition to these Medicaid (Medi-Cal) funds.

C) Receipt of unexpended federal funds from Hospital Financing Waiver and federal ARRA 61.59 Percent

California's existing Hospital Financing Waiver, enacted in 2004 through SB 1100 (Ducheny and Perata), is a key Waiver that provides reimbursement to designated safety net hospitals (about 146 hospitals). It is in effect until August 31, 2010.

This Waiver contains provisions for the receipt of $360 million for expansion of Medi-Cal Managed Care through "mandatory" enrollment of seniors and persons with disabilities. This $360 million (federal funds) was left unexpended at the time due to the need for considerable health care system

changes prior to such implementation. Through the Budget Act of 2009 (July), it was assumed California would obtain these unexpended federal funds pending discussions with the federal CMS.

The DHCS has reached a tentative agreement with the federal CMS to obtain the unexpended $360 million from the Waiver, plus an additional $423.8 million to reflect enhanced federal ARRA funding. This $783.8 million (across two-fiscal years) serves as an offset to General Fund support in the Medi-Cal Program. There are two key aspects to this tentative agreement:

- First, the DHCS has agreed to meet new milestones, as negotiated with the federal CMS, which focus on serving very medically involved individuals.

- Second, the $783.8 million (across two-fiscal years) in federal funds require a State match for their receipt. As provided for under the Hospital Financing Waiver, California can use "certified public expenditures" (CPE's) which include all sources of funds available to government entities (public) that directly operate health care. In an effort to mitigate demands on State General Fund, California has been utilizing "CPE" from several State-operate programs, as well as from Public Hospitals (as designated). The use of CPE's has been ongoing since inception of the Waiver.

D) Assume increase in base FMAP from 50 percent to 57 percent

The Governor is seeking federal law changes to the formula used to calculate the federal medical assistance percentage (FMAP) which would increase California's baseline from 50 percent to potentially 57 percent. The 57 percent figure used by the Administration is based on an average of what ten other large states receive. The January budget assumes $1.8 billion (federal funds) from this proposal. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

E) Enhanced FMAP for Medicare Part D "clawback"

The Governor's January budget assumes receipt of $250 million (federal funds—one time only) by applying the federal FMAP ARRA to California's payment to the federal government for its Medicare Part D "clawback" (States' cost-sharing requirement to the federal government for this prescription benefit). The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

In mid-February, federal HHS Secretary Sebeilus announced the federal government would be providing States with fiscal relief by applying federal FMAP ARRA to the "clawback" for October 2008 through December 31,

2010. This action provided California with a total of $680.6 million in one-time federal offsets to California's General Fund. The $680.6 million is $430 million more of an offset than contained in the Governor's January budget.

If the federal ARRA is extended to June 30, 2010, an additional offset of $166.5 million could be obtained (i.e., 11.59 percent for the six months), for a total of $847.1 million.

F) Request to change Medicare Part D "clawback" calculation

The Governor's January budget assumes federal relief of $75 million (on-going) by making changes to the federal government's formula for calculating the clawback. This requires federal law changes. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

G) Reimbursement to California for Medicare Disability Determination

The Budget Act of 2009 (July) assumed receipt of $700 million (federal funds-one time) from the federal government for repayment of funds expended through the Medi-Cal Program which should have been the sole responsibility of the federal Medicare Program. All states are affected by this systemic error on the part of the Social Security Administration. This issue continues to be part of the overall federal funding discussion for States, and would require federal law changes. The Administration would use these funds as an offset for General Fund support. This is part of the Governor's "trigger" calculation.

H) Federal CMS adjustment to State's Family PACT Waiver

Effective July 2009, the federal CMS reviewed California's existing adjustment within our Family PACT Waiver for individuals otherwise not eligible for Medi-Cal and determined this adjustment should be lower—from 24 percent to 13.95 percent. The effect of this adjustment is that California will receive increased federal funds of $50.8 million in 2009-10 and $58.2 million in 2010-11. These additional federal funds serve as an offset to General Fund support. This receipt of federal funds is not part of the trigger calculation.

GOVERNOR'S PROPOSED MEDI-CAL FEDERAL FUNDING ASSUMPTIONS *(Dollars in Thousands)*			
Federal Component	**Governor's Revised 2009-10**	**Governor's Proposed 2010-11**	**General Fund Savings**
Receipt of federal ARRA thru December 31, 2010*	**$3,794,472**	**$1,447,788**	**$5,242,260**
♦ Total DHCS	($2,879,478)	($1,190,873)	($4,070,351)
♦ Total Other Departments	($914,994)	($256,915)	($1,171,909)
Extension of federal ARRA to June 30, 2011***	--	**$1,500,700**	**$1,500,700**
♦ Total DHCS	--	($1,191,000)	($1,191,000)
♦ Total Other Departments	--	($309,700)	($309,700)
Apply federal ARRA to existing Hospital Wavier***	**$380,268**	**$43,501**	**$423,769**
Receipt of unexpended federal funds Hospital Waiver***	**$360,000**	--	**$360,000**
Assume increase in base FMAP from 50% to 57%***	--	**$1,819,000**	**$1,819,000**
♦ Total DHCS		($1,445,000)	($1,445,000)
♦ Total Other Departments		($374,100)	($374,100)
Enhance FMAP for Medicare Part D "Clawback"**		**$250,000**	**$250,000**
Request to change Medicare Part D "Clawback"***		**$75,000**	**$75,000**
Reimbursement of Medicare disability determinations***		**$700,000**	**$700,000**
Federal CMS adjustment for Family PACT Waiver*	**$50,800**	**$58,200**	**$58,200**
TOTALS	**$4,585,540**	**$5,894,189**	**$10,479,729**
* Federal dollars confirmed for these items			
** Federal dollars received are $430.6 million more than in Governor's January budget			
*** Discussions are continuing on these items			

STAFF COMMENT

The federal funding components for the Medi-Cal Program, and the Governor's proposed budget, are very complex. It is therefore vital that the Legislature be appraised of significant funding and policy opportunities and issues. Legislative Leadership has facilitated receipt of federal funds in several areas already and is poised to continue in this role.

As the State's designated entity, the DHCS has the responsibility to secure, track and monitor these federal funds. It is a complex task and a vital role. The work of the DHCS is appreciated.

It is recommended to have the DHCS provide the Subcommittee with a detailed update on the receipt of these federal funds, as well as more clarity regarding the CPE structure, at the May Revision.

Questions
The Subcommittee requests the DHCS to respond to the following questions:

1. Please discuss and explain the various components of the anticipated federal funds for the Medi-Cal Program.

2. With respect to the Hospital Financing Waiver, when will we have more clarity regarding the use of CPE's and federal CMS approval?

3. Please describe the most significant provisions of federal health care reform that will affect the Medi-Cal program.

20101-11 BUDGET PROPOSALS

ISSUE 1: EXTENSION OF MEDI-CAL MANAGED CARE TAX (AB 1422)

Budget Issue
AB 1422 (Bass, Chapter 157, Statutes of 2009) extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax is effective retroactively from January 1, 2009 through to December 31, 2010. The tax currently provides the state with $162 million in annual revenue, to which approximately $154 million is added in federal funds.

Revenues from this tax are matched with federal funds and are used for the following:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and
- Fund health care coverage for children in the Healthy Families Program (serves as a backfill to the General Fund).

Background
AB 1422 requires the State to allocate 38.41 percent of the tax revenue to the DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenues go to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families Program. The Medi-Cal Managed Care Plans affected by the tax include: 1) Two Plan Model (Local Initiatives); 2) County Organized Health Systems (COHS); 3) Geographic Managed Care; 4) AIDS Healthcare; and 5) SCAN.

The DHCS is proposing trailer bill language to: 1) extend the existing sunset from December 31, 2010 to July 1, 2011; and 2) amend the applicable percentages for reimbursement to the DHCS to correspond with the state's FMAP, at whatever the FMAP is, regardless of the time period. The proposed six-month extension would provide an additional $82 million in revenues, and a corresponding $63 million in additional federal funds, although the revenue will be less if the enhanced FMAP provided through ARRA is not extended for these same six months.

STAFF COMMENT

The May Revision should provide more clarity regarding the revenues to be generated from implementation of AB 1422, as well as the status of the federal ARRA extension.

Questions

The Subcommittee has requested the DHCS to respond to the following questions:

1. Please provide an update regarding the current-year rate adjustments for Medi-Cal Managed Care Plans due to the gross premium tax revenues. Are there any concerns from the Plans regarding these adjustments?

2. Please provide a brief summary of the trailer bill proposal.

ISSUE 2: MID-YEAR STATUS REPORTING FOR 6 MONTHS

Budget Issue
The DHCS proposes a reduction of $4.9 million ($2.5 million General Fund) reflecting savings to result from implementation of rolling back annual eligibility for Children from 12-months to 6-months as of January 1, 2011, as is provided for in current law. In order to avoid violating the ARRA eligibility MOE (as described below), 2009 budget trailer bill restored continuous eligibility (annual) for the time period that ARRA is in effect. Therefore, if the federal ARRA is extended to June 30, 2011, then this mid-year roll back will not occur. Yet the Governor's budget assumes extension of the federal ARRA to June 30, 2011. Therefore, the budget is clearly in conflict.

Background
Inclusion of children as part of the semi-annual reporting process (every 6-months) was enacted in Assembly Bill 1183, Statutes of 2008 (Omnibus Health Trailer Bill), and became effective as of January 1, 2009. Previously, annual reporting was required for children.

The enactment of the federal ARRA in February 2009 provided States with enhanced FMAP for 27 months (October 1, 2008 through December 2010) and a "maintenance of effort" was required. One of the key federal requirements is that states may not have eligibility standards, methodologies or procedures in place that are more restrictive than those in effect as of July 1, 2008. Any state that implemented more restrictive policies since July 1, 2008, had until July 1, 2009, to rescind them. The state would then be eligible for the enhanced match, retroactive to October 1, 2008.

Adoption of SB 3X 24 (Alquist), Statutes of 2009, among other things, restored annual reporting for children until the enhanced ARRA federal funds are no longer available. About $10.1 billion (federal funds) was at risk if California did not comply.

Federal Health Care Reform
President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. Therefore, this DHCS proposal would violate these MOE provisions.

STAFF COMMENT

Independent analyses have shown that annual reporting for children is cost-effective because it assists in assuring uninterrupted health care coverage and avoids the costs of "churning," eligible children being dropped from coverage due to unmet paperwork requirements, who then seek expensive emergency care which is then covered retroactively by Medi-Cal. Continuous (annual) eligibility also focuses limited state dollars on direct health care services instead of administrative paperwork.

ISSUE 3: NEWLY QUALIFIED LEGAL IMMIGRANT ADULTS & PRUCOL

Budget Issue

The Governor proposes legislation to eliminate full-scope Medi-Cal for newly-qualified legal immigrant adults, in the U.S. for less than five years, and for individuals designated as "PRUCOL," for a net reduction to Medi-Cal of $33.4 million (General Fund savings of $53.8 million and an increase of $20.4 million federal funds) in 2010-11 for legal immigrants, and a $39.6 million reduction to Medi-Cal (General Fund savings of $63.8 million and an increase of $24.2 million federal funds) in 2010-11 for PRUCOL.

Per this proposal, these individuals (48,600 legal immigrant adults and 17,000 PRUCOL) would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. The DHCS estimates that 56 percent of the cost for services would shift to emergency services and therefore would be partially reimbursed by the federal government (per the state's FMAP).

Background

California has always provided legal immigrant adults with full-scope services in Medi-Cal if they otherwise meet all other eligibility requirements. Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual and therefore Medi-Cal uses 100 percent General Fund for this purpose. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service. California has incorporated the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option to obtain federal funds for legal immigrant children and pregnant women by eliminating the previous five-year waiting period; as such, federal funds are now obtained for this population.

PRUCOL generally means that the immigration authorities are aware of a person's presence and have no plans to deport or remove them from the county. Medi-Cal lists several immigrant statuses that are considered PRUCOL. The various PRUCOL categories are permitted by the Department of Homeland Security to remain in the U.S.

Federal Health Care Reform

President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. As described above, these services do not receive federal reimbursement and therefore it remains unclear as to whether

eliminating these services would be a violation of the MOE. DHCS states that it would not be a violation.

STAFF COMMENT

Enactment of this proposal would likely: 1) impair people's health, particularly individual's with chronic conditions; 2) result in increased use of hospital emergency rooms; 3) result in increased uncompensated care costs for hospitals and clinics; and 4) shift some costs to county indigent health care programs.

ISSUE 4: 10 PERCENT REDUCTION TO PUBLIC HOSPITALS FOR 2010-11

Budget Issue

The DHCS proposes trailer bill language to shift a total of $54.2 million in federal funds from the Safety Net Care Pool, designated for uncompensated care for Public Hospitals and the Los Angeles Medical Services Preservation Fund (L.A. Preservation Fund), to backfill for General Fund support in certain state-operated programs during the 2010-11 fiscal year. AB 3X 5, Statues of 2009 (trailer bill), redirected $54.2 million, or 10 percent, as referenced for 2009-2010 and this proposal would extend the reduction to a second year.

The proposed trailer bill language provides that the reduction shall occur for hospital services provided during the period July 1, 2010 through June 30, 2011. Of the $54.2 million shift, almost $30 million would be used to backfill General Fund in 2010-11 and the remaining amount of $24.2 million would be expended in 2011-12, due to the time lag between the date of the service and the date that expenditures are paid.

The effect of the Governor's proposal on Public Hospitals and hospitals receiving funds from the L.A. Preservation Fund is that fewer federal funds would be available for uncompensated care provided to medically needy individuals.

Background

The Safety Net Care Pool (SNCP) was established in 2005, as part of the Medi-Cal Hospital/Uninsured Care Demonstration (hospital financing waiver), to reimburse Designated Public Hospitals (DPHs) for uncompensated care they provide to the uninsured. The SNCP makes $586 million available in each of the five years to be claimed using certified public expenditures of the DPHs, and by claiming State expenditures for four state-funded health care programs: California children's Services program; Genetically Handicapped Persons Program; Medically Indigent Adult – Long Term Care Program; and the Breast and Cervical Cancer Treatment Program.

STAFF COMMENT

It is unclear at this time how the overall structure of the 1115 Waiver will be crafted, particularly the complexities of the financing. The use of certified public expenditures (CPE's) and other funding sources besides General Fund support remain to be clarified.

ISSUE 5: 10 PERCENT REDUCTION TO PRIVATE HOSPITALS FOR 2010-11

Budget Issue

The Governor also proposes to reduce by 10 percent, or $52 million, the amount Private Hospitals and District Hospitals receive through the Waiver by making adjustments to certain disproportionate share hospital payments, including replacement payments. This issue corresponds to the 10 percent Public Hospital reduction, above.

The trailer bill language provides that the reduction shall occur for hospital services provided during the period of July 1, 2010 through June 30, 2011. As such, this reduction would be applied under the new, presently being crafted 1115 Medi-Cal Waiver.

AB 4X 5, Statutes of 2009 (trailer bill), redirected $52 million (Disproportionate Share Hospital Replacement Fund) to offset General Fund support in the Medi-Cal Program for 2009-2010.

Background

Under the state's Hospital Financing Waiver, hospitals participating in the Medi-Cal Program receive funds from several sources based on a complex formula. A key aspect of this arrangement is that Public Hospitals receive federal funds based on the use of their certified public expenditures and intergovernmental transfers, whereas Private Hospitals and District Hospitals receive a mixture of state General Fund support and federal funds.

STAFF COMMENT

As stated above, the new 1115 waiver is being developed and the details of its structure and financing remain unknown at this time. Therefore, it is unclear how this proposal would interact with the new waiver.

ISSUE 6: CHANGES TO SPECIAL NEEDS TRUST RECOVERY

Budget Issue

The DHCS is proposing trailer bill language to amend Section 3605 of the Probate Code and Section 14009.5 of Welfare and Institutions Code to change existing statute and case law (Shewry v. Arnold, from 2004; and Dalzin v. Belshe, from 1997) relating to Special Needs Trust recovery.

The budget assumes savings of $3.6 million ($1.8 million General Fund) through the enactment of the proposed trailer bill language. This savings level is based upon a DHCS estimate of recovery potential from these trusts and recoupment for Medi-Cal expenses.

STAFF COMMENT

The DHCS is seeking to substantially change the dynamics of recovery from Special Needs Trusts and therefore should be proceeding with policy legislation to ensure that thorough analysis and deliberations occur within the appropriate policy committees (including both Judiciary and Health).

The Administration proposed the same changes to statute in 2009 which was rejected without prejudice by the Joint Budget Conference Committee in 2009. Due to the complexities of both federal and state law, it was recommended for the Administration to proceed with policy legislation.

ISSUE 7: ELIMINATION OF ADULT DAY HEALTH CARE

Budget Issue
The Governor proposes legislation to eliminate Adult Day Health Care (ADHC) services for a savings of $350.7 million ($134.7 million General Fund) in 2010-11. A June 1, 2010 implementation date was assumed when the Governor released his January budget proposal.

Background
ADHC services are a community-based day program providing health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home, thereby enabling these individuals to live outside of institutional care, decreasing costs, and increasing their quality of life. There are 320 active ADHC providers in Medi-Cal who serve about 37,000 average monthly Medi-Cal enrollees. Under federal Medicaid law, ADHC services are "optional" for states to provide.

The average monthly cost per ADHC user is estimated to be $978 (all inclusive/bundled rate) in 2010-11. Several ADHC cost-containment actions have been taken in recent years. In 2004 the DHCS placed a moratorium on the expansion of ADHC providers which is still in place. In 2009, a rate freeze was enacted which is proposed for continuation into 2010-11, assuming ADHC is not eliminated. On-site treatment authorization reviews (TARs) were implemented in November 2009 and are estimated to reduce expenditures by 20 percent. Medical acuity eligibility criteria were placed into statute in 2009 but this was not implemented after being enjoined by the Court. DHCS estimated this would have reduced expenditures by another 20 percent.

The implementation of reducing ADHC benefits to a maximum of three days per week, as enacted in 2009, was enjoined in September 2009 in the case of *Brantwell v. Maxwell-Jolly*. The court found the 3-day cap to be a form of discrimination against these individuals based upon their disability, in violation of the "integration mandate" under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. It would be a violation because the reductions would increase the likelihood of nursing home placement and hospitalizations for the 800 program participants attending four and five days per week; the "integration mandate" specifies that persons with disabilities receive services in the "most integrated setting appropriate to their needs."

DHCS states that 1,500 people with developmental disabilities utilize ADHC services, making up $23 million in costs. Individuals with developmental disabilities would still be guaranteed services under the Lanterman Act, through

the state's "DD" system, however it is unknown how the DD system would provide these services if no longer covered by Medi-Cal.

If ADHC services are eliminated, some percentage of current consumers would experience the following:

- Increased institutionalizations in nursing homes, at significantly higher cost to the state;
- Increased individuals remaining at home with family, requiring a family member to quit a job to become a full-time care-taker;
- Worsening health conditions leading to increased ER visits and increased health care costs in general;
- Increased homelessness or various other undesirable, harmful outcomes;
- Loss of thousands of jobs; and
- Thousands of relatives having to either quit jobs or institutionalize their relatives.

STAFF COMMENT

In 2009, the Governor proposed elimination of ADHC which was rejected by the Legislature in favor of the cost-control measures described above. In response to last year's proposal to eliminate ADHC, the LAO provided that if 20 percent of ADHC consumers enter skilled nursing facilities (SNF) as a result of the elimination of ADHC, given the high cost of SNF care, there would be no savings for the state. Any percentage higher than that would lead to increased costs for the state. In addition to these increased costs, eliminating ADHC services could be expected to result in increased costs resulting from increased emergency room visits and hospitalizations. The Administration has not provided the Legislature with a savings estimate that accounts for all of these increased costs.

ISSUE 8: FAMILY PLANNING REIMBURSEMENT RATES

Budget Issue
The Governor proposes a reduction of $343,000 ($74,000 General Fund) in 2009-10, and $88.7 million ($15.3 million General Fund) in 2010-11 by reducing Medi-Cal rates for eight specified office codes billed for family planning services. The State receives a 90 percent federal match for family planning services, including these eight family planning office visits.

Background
Senate Bill 94, Statutes of 2007, provided an increase for these eight specified family planning office visits equal to the weighted average of at least 80 percent of the amount that the federal Medicare Program reimburses for these same or similar services. The rate became effective January 1, 2008. The Governor's proposal would restore the rates to the level they were prior to January 1, 2008. The proposed reduction includes fee-for-service providers, such as physicians and clinics, and managed care health plans. The Governor's proposal assumes that rate adjustments for managed care health plans will occur in 2010-11, including any needed adjustment for 2009-10. Prior to SB 94 in 2007, the rates for these services had been stagnant for approximately 20 years. These funds do not pay for abortions.

According to community clinics throughout the state that offer family planning services, the demand for such services far exceeds their capacity. Prior to the rate increase in 2008, California's clinics were turning away an estimated 10,000 people every month for lack of resources and capacity to serve them.

STAFF COMMENT

Family planning services save the state money by preventing unwanted pregnancies. According to a 2002 UCSF evaluation of the Family PACT program, within which a substantial portion of the state's family planning services are provided, 205,000 unintended pregnancies were averted which, collectively, would have cost the public $1.1 billion up to two years and $2.2 billion up to five years after birth.

ISSUE 9: DELAY CALIFORNIA DISCOUNT PRESCRIPTION DRUG PROGRAM

Budget Issue

The DHCS proposes trailer bill language to delay implementation of this new program until 2011-2012 due to continued fiscal constraints. Further, the DHCS proposes to end the program by February 1, 2012 if funding is not provided in subsequent legislation. DHCS states that it would cost $5.87 million to implement the program. Due to budget conditions in 2007-08 and 2008-09, the Governor vetoed funding for this new program. In 2009-2010 funding was not provided and statute was modified to delay implementation. The Governor's January budget for 2010-11 does not contain an appropriation for this new program.

Background

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

Individuals eligible for the program would include: 1) uninsured California residents with incomes below 300 percent of the federal poverty; 2) individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income: 3) share-of-cost Medi-Cal enrollees; and 4) Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

STAFF COMMENT

This new program has merit, however may be of less need in future years as a result of federal health care reform, which is anticipated to substantially reduce the number of uninsured people.

ISSUE 10: SUSPENSION OF COUNTY COLA

Budget Issue
The Governor proposes to suspend the 2010-11 cost-of-doing business increase for counties for Medi-Cal eligibility processing for General Fund savings of $22,133,000, and a reduction in total funds of $44,267,000 (General Funds and Federal Funds).

Background
The DHCS provides funding for county staff and support costs to perform all activities associated with the Medi-Cal eligibility process. State statute provides that counties shall receive cost-of-doing business (COLA) increases annually. However, exemptions were adopted in 2008-09 and in 2009-10 in order to not appropriate the increases. These increases are linked to performance standards in law.

Performance Standards
Performance standards were statutorily mandated in 2003 when annual cost adjustments and full funding for county operations were reinstated. In light of this, the Legislature adopted budget trailer bill stating that counties will not be penalized for not meeting the performance standards during the past two years when COLAs were suspended.

Governor's 2009 Veto
In addition to the COLAs being suspended for the past two years, the Governor vetoed an additional $60.6 million (General Fund) from this area of the budget. As with many of the Governor's 2009 vetoes, this reduction was never considered or approved of by the Legislature. The table on the next page outlines all reductions taken and proposed over the past two years.

SUMMARY OF COUNTY MEDI-CAL ELIGIBLITY REDUCTIONS (*Dollars in Millions*)		
YEAR	**GENERAL FUNDS**	**TOTAL FUNDS**
2008-09	$32.3	$64.6
2009-10 Base Reduction	$21.1	$42.1
2009-10 (COLA)	$24.7	$49.4
2009-10 (Veto)	$60.6	$121.1
2010-11 (Proposed COLA)	$22.1	$44.3
2010-11 (Proposed veto continuation)	$60.6	$121.1
TOTAL	**$221.4**	**$442.6**

Counties note that these reductions have occurred during a time period that has seen increased demand for services as well as furloughs and hiring freezes, and have resulted in the following:

1. Loss of eligibility workers and direct support staff;
2. Delayed application processing and the processing of federally required annual redeterminations and state-mandated status reports; and
3. Increased difficulty for recipients to contact eligibility workers.

GOVERNOR'S PROPOSED TRIGGER MECHANISM

General Issues

The Governor's proposed "trigger" mechanism has two key aspects. First, a sweeping Budget Control Section provides broad authority to the Department of Finance (DOF) to make fiscal reductions if the $6.9 billion federal fund target, as defined by the Governor, is not obtained. Second, a comprehensive trailer bill package provides authority to the DOF to drastically alter the Medi-Cal Program if the trigger is pulled. The Budget Control Section and trigger mechanism are described in more detail below.

Budget Control Section 8.26 (Budget Bill, page 646)

This control section provides: 1) broad authority to the Director of Finance to determine by July 15, 2010, if the State has received $6.9 billion in additional federal funds which can be used in lieu of General Fund support for 2010-11; and 2) enables the Director of Finance to *adjust appropriations as necessary* in accordance with statute.

Description of Governor's "Trigger" Mechanism

The Governor proposes *overall* reductions of $4.6 billion (General Fund) and revenue adjustments of $2.4 billion (General Fund) in the event the federal government does not provide $6.9 billion in additional federal funding. The table below provides a listing of the Governor's federal requests which are counted towards this trigger mechanism.

List of Governor's Federal Requests Associated with "Trigger" Proposal

Governor's Federal Request	2010-11 Budget Assumption
Extend federal ARRA to June 30, 2010 (all health & human srvs)	$2.1 billion
Increase FMAP from 50 percent to 57 percent	$1.8 billion
Obtain federal ARRA FMAP for Medicare Part D Clawback	$250 million
Change Medicare Part D Clawback calculation	$75 million
Reimbursement for Medicare Disability Redetermination	$700 million
Reimbursement for Special Education mandates	$1 billion
Reimbursement for cost of incarcerating undocumented immigrants	$879.7 million
Expanded federal funding for Foster Care	$86.9 million
TOTAL	**$6.9 billion**

ISSUE 1: ELIGIBILITY REDUCTIONS

Budget Issue

The trailer bill package would radically reduce Medi-Cal eligibility for various low-income people, most living below the federal poverty level ($18,310 annually for a family of 3), by imposing the existing federal minimum coverage required of States prior to the passage of federal Health Care Reform. Millions of Californians, including children, working families, and aged, blind and disabled individuals would be eliminated from health care coverage under the Governor's scenario. People would need to seek episodic care through emergency rooms, clinics and county indigent health facilities.

Federal Health Care Reform

President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) on Tuesday, March 23, 2010. Effective upon this date of enactment, States are required to maintain Medicaid (Medi-Cal) eligibility standards, methodologies, and procedures until a Health Insurance Exchange is operational in the State, with minor exceptions. All of these eligibility reductions would be violations of the federal health care reform eligibility MOE.

SUMMARY OF PROPOSED ELIGIBILITY REDUCTIONS		
Eligibility Category	**No. of Persons Impacted**	**General Fund Savings**
Rollback 1931 (b) to minimum	-433,582	-$27,375,000
Rollback Aged, Blind, & Disabled	-93,396	-$52,287,000
Eliminate Medically Needy Program	-42,809	-$290,888,000
Eliminate Children's Gateway Pre-enrollment	-676,216 screens	-$8,120,000
Eliminate Accelerated Children's Single Point of Entry	-35,925	-$1,461,000
Eliminate Medi-Cal Expansion—Former Foster Care	-4,776	-$1,559,000
Eliminate Breast & Cervical Cancer Treatment	-9,269	-$20,383,000
Eliminate Medically Indigent Adult Long-Term Care	-943	-$11,115,000
Eliminate Family PACT Program	-1,600,000	-$64,133,000
TOTAL	**-2,220,790**	**-$477,321,000**

ISSUE 2: ELIMINATION OF OPTIONAL BENEFITS

Budget Issue

The trailer bill package would provide DOF authority to eliminate certain benefits, which under federal law are considered "optional" for States to provide to adults. The Governor's trigger identifies nine "Optional" benefits in Medi-Cal which would be eliminated. The DHCS reduction amounts assume that some expenditure would shift to other Medi-Cal services. The table below displays the projected savings, number of fee-for-service users of each benefit, and the DHCS assumptions regarding potential cost shifts to other Medi-Cal provided mandatory services. For example, if hearing aids are eliminated, no other Medi-Cal service is available for treatment/assistance. With respect to outpatient heroin detoxification, it is likely that inpatient services would become necessary but this cost is not captured in the assumptions.

SUMMARY OF OPTIONAL BENEFITS PROPOSED FOR ELIMINATION

Optional Benefit	No. of Persons Impacted	General Fund Savings	Cost Shift to Mandatory Service Assumptions
Hearing Aids	17,396	-$2,691,000	No cost shift
Physical Therapy	6,025	-$40,000	90% shift
Occupational Therapy	332	-$4,000	60% shift
Orthotics	1,252	-$30,000	75% shift
Independent Rehab Facilities	430	-$4,000	60% shift
Outpatient Heroin Detox	947	-$61,000	No cost shift
Medical Supplies	-	-$19,204,000	30% shift
Prosthetics	11,486	-$570,000	75% shift
Durable Medical Equipment	222,993	-$24,669,000	25% shift
TOTAL	***Over 223,000**	**-$47,273,000**	

**The number of persons impacted by eliminating optional benefits only accounts for people in fee-for-service Medi-Cal, as there is no way to count beneficiaries in managed care who utilize these benefits. Therefore, the total is much higher than 223,000.*

Some of the above categories are quite broad as to what is covered, particularly "Medical Supplies" and "Durable Medical Equipment." The Medical Supplies category includes diabetic supplies, all wound care, infusion supplies, tracheotomy care, and many others. Durable Medical Equipment includes wheelchairs and accessories, oxygen and respiratory equipment, ostomy pouches, and many others. The Budget Act of 2009 (July) also eliminated ten

optional benefits for adults (not in nursing homes or pregnant) including dental, acupuncture services, chiropractic services, incontinence creams and washes, optician/optical lab services, optometry services, podiatry services, psychology services, speech therapy and audiology services.

STAFF COMMENT

Many of the Medi-Cal Optional benefits proposed for elimination are "core" benefits which provide medically necessary assistance for individuals with chronic conditions. Elimination would likely result in increased hospitalization, such as with Diabetes, significant concerns with mobility and employment, such as not having access to wheelchairs and Prosthetics.

Questions
The Subcommittee requests that DHCS answer the following question:

Is it accurate that some Medi-Cal beneficiaries were in the middle of extended dental care last year when the dental benefit ended, and therefore have not been allowed to finish the dental work that had already begun?

ISSUE 3: ELIMNATION OF PROP 99 FUNDING FROM EAPC

Budget Issue
Also a part of the Governor's package of "trigger" proposals, though not a part of Medi-Cal, the Governor proposes to eliminate all remaining $10 million in Proposition 99 funding in the Early Access to Primary Care (EAPC) Program that supports community clinics. This would result in $10 million in General Fund savings by backfilling General Fund dollars in Medi-Cal.

Background
This funding supports 580 clinics, thereby providing approximately $17,241 to each clinic. Though a relatively small amount of funding, this would be an additional reduction compounding the substantial loss of funding to clinics last year.

In the 2009 budget, rather than eliminating all General Fund support for community clinic programs, as proposed by the Governor, the Legislature reduced support by approximately one-third or $14 million total funds ($10 million General Fund and $4 million Proposition 99 funds); nevertheless, the Governor subsequently vetoed all of the remaining General Fund dollars (approximately $20 million). These programs included: Rural Health Services, EAPC, American Indian Health Program, and Seasonal Migratory Worker Clinics.

Clinics experienced a substantial loss of funds due to the cumulative impact of several budget reductions, including: elimination of optional benefits, reductions to the clinic-support programs listed above, and reductions to the Office of AIDS programs. The California Primary Care Association (CPCA) conducted a statewide survey of clinics and found the following impacts as a direct result of last year's budget reductions:

- Four clinics have closed;
- 170,000 patients have lost some degree of access to care;
- 500,000 encounters will not be provided;
- Layoffs of hundreds of providers and staff;

CPCA also states that clinics have experienced a 50 percent increase in the number of uninsured patients seeking care as a result of the economy.