

AGENDA
SUBCOMMITTEE No. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER JERRY HILL, CHAIR

MONDAY, MARCH 23, 2009
STATE CAPITOL, ROOM 447
4:00 P.M.

ITEM	DESCRIPTION	PAGE
ITEMS TO BE HEARD		
4260	DEPARTMENT OF HEALTH CARE SERVICES	2
ISSUE 1	MEDI-CAL OVERVIEW	2
ISSUE 2	2009-10 MEDI-CAL BUDGET	3
ISSUE 3	EFFECTS OF RECESSION ON MEDI-CAL	12
ISSUE 4	FEDERAL STIMULUS & CHIPRA	13
ISSUE 5	DEPARTMENT ISSUES	17
	ATTACHMENT 1 – OPTIONAL BENEFITS CHART	
	ATTACHMENT 2 – FEDERAL STIMULUS OVERVIEW (LAO)	
PUBLIC TESTIMONY		

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL OVERVIEW

The California Medical Assistance Program (Medi-Cal) provides health care services to qualified low-income persons (primarily children and families with children and the aged, blind, or disabled). The program provides health care to both CalWORKs and SSI/SSP recipients, but most Medi-Cal enrollees are not welfare recipients. Medi-Cal incorporates California's version of the federal Medicaid Program plus several state-only components. Normally, expenditures for benefits generally are shared 50-50 by the General Fund and by federal funds. Due to the federal economic stimulus bill, which is described in more detail under the federal stimulus portion of this agenda and in attachment 2, the temporary increase in the federal portion of the match ("FMAP") will increase from 50% to approximately 62% for the time period of the stimulus (October 2008 through December 2010), assuming California qualifies by suspending or restoring 12-month continuous eligibility for children.

The Department of Health Care Services (DHCS) is the single state agency accountable for all federal Medicaid funding. Consequently, the DHCS Medi-Cal budget also includes federal Medicaid funds for: (1) Disproportionate Share Hospital (DSH) payments and other supplemental payments, which provide additional funds to certain hospitals that serve large numbers of Medi-Cal and indigent patients; and (2) the federal match for state and local funds budgeted in other departments for programs that provide services that also serve Medi-Cal enrollees and qualify for Medicaid funding. These other departments include the Departments of Aging, Developmental Services, Mental Health, and Social Services (for the In-Home Supportive Services—IHSS—Program).

- ❖ Medi-Cal serves over 7 million people and is the source of health coverage for:
 - Almost one in five Californians under age 65;
 - One in three of the state's children; and
 - The majority of people living with AIDS

- ❖ Medi-Cal pays for:
 - 46% of all births in the state
 - 2/3 of all nursing home residents; and
 - Almost 2/3 of all net patient revenue in California's public hospitals.

- ❖ Medi-Cal brings in more than \$20 billion in federal funds to California's health care providers.

- ❖ Medi-Cal accounts for the second largest share of the state's General Fund spending (after K-12 education), at approximately 17% of the General Fund.

ISSUE 2: 2009-10 BUDGET

The 2009-10 DHCS budget includes Medi-Cal expenditures totaling approximately \$35 billion from all funds for state operations and local assistance.

- Figure 1 below shows the 2009-10 Medi-Cal (DHCS-only) budget by funding source, and 2009-10 Budget Act numbers as well as preliminary estimates of the funding distribution assuming California qualifies for the enhanced FMAP available as part of the federal economic stimulus (described in more detail later in this agenda).
- Figure 2 below displays a summary of Medi-Cal General Fund expenditures in the DHCS budget for the 2007-08, 2008-09, and 2009-10 fiscal years. This figure does not include FMAP relief.
- General Fund spending for local assistance (\$15.5 billion) increases by about \$1 billion, or 6.9 percent, compared with the current-year estimate. DOF states that a 7-8 percent increase is consistent with a normal projected annual growth pattern.

Figure 1			
2009-10 DHCS-only Medi-Cal Local Assistance			
		Before FMAP Relief	After FMAP Relief
General Fund		15,461,430	12,623,370
Federal Funds		18,932,254	21,770,314
Other Funds		862,500	862,500
Totals		35,256,184	35,256,184

Figure 2

Medi-Cal General Fund Budget Summary Department of Health Care Services^a

(Dollars in Millions)

	Expenditures			Change From 2008-09	
	Actual	Estimated	Enacted	Amount	Percent
	2007-08	2008-09	2009-10		
Local Assistance					
Benefits (medical services)	\$13,167	\$13,563	\$14,553	\$990	7.2%
County Administration (eligibility processing)	781	782	806	24	3.1
Fiscal Intermediary (claims processing)	92	108	102	-6	-5.3
Totals, Local Assistance	\$14,040	\$14,454	\$15,461	\$1007	6.9%
Support (State Operations)	\$128	\$125	\$127	\$2	1.6%
Caseload (Thousands)	6,650	6,861	7,137	276	4%

^a Excludes General Fund Medi-Cal budgeted in other departments.

Note: Revised based on LAO 2009-10 Budget Analysis Series: Health Figure 4

The net increase in the 2009-10 Med-Cal budget incorporates the major program-related reductions in Figure 3 below:

Figure 3	
Medi-Cal Local Assistance	
Major General Fund Program Reductions	
2009-10 Budget	
<i>(In Millions)</i>	
Savings From Cuts in Rates and Services	
Safety Net Care Pool	\$54
Elimination of various optional services	\$129
Reduction in County Administration COLA	\$25

Loss of Federal Funds. Traditionally, most of the spending reductions and impacts on services that result from Medi-Cal reductions are double the amount of General Fund savings because of the loss of federal matching funds. Due to the temporary increase in the FMAP, the loss of federal funds will be more than 50 percent. California's federal match likely will increase from 50 percent to approximately 62 percent for benefits.

Suspension of County Administration COLA (\$24.7 Million Savings). The 2009-10 budget eliminates the 2009–10 cost-of-doing-business increase (\$24.7 million GF savings) to counties for the determinations of Medi-Cal eligibility. Similarly, the 2008-09 budget eliminated the county COLA as well as made cuts to counties' base funding. According to the LAO, both the current-year and budget-year under-fund county administration by not accurately reflecting upwards adjustments that DHCS made to its caseload growth projections due to the economic downturn. LAO states that the 2009-10 budget under-funds counties by \$3.5 million GF.

Medi-Cal Benefits & 2009-10 "Trigger" Cuts

The 2009-10 budget discontinues nine categories of Medi-Cal "optional" benefits for adults (age 21 or older), unless the state receives sufficient federal economic stimulus dollars (as specified in the 2009 budget package, referred to as the "trigger"). As stipulated in the budget package, if the State Treasurer and Director of the Department of Finance deem that the state has received at least \$10 billion in federal funds, the "trigger" will be pulled and various cuts (including optional benefits) and increased revenues will not take effect. These benefits are optional because federal Medicaid law does not require states to provide them to adults who are not in nursing facilities, although the federal government provides matching funds for states that choose to provide them. The budget assumes \$129 million in GF savings from this change, which is based on the current FMAP of 50 percent. At the enhanced FMAP of approximately 62 percent, the savings would drop to approximately \$100 million.

Attachment 1 lists information provided by DHCS showing total (state and federal) fee-for-service spending for each of the optional benefits provided by Medi-Cal in 2005-06 and also showing the estimated 2009-10 savings from the specific optional benefit eliminations adopted in the budget (based on California's usual 50 percent FMAP).

The optional benefits which have been eliminated, pending a final decision on the "trigger," are discussed briefly below. The pre-enhanced FMAP savings figures are assumed in the 2009-10 Budget Act.

- **Adult Dental (\$109 million; \$83 million enhance FMAP).** Six other states besides California provide Medicaid dental services to adults. Federal law requires states to provide dental services to children. The budget discontinues Medi-Cal dental services for adults 21 years of age or older and to individuals with developmental disabilities. Children, pregnant women, and adults in nursing facilities will continue to receive Medi-Cal dental services as required under federal law.
- **Optical Labs (\$5.8 million; \$4.4 million enhanced FMAP).** Eliminates eyeglasses and contact lenses.
- **Optometrists/Opticians (\$1.8 million; \$1.4 million enhanced FMAP).** Eliminates these services, including low-vision services for the visually impaired and the legally blind.
- **Chiropractor (\$350,000; \$266,000 enhanced FMAP).** Savings estimate is net of 25-percent offset for shifts to physician services.
- **Psychologist (\$170,000; \$129,000 enhanced FMAP).** Current benefit limited to 2 visits per month unless provided by county mental health services (access to those services would remain for those with severe mental illness). Savings are

offset by 50 percent for shift to psychiatric and other services. Access to anti-depressants and other medications by physician prescription would remain available to Medi-Cal beneficiaries with less severe mental illness.

- **Podiatrist (\$1.5 million; \$1.1 million enhanced FMAP).** Savings are offset by 40 percent for shift to physician and other services.
- **Acupuncturist (\$2.5 million; \$1.9 million enhanced FMAP).** The budget assumes that there will be no cost-shift to other services from elimination of acupuncture.
- **Audiologist and Speech Therapist (\$3.2 million; 2.4 million enhanced FMAP).** Savings have been reduced by 50 percent due to increased costs for nursing homes, according to the budget.
- **Incontinence Creams and Washes (\$4.5 million; \$3.4 million enhanced FMAP).** Eliminates these prescribed incontinence supplies as a benefit. No cost shift or impact on other services is assumed.

Safety Net Care Pool Funds Shift. The 2009-10 Budget shifts to the state from the Safety Net Care Pool (SNCP) \$54.2 million in federal funds provided to designated public hospitals under the state's Hospital Financing Medicaid Waiver demonstration program from the federal government, unless the state receives sufficient federal economic stimulus dollars to pull the "trigger." As stipulated in the budget package, if the State Treasurer and Director of the Department of Finance deem California's receipt of federal funds to be at least \$10 billion, the trigger will be pulled and various cuts (including this SNCP shift) and increased revenues will not take effect. The shifted SNCP funds will be used to replace additional state General Fund costs in four state-operated programs: the Medically Indigent Adult Long-Term Care Program, the Breast and Cervical Cancer Treatment Program (BCCTP), the California Children's Services (CCS) Program, and the Genetically Handicapped Persons Program (GHPP).

SNCP Funds are capped at \$560 million annually and are provided to ensure continued support for health care services to the uninsured. Under the terms of the waiver, \$180 million each year is designated for the Coverage Initiative--expanded coverage options for the uninsured, generally making use of safety net hospitals, clinics and other resources in ten counties. Most of the remaining funds are allocated to the designated public hospitals to assist them in meeting their uncompensated care costs to treat the uninsured. However, \$44.5 million of SNCP funds are currently used by the state to offset General Fund costs in the state-operated programs cited above.

The federal government provides the SNCP waiver funds on a matching basis. The designated public hospitals match the federal funds with "certified public expenditures" (CPEs)—amounts that they spend from their own funds (including Realignment funds) to provide care. The state uses General Fund dollars spent on the designated programs as the match for those programs. This budget action will reduce SNCP funding to

public hospitals which could affect access to services by both Medi-Cal enrollees and the uninsured.

Medi-Cal Eligibility: Overview and Key Issues

General Eligibility. Medi-Cal eligibles fall into four categories of low-income people 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 no matter how low their income. 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.

Special Categories. The Medi-Cal Program also has several special eligibility categories that provide limited services for certain populations. These include: (1) Emergency Medical Services which provides emergency medical services to immigrants; (2) the Family PACT Program which provides family planning and 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.

In the 2008-09 and 2009-10 budgets, the Legislature restored almost all of the Governor's proposed cuts to Medi-Cal eligibility by rejecting:

- rollbacks in eligibility for poor families;
- restrictions on services to legal immigrants;
- monthly eligibility hurdles to emergency care for immigrants; and
- quarterly status reports for children and parents.

Now, with passage of the federal economic stimulus, any changes that would limit or restrict Medicaid eligibility would disqualify California from receiving the enhanced FMAP that is part of the federal stimulus package.

Mid-Year Status Reports. The one restriction in eligibility that the Legislature did adopt last year was continuous eligibility for children. In January 2008, the Governor proposed 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 have resulted in disenrollment without any actual redetermination of eligibility. In the final Budget Act of 2008-09, the Legislature rejected this proposal and instead adopted semi-annual redeterminations for children in Medi-Cal. According to DOF, this will result in an estimated GF savings of \$9.3 million in 2008-09 and \$91.9 GF in 2009-10, and caseload reductions of 24,565 in 08-09, 155,761 in 09-10, and 471,500 at full implementation. Previously, children were enrolled on an annual basis. The semi-annual reporting for child eligibility conforms to the existing enrollment requirement for parents on Medi-Cal. In current law, the semi-annual requirement will sunset on December 31, 2011, and will not apply to disabled children, pregnant young women, and certain other special eligibility groups.

The DOF savings estimate of reducing Medi-Cal continuous eligibility for children from twelve to six months is overstated as it would be offset by some increased costs including: 1) churning (repeated disenrolling and re-enrolling of eligible children) leading to higher county administrative costs; 2) increased emergency room care; and 3) a higher per child cost, as healthier children fall out of the program. It is also overstated in that it assumes California's regular FMAP of 50 percent, rather than the enhanced FMAP.

As a condition of receipt of the enhanced FMAP, states are required to meet specific federal requirements outlined in the federal legislation. One of the federal requirements is a prohibition against having eligibility standards, methodologies, or procedures under the state Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures that were in effect on July 1, 2008. Because the six-month status report requirement for children, and the shorter period of continuous eligibility were signed into law after July 1, 2008, California must rescind or suspend these provisions as a condition of receipt of the enhanced FMAP.

To draw down the maximum amount of federal funds, the state must make changes to the eligibility standards prior to July 1, 2009. If California does not make the changes prior to July 1, 2009, the state forfeits the increased FMAP for the time period from October 1, 2008, until the first calendar quarter in which the eligibility changes are made. SB 24 X3 (Alquist) would suspend mid-year status reports for the time period of the economic stimulus, and is awaiting action in the Senate.

Implementation of SB 437 Self-Certification Pilot (\$13 Million Cost). Chapter 328, *Statutes of 2006 (SB 437, Escutia)*, authorizes a pilot program to evaluate self-certification of income and assets by applicants and beneficiaries. The Governor vetoed funding (which he had proposed) for this program in the 2007-08 budget, on the basis that he was delaying implementation for one year. The Governor's proposed 2008-09 budget included a General Fund increase of \$11.4 million for increased caseload growth of 17,000 individuals, \$900,000 for counties to administer the pilot, and \$700,000 for an evaluation of the program's implementation and necessary computer systems changes. The final 2008-09 budget did not include this funding and

instead delayed implementation of SB 437. The 2009-10 budget again delays implementation of SB 437.

Fee-for Service Physician Rates: Legislation and Litigation

Medi-Cal rates are quite complex, varying by provider type, type of service, institutions versus individual providers, managed care versus fee-for-service, and other variables. The following is an overview and brief history of fee-for-service physician rates.

History:

- **2003-04:** Budget Act includes a 5 percent rate cut to Medi-Cal providers.
- **2003:** CMA sues the state in *CMA v. Bonta*. The federal district court judge found in favor of CMA and issued an injunction preventing the cut from taking place.
- **2005:** U.S. 9th Circuit Court of Appeals found that private parties do not have a right to challenge the state's compliance with federal Medicaid Law. CMA filed a petition for rehearing which prevented the state from implementing the rates. CMA sponsored legislation which was signed to eliminate the rate cut, but allowing the cut to take place for the 2006 calendar year.
- **2006:** A 5 percent rate cut was implemented. CMA again successfully sponsored legislation which stopped the rate cut.
- **2008: January Special Session:** Governor proposed and Legislature adopted a 10 percent rate cut to begin July 1, 2008. CMA and others sued the state to prevent the rate cut (*Independent Living Center of So. Cal. v. Shewry*). Federal court granted an injunction preventing implementation of the rate cut for fee-for-service providers.
- **2008-09:** Final budget included a restoration of most of the 10 percent rate cut effective March 1, 2009, maintaining a 1 percent rate cut for most providers, a 5 percent rate cut for long term care, pharmacy, and adult day health care providers, and a 10 percent rate cut to non-contract hospitals.

Given the status of these lawsuits, the 2008-09 budget restored nearly all of the 10 percent Medi-Cal rate cut for most providers: doctors, nurses, dentists, home health providers, etc., and half of the rate cut for pharmacy, managed care and long-term care facilities that do not pay the quality assurance fee (most nursing homes pay the fee and will receive a cost-based rate increase). These rate restorations were to take effect on March 1, 2009 and result in a total GF cost of about \$100 million. The 2008-09 budget also included \$221 million as a contingency to cover the costs of complying with a federal court order to fully restoring most rates, pending the outcome of the state's appeals.

The 2009-10 budget package included no significant changes to fee-for-service physician rates and assumes the rates to be the same as the 08-09 budget. Subsequent to passage of the 09-10 budget, another court injunction was issued prohibiting implementation of the 5 percent rate cut to pharmacies and adult day health care providers. The budget impact of this will be addressed in the Governor's May estimate.

Physicians Have Not Received Rate Increases in Recent Years. In general, FFS physician rates have not changed since the Legislature granted rate increases in the 2000–01 budget year, though medical costs continue to rise. A recent study that compared the rates Medi-Cal pays to its FFS providers to rates paid by Medicare found that, on average, Medi-Cal rates are about 61 percent of what Medicare pays to its service providers. A 10 percent rate reduction would reduce the rates to approximately 57 percent of what Medicare would pay. Typically, California ranks near the bottom of all fifty states in terms of provider rates.

One-month Cash-Flow Delay of Provider Payments. The 2009-10 budget provides the Department of Health Care Services the authority to delay one month of payments to Medi-Cal institutional providers and managed care plans during any month at the department's discretion prior to June 2009. This is a one-month cash disbursement delay of \$440 million GF (though no budget impact) in order to reduce the state's cash needs in the critical period prior to April tax receipts. DHCS will implement this authority beginning with the last week of March through the first three weeks of April 2009.

ISSUE 3: EFFECTS OF RECESSION

In light of the severity of the current recession and budget crisis, the subcommittee has invited a panel of experts to discuss the impacts of the recession on the Medi-Cal program, recipients, and low-income Californians generally. Panelists have been asked to share information on current impacts of the economic downturn on Medi-Cal as well as expected impacts over the next 1-2 years. As the subcommittee, and the full Legislature, make budget choices and decisions throughout this year, it is critical for legislators to be aware of not just diminishing state revenue, but also the increasing demand for services that simultaneously drives up costs.

The panelists include:

- ❖ **Toby Douglas** – Department of Health Care Services
- ❖ **Kirk Feely & Elizabeth Cheung** – Legislative Analyst's Office
- ❖ **Cathy Senderling** – County Welfare Director's Association
- ❖ **Elizabeth Landsberg** – Western Center on Law and Poverty
- ❖ **Erica Murray** – California Association of Public Hospitals
- ❖ **Judy Darnell** – United Ways of California

ISSUE 4: AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) & CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)**ARRA**

The following is a very general overview of the health provisions included in the ARRA. Please refer to attachment 2 for a more detailed description from the Legislative Analyst's Office.

Medicaid Provisions

Federal Medical Assistance Percentage (FMAP): ARRA provides a temporary increase in FMAP beginning retroactively from October 2008 and continuing through December 2010. This includes a base increase of 6.2 percent for all states, plus additional increases based on each state's unemployment rate and current federal share. The DOF estimates that California's FMAP will increase from 50 percent (for most Medi-Cal services) to 61.59 percent. ARRA includes three key restrictions that states must comply with in order to qualify for this enhanced FMAP: 1) States may not move these funds to "rainy day funds;" 2) states must meet prompt pay requirements; and 3) states may not have changed eligibility standards since July 1, 2008. California does not meet the third restriction due to the change in law through last year's budget act that reduced Medi-Cal continuous eligibility for children from twelve months to six months. California can qualify for the full FMAP enhancement by either rescinding or suspending this eligibility change and reinstating twelve-month continuous eligibility. If California does not make the changes prior to July 1, 2009, the state forfeits the increased FMAP for the time period from October 1, 2008, until the first calendar quarter in which the eligibility changes are made. The Legislative Analyst's Office has estimated that California will receive \$10.1 billion in enhanced FMAP, assuming the eligibility change occurs. SB 24 X3 (Alquist) would suspend mid-year status reports for the time period of the economic stimulus, and is awaiting action in the Senate.

Health Information Technology (HIT): ARRA includes \$15 billion for Medicaid, \$22 billion for Medicare, for incentive payments to providers, and \$2 billion for grants to expand and accelerate the implementation of electronic health records. ARRA requires states to provide oversight.

Disproportionate Share Hospital (DSH) Payment Increase: ARRA increases funding to DSH hospitals by 2.5 percent a year for two years. The LAO estimates this will provide California's DSH hospitals with an additional \$54 million.

Transitional Medi-Cal: ARRA provisions allow states to loosen restrictions on extending 12 months of coverage to families enrolled in Medicaid when the family's income rises above Medicaid eligibility.

Delay of Medicaid Regulations: The ARRA extends through June 30, 2009 the existing moratoria on certain federal regulations that could increase state and local costs for the Medi-Cal program.

Non-Medicaid Health Provisions

Health Centers: The ARRA provides \$2 billion nationally for qualified health centers.

Health Workforce Funding: The ARRA provides \$500 million nationwide to support health care workforce development programs.

Early Start Program: The ARRA provides about \$500 million in grant funding for the federal program that is called Early Start in California, and administered by the Department of Developmental Services. The LAO estimates that California will receive approximately \$50 million.

Prevention and Wellness Funds: The ARRA includes \$1 billion nationwide to: prevent health care-associated infections; increase vaccinations; and support local strategies to reduce chronic disease.

WIC Supplemental Funds: The ARRA includes \$500 million in supplemental funds for the WIC program.

Safe Drinking Water State Revolving Fund: The ARRA includes \$2 billion (nationwide) and \$160 million (for California) for drinking water projects that can begin construction by February 17, 2010.

COBRA Provisions: The ARRA includes provisions that offer persons who have lost employer-based health coverage between September 1, 2008 and January 1, 2010 due to job loss a 65 percent federal subsidy for their COBRA premiums, lasting nine months. AB 23 (Jones) would require health care service plans and health insurers, among others, to provide notice of the availability of premium assistance under ARRA and otherwise addresses state law changes necessary to implement the federal COBRA changes in ARRA.

CHIPRA

On February 4, 2009, the President signed a reauthorization of SCHIP, renamed "CHIP," via the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). California's primary CHIP program is the Healthy Families Program, operated by the Managed Risk Medical Insurance Program (MRMIB). Healthy Families and MRMIB will be discussed in detail at a later hearing; however, CHIPRA contains several provisions that affect Medicaid, as described below:

Citizenship Documentation. The Deficit Reduction Act of 2005 (DRA) added a new requirement for children, parents, and pregnant women who declare that they are citizens or nationals when applying for public programs. Under the DRA, they must meet prescribed paperwork-intensive rules to document their citizenship. Non-citizen applicants have always had to provide documentation of their immigration status.

CHIPRA gives states a new way to comply with the citizenship documentation requirement while also extending the requirement to CHIP. The new option, effective January 1, 2010:

- Allows states to document citizenship by submitting the names and Social Security Numbers (SSNs) of individuals declaring they are citizens or nationals to the Social Security Administration (SSA).
- If SSA finds that the name, the SSN, or that the applicant's declaration of citizenship or nationality is inconsistent with its records, the state must make a reasonable effort to address the discrepancy while providing coverage to the otherwise eligible individual.
- If the issue is not resolved by the state, individuals have 90 days to document their citizenship or fix the problem with SSA. If not resolved, they will be disenrolled within 30 days following the 90-day period.

Legal Immigrants. CHIPRA gives states a new option to provide Medicaid and CHIP coverage to lawfully residing immigrant children and pregnant women during their first five years in the country, if otherwise eligible. Prior to CHIPRA, states were prohibited from providing federally-funded Medicaid and CHIP coverage to legal immigrants during their first five years in the country. About 18 states, including California, made the decision to provide this coverage anyway, using only state funds to cover the costs. The new provision allows all states the option to receive federal matching funds to provide Medicaid and CHIP coverage to legal immigrant children and pregnant women (beyond pregnancy-related care, which is provided as an emergency benefit), without requiring them to wait five years after entry.

Performance Bonus. CHIPRA offers financial incentives to states (a "performance bonus") to find and enroll Medicaid-eligible uninsured children. The performance bonus offers additional payments in FFY 2009 to FFY 2013 to states that: (1) increase their Medicaid enrollment among low-income children above a target enrollment, and (2)

implement five of a specified eight outreach and enrollment activities. To be eligible for performance bonus payments, a state must implement (throughout the entire fiscal year) at least five of the following practices for children in SCHIP and Medicaid:

- 1) 12-month continuous eligibility;
- 2) elimination of the asset test (or the state must allow self-declaration when appropriate);
- 3) elimination of in-person interview requirements;
- 4) use of a joint application and the same information verification process;
- 5) use of streamlined or “administrative” renewal;
- 6) use of presumptive eligibility;
- 7) use of the Express Lane option; and
- 8) the use of premium assistance subsidies.

The amount of money that states can receive in performance bonus payments is not capped.

California already has implemented four of the eight practices, thereby needing to implement one more in order to qualify. If California were to permanently restore 12-month continuous eligibility, we would qualify under the second condition described above. In order to receive the performance bonus, California still would need to reach a rigorous enrollment target, per the first qualification.

ISSUE 5: DEPARTMENT ISSUES

In order to increase accountability in state government and maximize efficiency in the use of state resources, one of the responsibilities of the budget subcommittees is to provide oversight over state departments and programs. This responsibility becomes particularly critical in times of severely strained resources. To this end, the subcommittee has asked DHCS to provide information and updates on the following department issues:

CA-MMIS Procurement. The subcommittee has asked DHCS to provide an update on the CA-MMIS procurement process that is underway.

Background:

DHCS has begun the procurement process for establishing a new contract for operation of California's Medicaid Management Information System (CA-MMIS), the system that processes nearly all of the approximately 200 million Medi-Cal provider claims per year. The state contracted with the current fiscal agent ("EDS") in 2002. The current system is 30 years old and was designed to manage a much smaller and less complex Medi-Cal program. As a result, the system is very inflexible and unable to manage changes to the program or system.

In 2006, DHCS contracted with Eclipse Solutions, an independent consultant, to assess the current MMIS system. Eclipse recommended that the state procure an entirely new system in order for the Medi-Cal program to operate efficiently and effectively. Also in 2006, the California Attorney General's Medi-Cal Task Force reported that the current system lacks the ability to detect and prevent fraud and abuse. In 2007, a Little Hoover Commission report recommended replacing CA-MMIS in order to improve anti-fraud efforts and provide a higher quality service to beneficiaries.

The contract being procured at this time will be a five year contract, with the potential for five 1-year extensions, totaling ten years. The federal match for the development of the new system is 90%. Once the system is up and running, the federal match drops to 75%. DHCS estimates the total cost of the project to be \$1.25 to \$1.5 billion. New system costs are estimated to be \$225 million.

Department reports and pilot projects. The subcommittee has asked DHCS to provide an overview of:

- a. Outstanding statutorily required reports, such as how many DHCS has that are incomplete, an overview of their subject matter, and how many and which reports are late; and
- b. Pilot projects that DHCS oversees, including how long they have been in operation, whether they have been evaluated, and how much longer they are scheduled to be in operation.

Impact of budget cuts on the department. The subcommittee has asked DHCS to provide an overview of the budget cuts that have affected the department, their impact on programs and resulting resource challenges facing the department.

Potential future opportunities to achieve savings. The subcommittee has asked DHCS to discuss any new savings proposals that they have developed and can share at this point in time.