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

Assemblymember Hector De La Torre, Chair

MONDAY, MAY 1, 2006, 4PM
STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: AUDIT COUNTY ADMINISTRATION COSTS

The Department of Health Services requests $506,000 and five full-time positions for the Fiscal Forecasting and Data Management Branch. According to the Department of Health Services the goal of the initiative is to improve the County Administration allocation process by incorporating the results of county reviews in the county administrative funding process. The 2004 Budget Bill required the Department of Health Services to present a more comprehensive plan for reviewing county charges for eligibility to costs and overhead functions. The costs had risen 54 percent from 2001-02.

Funding for eligibility administration is a small but significant cost of the Medi-Cal Program. The 2006-07 budget for the program is $1.3 billion. There is no county share of cost for the Medi-Cal Program. Therefore, there is limited incentive for the counties to aggressively pursue cost control or efficiency.

The Budget Bill of 2004 required the Department of Health Services to work collaboratively with the California Welfare Directors Association to develop options and recommendations to modify the existing budgeting and allocation system for the funding of the county administered Medi-Cal eligibility process. The Department developed an initial plan for County Budgeting for the 2005-06 fiscal year. The Department states the plan was not sufficiently comprehensive and determined it needs to review substantially more county documentation and develop a more through and detailed cost allocation plan. The Department anticipates there will be an indeterminate level of savings from this initiative.

Reduce request by 2 AGPAs. Reviews shouldn't take as long as estimated, Data could be requested in advance to have available for reviewers. AGPA request not based on annual workload (based on 3 years workload). Should be able to automate the analysis and report to reduce analysis and preparation time to one week. In addition, SSM I time over budgeted because based on 58 reviews annually when annual workload will be 36 reviews. This position can help out with reviews of counties.

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ISSUE 2: PHYSICIAN MEDI-CAL RATES

The California Medical Association urges the Subcommittee to increase the rates paid physicians for providing services to Medi-Cal beneficiaries. The Association notes that low reimbursement rates has caused many physicians to stop taking new patients or dropping out of the program completely. Children, low income adults and people with disabilities often are unable to find a physician. Stagnant rates will make health access in Medi-Cal worse and put pressure on the emergency care system as Medi-Cal beneficiaries seek care in the Emergency Department when they don't have access to primary and preventative care.

The Association asserts there has been one rate increase over the last 20 years. Concurrent with the stagnant rates the cost of doing business has increased in an unabated fashion. On average Medi-Cal rates for physician rates are less than 60 percent of Medicare rates and 50 percent of commercial rates. Over the last five years the value of the reimbursement has declined by more that 20 percent.

The California Medical Association requests the Subcommittee increase the rates for physicians.

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ISSUE 3: ANTI-FRAUD PROGRAM

The Medi-Cal Anti-Fraud Initiative of 2003-04 included 39 positions for Audit and Investigation to increase onsite enrollment and or enrollment reviews of providers identified as high risk for fraud or abuse the Department during the application review process. Of the positions, 19 were permanent and 20 were limited term positions. The Department requests the conversion of the 20-limited term to permanent to continue pre- and re-enrollment onsite reviews of applicants and current Medi-Cal providers that have been identified as high risk for fraud or abuse.

When the positions were, added Audits and Investigations had a backlog of some 600 referrals waiting for onsite review. It was anticipated that the number of providers referred to Audits and Investigation for an onsite enrollment or re-enrollment review would decrease over time and the Audits and Investigation could reduce the number of staff dedicated to onsite reviews. It was this expectation that caused the Department to request limited term positions rather than permanent. However, the number of referrals has not decreased and Audits and Investigations continues to receive over 700 high risk provider referrals for both enrollment and re-enrollment reviews annually.

DHS had not yet released the 2005 annual error rate study that is intended to assess the level and nature of Medi-Cal fraud. The LAO believes the report will be valuable as the Legislature considers appropriate staffing for antifraud activities.

At the time when the LAO updated its analysis the Legislature still had not received the report from the administration, although DHS indicates that it expects to release the report soon. Thus, the LAO continues to withhold recommendation on these positions at this time. Should the administration not release the error rate report by the time of the May Revision, the LAO recommends that the Legislature deny the proposal to extend the 20 positions beyond the current fiscal year.

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ISSUE 4: TREATMENT AUTHORIZATION PROCESSING

The Department of Health Services requests six staff to create a Quality Assurance and Program Integrity unit to collect, manage and monitor Medi-Cal utilization review (UR) data, optimize and expand the current e-TAR and auto adjudication processes and improve the UR process. Utilization review is an important part of Medi-Cal's cost containment process. The Department estimates that it saved over $413 million in health care services and $111 million in pharmacy services in 2004.

The Department believes the Medi-Cal program is cost-effective it has not kept pace with opportunities to improve the UR process. The lack of improvements has resulted in delays in TAR adjudication and inconsistent adjudication decisions. As a result a number of reports have been published over the last few years.

TARS are submitted by providers to Medi-Cal Field Offices. Information from the TARs are entered into an automated TAR System by EDS Staff. The TAR is routed to a DHS consultant who reviews the TAR and accompanying medical records for medical necessity. The consultant writes his/her decision on the TAR and enters it into the automated system and then the Medi-Cal Field Office sends it on to the provider. The paper TAR process for obtaining TAR authorization is cumbersome and not responsive to beneficiary and provider needs.

The complaints of the providers, increase in TAR appeals and litigation activity demonstrate the need to reform the process and provide consistency in TAR adjudication. The Department states that it lacks the resources to ensure uniformity and consistency in the TAR process. DHS states that it has worked with EDS to develop a more cost efficient and less manual intensive TAR infrastructure. The statewide TAR automation effort has two major components that are linked and designed to interface with one another. They are:

1. E-TAR, which is a secure, web-based direct data entry system used by Medi-Cal providers to submit TARs and retrieve TAR decisions. E-TARS submitted by providers are stored in,

2. SURGE, Service Utilization Review Guidance and Evaluation, which is a computer processing system used by DHS Medi-Cal consultants to review and adjudicate TARs. Once a decision is rendered, the information is stored in the secure SURGE TAR database for provider and field office access.

The Department proposes four positions for the Quality Assurance and Program Integrity. The Department believes the staffing is necessary to develop and meet the demands of a program that has come under increasing criticism for its lack of uniformity and consistency in decision-making. The Department states that the positions would provide senior management with access to TAR adjudication and cost decision data on which to base decisions related to cost containment.

Also, the Department is proposing two staff for E-TAR and Auto-adjudication efforts. The Department states the positions are necessary to expand the utilization E-TARS and the capabilities of SURGE and to expand the implementation of the TAR auto-adjudication. While some of the components of the TAR process remains primarily a paper base system.

It is unclear why DHS needs additional resources to address TAR issues after receiving 18 positions in 2004-05 for TAR activities. Also, DHS indicates that use of the e-TAR and SURGE systems has increased significantly during 2005, which should allow DHS to redirect resources for the proposed projects.

ISSUE 5: LONG-TERM CARE COMMUNITY OPTIONS TOOL

The Department of Health Services is requesting one position and $595,000 ($297,000 General Fund) to develop and test a "Community Options and Assessment Protocol". The Department would be authorized to use up to $500,000 for contracting. The tool would be used by several state departments and their contractors to help keep people in their homes and out of long-term care facilities.

There is no assessment protocol available. There are no agreed upon or consistent data elements.

The proposal requires a statutory amendment to implement. The bill AB 3019 is the Administration's proposal. The bill was heard in Assembly Health on April 18th, and was passed and sent to the Appropriations Committee.

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ISSUE 6: DRUG REBATES

The Department of Health Services request authorization to extend 11 limited term positions for one year. The positions were as a three-year limited term positions. The positions were authorized in the 2003-04 fiscal year to resolve the outstanding balance of aged drug rebates.

Prior to the authorization the outstanding balance had reached over $300 million in January 2003. By December 2005 the balance was $150 million. The Department states that the positions were cost effective as the Department has realized over $20 million dollars. The Department expects that in June of 2007 the volume of the aged rebates will be $100 million. According to the Department the dispute process is complex. It takes time to develop the skills necessary to operate the Rebate Accounting Information Systems and rebate related software applications. The turn over rate among limited-term positions is quite high. The loss of trained staff slows the resolution of outstanding rebate balance. The Department has experienced difficulty to recruit qualified employees for the limited term positions. In addition, the experienced staffs from the drug rebate program are redirected from their work to train the replacements.

The LAO recently updated its review of the issue and now recommends approval of all of the 11 positions. According to DHS, as of April 5, 2006 all of the 11 positions are filled. Based on this information, the LAO believes all 11 positions should be provided a one-year extension.

However, the LAO further recommends the Legislature ask DHS for an update on the number of filled positions during the hearings of the Governor's May Revision. If in May the number filled differs from the LAO's recommendation, then it would recommend that the Legislature approve a number of positions that is the equivalent of the number of the 11 positions that are filled as of May 2006.

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ISSUE 7: BREAST AND CERVICAL CANCER TREATMENT PROGRAM

The Breast and Cervical Cancer and Treatment Program (BCCTP) is a specialized program that provides treatment service to eligible women diagnosed with breast and or cervical cancer. The program was initiated in January 2002. The program has backlogs in processing eligibility determinations and is out of compliance with federal rules. The program also is unable to keep current with new applications. To address the inability to achieve currency in eligibility determinations, the Department of Health Services requests 26 positions and $1,902 million, $951,000 General Fund.

The ongoing BCCTP workload activities include:

- Application review and eligibility determination for new and backlogged cases including applying State-funded BCCTP rules for those determined not eligible under the federal BCCTP;
- Completing annual re-determinations for all of the federal cases that have received BCCTP coverage for 12 months, including backlogged cases and cases determined eligible in the prior year;
- Processing three months retroactive coverage requests after the initial announcement
- Transferring cases to the county annual re-determination if the woman is no longer eligible for the federal BCCTP to determine is she is eligible for any other Medi-Cal program
- Providing explanations of program rules and regulations to applicants and others; and
- Making referrals to local cancer support agencies and counties.

Current and on going Workload:

- 12,900 current BCCTP eligibles (2,900 State Program and 10,000 Federal Program)
- 25 new applications received each month, of which155 are for the federal program and 70 for the State-funded program
- The six permanent analyst staff with the State funded program stay current with the new 70 applications each month and terminate cases after the 18 or 24 months of eligibility under the state funded program
- The nine limited term analyst staff with the federal program stay current with the new 155 applications received each month

<u>Backlog Workload (Prior to FY 2004-2005)</u>

- 6,200 current backlog of cases that require initial eligibility determinations
- 2,200 current cases that require re-determinations of eligibility that have been on the program for over one year without an annual re-determination

Additional Ongoing Workload

- Annual re-determinations, plus 2,200 that are receiving full-scope BCCTP and will require annual re-determinations each year for all currently enrolled beneficiaries after initial determination of eligibility, including 6,200 cases that are on accelerated eligibility and will need annual re-determination each year following the initial eligibility determinations.

Workload Effective January 2006

- 12,900 BCCTP eligibles: provide notice of availability of retroactive coverage for three months.
- 155 new federal cases/month = 1,860 annually; provide notice of the availability of retroactive coverage for three months.
- Process resulting requests for retroactive coverage.

The current federal backlog consists of:

- 6,200 current cases on accelerated eligibility that are overdue for final eligibility determination.

The women receive temporary, full scope Medi-Cal benefits under accelerated eligibility status because the women appeared to be eligible for federal BCCTP based upon information presented. The accelerated eligibility continues while a final eligibility decision is made. Federal law requires that eligibility determination be completed within 45 days. Many of these women have not had a final eligibility determination since the inception of the program in 2002

The LAO in a comparison of current caseload and backlog to staff productivity indicates that fewer new positions than requested are warranted. in order to maintain position continuity, we recommend that 4 of the 11 positions set to expire 12/31/06 be made permanent and that the other 7 be extended for 1.5 years. Also recommend six new two-year LTs beginning 7/1/06. The LAO recommends position count: 4.0 x .5 = 2.0 perm positions; 7.0 x .5 + 6.0 = 9.5 LT positions.

The Administration argues quite persuasively that without the positions, the department is at risk of significant federal sanctions for failure to make eligibility and annual re-determinations timely. Also, the Department asked for 4 limited term positions for processing retroactive eligibility after notice is sent to the 15,000 current and former beneficiaries about the availability of retroactive coverage. Without the 4 positions, the Department believes it may be impossible to implement retroactive coverage on a statewide basis except for new applications as they are received.

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ISSUE 8: HIPAA

The Department of Health Services request the authority to establish 12.5 position as two-year limited term to augment its efforts to comply with the Health Insurance Portability and Accountability (HIPAA) mandated by the federal Government. The Department is also requesting $322,000 in reimbursements. The Reimbursements will be provided by the California Office of HIPAA Implementation. The positions are important for ensuring continuity of services to beneficiaries and payments to providers during the transition to HIPAA compliance as well as provide ongoing support of implemented technical and business solutions. The resulting changes will also avoid potential fines, loss of federal funding, and provide the opportunity for additional savings.

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ISSUE 9: VITAL RECORDS IMAGE REDACTION AND STATEWIDE ACCESS PROJECT

The Budget Change Proposal requests 19 positions and $10.8 million in the budget year. The corresponding Feasibility Study Report ($22.2 million over 3 years) is in response to SB 247 of 2002, which mandates the development of safety and security measures to protect against the fraudulent use of birth and death records. The system will store digitized document images and respond to online requests for copies by automatically removing private information and then producing the modified record image via fax, email or online for printing. The volume is 45 million records and 380,000 requests annually.

The Legislative Analysts Office states:

1. The LAO has no concerns with the staffing request. The workload justifies the number of positions and levels.

2. Department of Finance's Feasibility Study Report approval letter directed DHS to submit an analysis to DOF within 30 days of the Jan. 19 letter "identifying the costs, benefits, and risks of hosting the servers and backup site at the DHS versus the Dept. of Technology Services. The analysis was to include the costs for all staff, equipment, facilities, and training required to support the servers and backup site at the DHS." The DHS report submitted in late March recommended housing the system storage infrastructure at DHS but the analysis was very superficial, one-sided and didn't reconcile to the FSR. The LAO's understanding is that DTS was not asked to validate any of the statements. Therefore, the LAO recommends the Budget Bill Language below.

3. The department proposes revised TBL deleting the July 1, 2007 implementation date, adding language to make online requests available only after the system becomes operational, and the requested year's records have been input. The language addition is reasonable and necessary but LAO sees no reason to delete the implementation date. The FSR project schedule reflects this date and if the department doesn't believe their schedule is realistic then both the document and the TBL date should be revised. This date has been revised once already and it has taken almost 3 years to produce an FSR. Removing the TBL date could lower project visibility and priority; further jeopardizing the timeliness of legislative intent to protect against the fraudulent use of birth and death records. Therefore, the LAO recommends rejection of the Trail Bill Language.

4. SB 247 called for the establishment of a Vital Records Protection Advisory committee in Health and Safety Code 103527 to make various recommendations relating to protecting the privacy of records. The Department never formed the advisory committee. Instead, they are using an existing advisory committee (Vital Statistics Advisory Committee) for this purpose.

5. The federal Real ID Act of 2005 requires (among other things) that electronic copies of identity source documents be maintained. This appeared to create over-lapping system requirements between DMV and the DHS Vital Records Image System. However, DHS has sufficiently explained the difference between the two projects to allay our concerns on this issue. However, going back to # 2 above, DMV is proposing to use the DTS for their storage infrastructure needs. And, while the DMV and DHS systems differ, their described infrastructure storage technology requirements are the same.

Proposed ***BBL:***
Item *4260-001-0099*
Provision 1. Funding in this appropriation for the Vital Records Image Reduction and Statewide Access Project (VRIRSA) and the related computerization of vital records is provided on the following basis:
(a) The Department of Finance (DOF), in collaboration with the Department of Health Services (DHS) and the Department of Technology Services (DTS), shall prepare a revised analysis to determine the most appropriate and cost-effective location for the production and backup services for the VRIRSA Project and the related computerization of records project;
(b) To assist in this effort, DTS shall estimate an interim rate to be charged for its support of VRIRSA infrastructure requirements;
(c) Based on this information, DOF shall develop an appropriate infrastructure implementation approach that is based on the project's cost, support and security needs and is in line with the state's data infrastructure consolidation goals;
(d) Within 30 days of its completion, DOF shall submit the revised analysis to the chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature.

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ISSUE 10: IMPLEMENTATION OF NURSING FACILITY QUALITY ASSURANCE

The Department of Health Services requests 41 additional permanent full time positions and funding for 14.5 positions that were administratively established with no funding. DHS states the positions are needed to implement and administer the requirements of AB 1629. In addition the BCP requests $1 million in contractor funding for completing and implementing the new rate system for Nursing Facilities and $500,000 for the follow-up comparison report on collection and evaluation of nursing facility data.

AB 1629 authorizes the Department of Health Services to:

- Impose a quality-related fee on nursing facilities retroactive to July of 2004. The Department of Health Services estimates the fee will be assessed on 1,100 of 1,324 facilities;
- Lift the rate freeze mandated in 2003;
- Implement, by August 2005 a new facility-specific Medi-Cal Reimbursement rate; and
- Collect baseline information regarding citations, staffing levels, worker wages, benefits, residents care, and a report to the Legislature by January 2007.

Adopt the overall recommendation of the LAO. Fund the AGPA positions with the Licensing and Certification. Reduce the Legal Office staffing. Finally, retain all other financial aspects of the BCP.

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ISSUE 11: COORDINATE CASE MANAGEMENT PILOT PROJECTS

The Department of Health Services requests five staff and contract services to implement a Coordinate Case Management Demonstration Project. The goal of the program is to maintain access to medically necessary and appropriate services, improve health outcomes and provide care in a more cost effective manner for two populations enrolled in the Fee-For-Service Medi-Cal Program who are not on Medicare. The populations are: seniors and Persons with Disabilities who have chronic conditions; and persons with chronic health conditions and Serious Mental Illness.

The two proposed implementation dates are January 2008 through December 2010 for the SPD with chronic conditions project and from January 2008 through January 2012 for the persons with Serious Mental Illness and chronic conditions project.

ISSUE 12: ONGOING WORKLOAD FOR MEDICARE PART D

The Governor's budget plan proposes to provide the Department of Health Services with four Program Technician III positions in 2006-07 at a cost of $264,000 from all fund sources ($66,000 from the General Fund) to support ongoing workload for Medicare Part D. According to the administration, the unit has additional workload created by the implementation of the federal Medicare Part D drug benefit, such as resolving problems related to the enrollment of Medi-Cal beneficiaries into Medicare Part D and ensuring that Medi-Cal is the payer of last resort for beneficiaries.

In its *Analysis,* the LAO withheld recommendation on the proposal for the additional staff and funding until the Legislature has been provided the information it needs to conduct an updated workload analysis of the request. The rationale for withholding the recommendation was that there was no available data on what the ongoing workload from implementation of Medicare Part D would consist of for the third party liability unit. After Part D was implemented on January 1, 2006, the LAO thought there would be a few months worth of data upon which the Legislature could base a decision in the spring about the appropriate amount of resources necessary to address Part D workload.

Unfortunately, the implementation of Part D has been problematic and federal agencies are still working to correct glitches in the enrollment and billing processes. As a result, the LAO does not believe that the data for the first few months of Part D implementation can be used to accurately estimate the ongoing workload related to Part D. Therefore, the LAO recommends that the Legislature approve the four positions on a two-year, limited-term basis. At the end of that period, the Legislature could then revisit whether ongoing caseload for these activities continues to justify the additional staff positions.

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ISSUE 13: CONTRACT STAFFING FOR TREATMENT AUTHORIZATION REQUESTS

The administration's 2006-07 budget plan proposed a reduction of $4.8 million ($1.2 million General Fund) for contract staff for the state's fiscal intermediary related to a decline in pharmacy-related workload due to the shift of prescription drug coverage from Medi-Cal to Medicare. Also, no reduction was proposed in the level of staffing for the DHS TAR unit as a result of the implementation of Medicare Part D

In its 2006-07 Budget Analysis, the LAO withheld recommendation on the proposed administration adjustments for TAR resources. The LAO lacked information about the level of filled and vacant positions for these functions at EDS and DHS. The LAO has since received this information. However, it is still unclear whether the appropriate level of contract and DHS staff resources is provided for pharmacy-related TARS because of the lack of data showing the actual volume of TARs that DHS will be responsible for processing after the full implementation of Medicare Part D.

The LAO believes that DHS is over-budgeted for this function. The administration's budget proposal would reduce the level of contract pharmacists at EDS by 78 percent (compared to the number of filled positions as of April 2005) and would reduce other EDS support staff used for these functions by 35 percent. As mentioned earlier, none of the 55 state DHS staff pharmacists or related support staff have been proposed for reduction. Taking both DHS and EDS resources into account, the budget proposes about a 30 percent reduction in the state's overall resources to process TARs. In contrast, however, DHS estimates that the full savings of dual eligible costs due to the shift of drug coverage to Medicare Part D would reduce drug expenditures by nearly 57 percent. The LAO believes it reasonable that pharmacy-related TAR volume would be reduced by at least 50 percent due to the Medicare Part D implementation.

Accordingly, the LAO recommends that, in addition to the budget adjustments proposed by the administration, that the Legislature further eliminate all of the EDS contract funding for pharmacists used to process TARs and adopt a further reduction in the EDS contract funding that is equivalent to 14 support staff positions (including key entry positions, clerks, and supervisors). Such a change would increase the overall reduction in the state's effort to process TARs to about 40 percent.

The LAO estimates that these changes would result in additional savings of about $1.5 million ($750,000 General Fund) in the budget year.

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ISSUE 14: MEDI-CAL RE-DETERMINATIONS

To assist Medi-Cal beneficiaries in retaining their health coverage the following trailer bill language is proposed. The language of the bill would require the Department of Health Services to adopt a mechanism for providing information to Medi-Cal providers regarding a beneficiaries renewal due date. The providers would thereby be able to remind and assist Medi-Cal beneficiaries regarding the completion of the forms so no Medi-Cal coverage is lost.

There is current statute that requires the Department of Health Services to conduct a feasibility study for providing renewal date information to Medi-Cal managed care plans. However, this study has not been implemented and does not ensure the information is accessible to all Medi-Cal providers.

Medi-Cal beneficiaries are currently required to submit annual and/or semi-annual status to demonstrate their continued eligibility for Medi-Cal coverage. Although the vast majority of beneficiaries remain eligible for Medi-Cal, they may lose coverage if the complex forms and appropriate documentation are not submitted.

- A RAND study found that disenrollment rates among former welfare recipients ranged from 22% to 82% across California counties, for an average of 50% statewide.[1]

- Studies show that when Medi-Cal individuals fail to renew during the eligibility determination process and then subsequently re-apply once their coverage has been dropped, there are unnecessary increased administrative costs and use of limited staff time.[2]

- In addition, the disruption in Medi-Cal coverage means Californians are less likely to obtain timely preventive health, primary care, and chronic disease services that could result in unnecessary and expensive hospitalization or emergency room care.[3]

- The California Healthcare Foundation commissioned a study on the provision of renewal date information to health plans and concluded that a process designed to address this need is already in place.[4]

The provisions will ensure that Medi-Cal patients who visit clinics are informed that their filing date is approaching, so they can be sure they stay enrolled in Medi-Cal. Thus, the State does not increase its numbers of uninsured and community clinics will not lose money for treating people who used to have Medi-Cal coverage but now have no insurance

Proposed Trailer Bill Language

SECTION 1. Section 14018.15 is added to the Welfare and Institutions Code, to read:
14018.15. (a) The department, in consultation with the counties, providers, and advocates, shall implement a state-level automated procedure to give Medi-Cal providers access to information regarding any of the following, with respect to their patients who are beneficiaries in the Medi-Cal program:
(1) The date upon which any annual eligibility redetermination forms or scheduled status report forms must be submitted by a beneficiary to continue eligibility in the Medi-Cal program.
(2) A beneficiary's final month and year of eligibility in the Medi-Cal program.
(3) The month and year in which a Medi-Cal beneficiary's next scheduled status report is due.
(b) Based on the information provided under subdivision (a), the Medi-Cal provider may, but shall not be required to, notify a beneficiary of an approaching deadline.
(c) This section shall be implemented on or before June 30, 2006.
(d) This section shall be implemented only to the extent that funds for this purpose are appropriated by the Legislature in the annual Budget Act or other statute.

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ISSUE 15: HOSPITAL FINANCING WAIVER

For 2006-07, the Governor's budget plan requests additional resources for the Department of Health Services (DHS) to administer the hospital waiver. Specifically, the proposed budget includes requests for the following:

- $748,000 from the General Fund ($1.5 million from all fund sources) for 13 DHS positions for continuation of hospital waiver implementation. These positions are supported in the current year with an appropriation made in last year's hospital waiver legislation. The Governor's budget requests this funding in the budget year to make all of these positions permanent;
- A shift in support to the General Fund for 21 existing DHS positions previously supported through intergovernmental transfers of hospital funding;
- Permanent authority and budget resources for seven limited-term positions currently due to expire in either 2006-07 or 2007-08; and
- Continued funding and two positions in the DHS budget for staff related to California Medical Assistance Commission (CMAC) hospital waiver implementation activities.

In an April finance letter, the administration revised its request for CMAC staffing related to the hospital waiver. Specifically, it proposed to reduce funding in the DHS budget by $119,000 General Fund ($238,000 all funds) to reflect the fact that two positions for these purposes were instead established within CMAC itself in 2005-06.

The Legislative Analyst withheld a recommendation on the January budget proposal because of outstanding issues related to the workload justification that was provided for the positions and several technical questions. Based on additional information the LAO reviewed regarding the January proposals, and its review of the April finance letter relating to CMAC, it now recommends that the Legislature take the following actions:

- Modify the request for additional funding for the 13 requested DHS positions by establishing nine of these positions as one-year limited-term;
- Modify the funding shift proposed to support the 21 existing DHS positions to continue to use interest on intergovernmental funds to the maximum extent possible in lieu of General Fund;
- Deny the request to make permanent the seven limited-term positions; and
- Eliminate the two additional DHS staff positions related to CMAC hospital waiver activities, and approve the administration April finance letter that eliminates the DHS funding for them.

Funding for nine of the thirteen positions was provided to DHS ten new positions to develop and administer the hospital financing waiver. Last year, Chapter 560, Statutes of 2005 [SB 1100 (Perata)], the legislation implementing the hospital waiver, appropriated an additional $1.7 million General Fund ($3.4 million all funds) for additional staffing for these purposes. Using these resources, DHS administratively established 13 more positions in the current year. The 2006-07 Governor's budget proposes to make these 13 additional positions permanent.

The DHS indicates that nine of the 13 administratively established positions are currently filled or will soon be filled and that it will spend slightly over half the funding augmentation provided by Chapter 560 in the current year. We also note that according to DHS, the four divisions requesting these new positions had a vacancy rate of about 8 percent as of January 31, 2006, indicating that the department could fill about 50 additional positions while still maintaining a 5 percent vacancy rate for budgeted salary savings.

The LAO's analysis indicates that the proposed 13 additional positions are unwarranted on a workload basis and that the ten positions initially approved for these purposes in the *2005-06 Budget Act* should be sufficient to support these activities. Under the administration budget proposal, DHS would have much more intensive staffing for this function than it previously had for administration of a related hospital financing program for disproportionate share hospitals (DSH). Under the DSH program, DHS had the equivalent of one staff member for every 12.5 hospitals. Under the administration's new hospital waiver staffing proposal, DHS would have the equivalent of about one staff member for each hospital.

However, the LAO agrees that some additional staffing is necessary during the transition to the new waiver payment methods. Because it was provided in a separate appropriation, the funding provided by Chapter 560 could be carried over into 2006-07 to support the nine positions that DHS has already filled. As such, the LAO recommends that the Legislature establish these nine as one-year limited-term positions for 2006-07 but deny the remaining four positions requested in the budget. We further recommend that the Legislature adopt budget bill language to revert any remaining funds appropriated by Chapter 560 at the end of 2006-07.

The Governor's budget proposes to shift funding for 21 existing positions to the General Fund and to no longer use funds from intergovernmental transfers for this purpose. Interest earned by the state on these transferred funds previously supported these positions. We recommend that the Legislature modify the proposed funding shift to continue to use interest on intergovernmental funds to the maximum extent possible in lieu of General Fund. The most recently available fund condition statement suggests that enough interest earnings are available for this purpose in 2006-07.

The DHS asserts that the interest is no longer available under Chapter 560 to support these staff resources, and, moreover, that some of the staff positions are no longer appropriate to support with interest earnings because they are not directly involved in DSH-related work. However, an existing statute (Welfare and Institutions Code Section 14163(d)) appears to permit the Legislature to appropriate funds for staff to administer the DSH program. The LAO has not been able to identify any provision of Chapter 560 that amends this provision of law. Also, while the administration is correct that some of the positions cannot appropriately be funded with interest earnings, some of them could be.

Accordingly, this fund source be used in lieu of General Fund for a portion of the 21 existing positions unless DHS is able to identify a specific provision in law that would prohibit this continued practice. The administration also should be directed to identify the DHS positions that appropriately could be supported with interest earnings on intergovernmental transfers.

The LAO recommends that the Legislature deny the request to make seven limited-term positions permanent, waiver staff resources should be sufficient to administer the waiver. Moreover, four of these positions would not expire until 2007-08. As such, it is premature at this time to consider making them permanent.

The 2005-06 budget provided two positions and funding for CMAC to assist in the implementation of the new hospital waiver. However, these resources were inadvertently established at DHS, which then agreed to administratively transfer the positions and funding to CMAC. The Governor's 2006-07 January budget plan would correctly provide these resources in CMAC's budget, but it would incorrectly provide continued funding and position authority for the two positions at DHS.

An April 1, 2006 finance letter proposes to eliminate the funding for the two positions in the DHS budget, but the administration has not proposed to eliminate the position authority. The administration indicates that it believes these positions are needed by DHS. However, DHS has not provided any workload justification for these two positions in its budget request. Accordingly, the LAO recommends that the DHS positions be abolished and that the Legislature adopt the finance letter that eliminates the related funding.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 16: REFORM OF ADULT DAY HEALTH CARE PROGRAM

The Department of Health Services requests the staff necessary to make the changes required in a Policy Bill that is to decrease fraud and abuse in the program.

The changes include:

- Unbundled the current all-inclusive procedure code and reimbursement rate for ADHC into its component services. Codes and rates have already been established as part of the work done on a potential ADHC waiver.

- Tighten medical necessity criteria so that only those beneficiaries that require specific services can receive authorization. As with individual rates and procedure codes, medical necessity is being developed.

- Increase Medi-Cal field office staffing by four nurses to be used to increase onsite adjudication of Treatment Authorization Requests for ADHC services. Onsite adjudication of TARS will provide utilization control on a pre-service basis

- Increases the California Department of Aging staffing by four nurses to be used to do post-payment reviews. The reviews would be done via the current interagency agreement with the Department of Health Services to ensure that services that were billed were actually provided and were medical necessary. Payment for those services not provided or not determined to be medically necessary would be recouped from the ADHC center.

While many ADH centers provide critical series that enable people to avoid going into nursing facilities, the ADH program has seen significant growth, largely by centers that provide minimal care to their patients, many of whom would be able to successfully function without the services. Legislation in 2004 placed a moratorium on enrollment of most ADHC Centers. For the budget year, the Department forecasts that 45,900 beneficiaries were expected to use ADHC services each month. The proposed DHS reforms are anticipated to slow the growth in ADHC centers and to ensure the quality of care to beneficiaries who require the services in order to remain independent.

The Department believes that fraud and abuse will be decreased in the Adult Day Health Care Program. In addition, the Department projects that up to $19.8 million ($9.9 million General Fund) will be realized in the budget year. Beginning in BY+1, the Department projects savings will equal a $121.8 million ($60.9 million General Fund)

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 17: SELF-DIRECTED WAIVER FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

The Department of Health Services, as the State's Single State Medicaid Agency, requests approval for two permanent full time positions for $193,000 (96,000 General Fund). The request pertains to the development, implementation, and level of care monitoring and ongoing oversight of a new Medicaid Self-Directed Waiver Program. The Department of Developmental Services is preparing the waiver application for submittal to Centers for Medicare and Medicaid Services (CMS). With direction and support from the Department of Health Services, the Department of Developmental Services is funding an outside contractor to develop the waiver application and prepare an interagency agreement for reimbursement of federal funds. DHS will monitor the contractor's performance to ensure development of the Waiver application is consistent with State and federal laws and regulations.

CMS requires DHS to perform as the State's Single State Medicaid Agency, including submittal of the waiver application to CMS and performing required State and federal oversight and monitoring functions. The Department states that the two requested positions would ensure that DHS meets federal requirements to administer all waiver programs. Position authority is requested to carry out all required monitoring and administrative oversight activities. The waiver proposal would allow developmentally disabled Medicaid eligible clients to reside in the community rather than in institutions. The state currently pays 50 percent of the institutional costs and receives federal funding for the other 50 percent of the costs. The cost of clients who are currently residing in an institution would be reduced significantly when transitioned into the community.

The LAO notes the workload does not justify two positions. The savings will be $100,000 ($50,000 General Fund).

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 18: IMPLEMENTATION OF THE ASSISTED LIVING WAIVER

The Department of Health Services is required to implement, monitor, and oversee the Assisted Living Pilot Project. The Department requests six full-time positions. The positions are two Nurse Evaluators and four Health Facility Evaluator Nurses. In addition, the Department is requesting $1.2 million from all sources ($467,000 General Fund). It is expected that 1,000 participants will be living in 15 sites in the three geographic areas over the three year term.

In 2001-02, a state contractor was retained to assist with design and implementation of an assisted living pilot project. The project is to serve persons with disabilities over the age of 21 living in residential care facilities for the elderly or in publicly subsidized housing and who require certain relatively intensive levels of nursing care. Enrollment in the pilot program was to have begun recently, the Budget Change Proposal projected a January 2006 as the start date.

The LAO states that only three of the six staff positions are justified on a workload basis. Savings of $363,000 ($107,000 General Fund) would be achieved.

ISSUE 19: CMAC FINANCE LETTER

The Department of Health Services request that Item 4260-001-0001 be decreased by $119,000 and Item 4260-001-0890 be decreased by $119,000. The 2005 Budget Act provided two positions and $238,000 intended for CMAC. However, the funding and position authority were mistakenly place in the Department of Health Services budget. The Governor's Budget includes a baseline adjustment to increase the CMAC budget for this issue in 2006-07. However, a corresponding baseline adjustment to decrease the DHS budget was not included in the Governor's Budget.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 20: DISEASE MANAGEMENT PILOT PROGRAM IMPLEMENTATION

The Department of Health Services plans to test the efficiency of providing disease management services to fee-for-service Medi-Cal beneficiaries with chronic conditions such as heart disease. The Department intends to award a competitively bid contract to a disease management organization. Release of the request for proposal (RFP) for this pilot project was initially delayed from March 2005 to December 2005 and the LAO reports that it is now likely the RFP will be further delayed. Therefore, it is unlikely that the contract would be awarded by the spring of 2006 or that payments to the contractor will begin in May 2006. Given the delays to date, the LAO estimates the contract will not be awarded until July 2006 and that implementation of disease management will not begin until September of 2006 at the earliest.

Based on the RFP the level of funding needed for 2006-07 will be less than the LAO anticipated. The LAO estimates that the level of funding needed in 2006-07 will be $3.1 million ($1.5 million General Fund.)

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 21: TREATMENT AUTHORIZATION REQUESTS

The California Podiatric Medical Association and the California Medical Association request the Legislature to address a Treatment Authorization Request (TAR) issue. Their primary goal is to remove a barrier to care for Medi-Cal patients in California. Specifically, when a Medi-Cal beneficiary is referred to a podiatrist by a medical doctor, the current process for obtaining a treatment authorization request delays care. Also, the California Podiatric Association and the California Medical Association, say the process adds unnecessary costs and reduces the chances of obtaining a satisfactory outcome for the beneficiary. The Associations note if the purpose of a TAR is to "curb over utilization of certain procedures," this certainly should not apply to non-elective, urgent conditions for which curbing treatment is a medically unsound approach.

The Associations urge the Legislature to adopt the following trailer bill language:

Section 14133.07 is added to the Welfare and Institutions Code, to read:

14133.07. The department shall adopt regulations to authorize Medi-Cal reimbursement without the submission of a treatment authorization request for services provided by a doctor of podiatric medicine, within the doctor's scope of practice, if all of the following conditions are present:

(a) The treatment are covered by billing codes related to trauma, infection management, pain control, wound management, diabetic foot care, and limb salvage. The regulations shall list the specific billing codes;

(b)The treatment or procedure billed for was medically necessary;

(c) The treatment or procedure was within the scope of practice of a doctor of podiatric medicine;

(d)An immediate or emergency need for the treatment or procedure existed;

(e)The patient was referred by a physician and surgeon; and

(f)A physician and surgeon would be eligible for Medi-Cal reimbursement without submission of a treatment authorization request for the same treatment or procedure

According to the Associations, only a small number of treatment codes meet the criteria laid out in the language. The Associations assert that according to the Department of Health Services the changes would add very small costs to the system. The Medi-Cal beneficiaries who benefit from this change are medically compromised diabetic, dialysis patients, peripheral vascular disease, peripheral neuropathy and patients that suffer trauma.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 22: AUTOMATION OF OTHER HEALTH COVERAGE FOR MEDI-CAL BENEFICIARIES

The state should implement a pilot project to fully automate its Other Health Coverage recoveries. The current system relies on the state chasing after third-party payers rather than automating the process and identifying the third party coverage up front before the Medi-Cal bill is paid. A competitive pilot program of the process may be needed to identify the benefits to the state.

The process used to identify Other Health Coverage (OHC) for Medi-Cal beneficiaries is manual and paper intensive, causing backlogs and lost opportunities to avoid expenditures by the Medi-Cal program. In addition, the current process does not capture all OHC information for Medi-Cal beneficiaries.

The Department of Health Services (DHS) records OHC information for Medi-Cal beneficiaries in the Medi-Cal Eligibility Data System (MEDS) via a manual process. MEDS is the database of Medi-Cal eligibility records maintained by DHS. County welfare departments process Medi-Cal applications and are required to complete a form that identifies any OHC. The form is sent to DHS and manually keyed into MEDS. When MEDS has an OHC indicator on the beneficiary record, claims from providers are rejected, thus avoiding expenditures for the Medi-Cal program. Providers are also able to access MEDS prior to rendering services, so they can identify beneficiary eligibility for OHC or Medicare to bill accordingly.

In addition to people who apply for Medi-Cal in county welfare offices, other individuals eligible for federal supplemental security income or Medicare programs are also eligible for Medi-Cal. Medicare and OHC for these recipients are recorded in a database maintained by the federal Center for Medicare and Medicaid Services, which sends a monthly tape that reports recipient Medicare and OHC. DHS runs the monthly tape against MEDS to update eligibility records. DHS uses this electronic process to identify supplemental security income and Medicare beneficiaries whose claims should be billed to Medicare or OHC. Medi-Cal avoids substantial expenditures. Only as mall part of the savings are due to OHC. Generally, the bulk of cost avoidance savings is Medicare eligibility.

DHS' manual operation to record OHC or changes to OHC (loss of eligibility for commercial or private health coverage) are staffed by employees who input data on the OHC forms received from the county welfare departments. DHS receives a significant amount of correspondence in the mail per week. A backlog of unrecorded forms may be from four to six months. The gap in keying OHC updates to MEDS causes results in significant expenditures for the Medi-Cal program. In addition, newly acquired OHC is often never reported by existing Medi-Cal beneficiaries and there is no automated process in place to capture this information.

When the MEDS record has not been updated with an OHC indicator, DHS will erroneously pay provider claims for beneficiaries with OHC. Conversely, beneficiaries who have lost OHC can experience access-to-care problems if the OHC indicator has not been removed from MEDS. Nine employees staff a toll-free line to take calls on access-to-care problems caused by OHC changes not reflected on MEDS. Some of these calls also relate to unreported Medicare eligibility.

DHS contracts with Health Management Systems (HMS), on a contingency fee basis, to initiate data matches and billings to commercial health plans. The billings are initiated to recover claims erroneously paid by Medi-Cal because of the backlog for recording OHC on MEDS. HMS is allowed to keep up to 15 percent of any amount recovered. For a claim that was erroneously paid, HMS initiates a billing and data match with the carrier to provide updated OHC information to MEDS. The level of recovery for erroneously paid claims is very low. Less than $8 million per year is recovered or only 4 percent of the billings. Commercial health plans reject the billings primarily due to untimely filing of the claim, unauthorized services by the health plan or absence of electronic billing. Currently, HMS has not been requested by DHS to initiate monthly data matches for all carriers or Medicare.

There has been limited success in receiving OHC data electronically from counties. Files received from two of the existing county systems have had poor data quality. There are four different platforms and up to 19 different eligibility systems in the 58 counties. [13] The numerous county systems have made it difficult to secure cooperation and recognition of this data exchange as a priority. In addition, DHS' Information Technology Division has had no resources to devote to development of an electronic process for OHC identification

The State's 3rd party is pay and chase, it is not fully automated. DHS pays out on a claim – then once their person gets insurance information from the insurers (twice a year) a person manually inputs the information — only to find out the claim they paid on assuming that person was covered by Medi-cal – was actually covered by another insurance company (i.e. Blue shield or Kaiser). Then DHS contracts out with a 3rd party to then chase that money down for it to be returned to the State of California – thus forcing Blue shield or Kaiser (whomever the original insurer was) to pay the claim. The state should consider automating the process to improve its accuracy and capture savings.