# **AGENDA**

# Assembly Budget Subcommittee No. 1 On Health & Human Services

# **Assemblymember Dave Jones, Chair**

Thursday, May 27, 2010 9:00 a.m. - State Capitol Room 4202

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#### **CONSENT ITEMS**

### 4280 Managed Risk Medical Insurance Board

# ISSUE 1: TECHNICAL ADJUSTMENTS FOR MAJOR RISK MEDICAL INSURANCE PROGRAM

#### **Governor's May Revision Issue**

Due to declining revenues in Proposition 99 (Cigarette and Tobacco Product Surtax Fund), the MRMIB is requesting approval of Budget Bill Language to shift its receipt of \$295,000 from one account within Proposition 99 (Physician Services) to another account within Proposition 99 (Unallocated Account). Both accounts are applicable for expenditure within the MRMIP. The proposed Budget Bill Language is as follows:

4280-112-0236—For transfer by the Controller from the Unallocated Account, Cigarette and Tobacco Products Surtax Fund to the Major Risk Medical Insurance Fund, for the Major Risk Medical Insurance Program (\$295,000).

The Administration notes this action provides no additional revenue for the MRMIP but it does allow for the six accounts within Proposition 99 to remain balanced due to declining revenues as noted.

#### **Background**

The MRMIP provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered coverage at rates they could not afford. Caseload for this program varies as funding is available.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposed technical adjustment.

### ISSUE 2: AVAILABILITY OF SPECIAL FUNDS TO OFFSET THE GENERAL FUND

The Legislative Analyst's Office has identified a miscalculation within the Healthy Families Program regarding the amount of revenues available from the Children's Health and Human Services (CHHS) Fund. Specifically, about \$11 million more in revenues is available to offset General Fund support by reflecting revenues available from 2008-09 and capturing enhanced federal funds (American Recovery and Reinvestment Act [ARRA] extension to June 30, 2011).

#### Staff Recommendation

Subcommittee staff recommends approval of this proposed technical adjustment.

### 4440 DEPARTMENT OF MENTAL HEALTH

### **ISSUE 1: CA HEALTH INTERVIEW SURVEY (ISSUE 450)**

#### **Budget Issue**

The Department of Mental Health (DMH) proposes an increase of \$800,000 (MHSA Funds) to continue the development and administration of the mental health components of the University of California, Los Angeles Center for Health Policy Research's CA Health Interview Survey (CHIS).

The CHIS is an assessment tool that collects data on health status and access to health care services in California. The survey is conducted every two years. Data collection and dissemination are made possible through a collaborative effort between the DHCS, DPH, the Public Health Institute, the MHSA Oversight Commission and the DMH.

The CHIS survey is the largest health survey conducted in the United States and is well known for providing incredibly useful data regarding demographics, trends, and other assessments. MHSA funds were used for this purpose in 2009 as well. These MHSA funds would be appropriated from the State administrative portion of funds.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposal.

#### ISSUE 2: PATTON & NAPA STATE HOSPITAL CAPITAL OUTLAY PROJECTS

#### **Budget Issue**

The Governor's January budget for the DMH includes a request for reappropriation of \$7.7 million (General Fund) for working drawings (\$711,000) and construction phases (\$7 million) of the "satellite" kitchens at Patton State Hospital. In addition, the budget includes a reappropriation of \$35.8 million (bond funds) for the "main" kitchen (working drawings of \$2.7 million, and construction phases of \$33.1 million) at Patton State Hospital. The DMH states these reappropriations are needed due to current delays.

Governor's January budget includes a request for reappropriation of \$10.8 million (General Fund) for working drawings (\$605,000) and construction phases (\$10.2 million) of the "satellite" kitchens at Napa State Hospital. In addition, the budget includes a reappropriation of \$31.6 million (bond funds) for the "main" kitchen (working drawings of \$2.7 million, and construction phases of \$28.9 million) at Napa State Hospital. The DMH states these reappropriations are needed due to current delays.

No issues have been raised regarding the main kitchens (using bond funds). However, due to the fiscal crisis and need to provide direct health and human services to individuals during this economic crisis, it is recommended to deny the General Fund reappropriations for the satellite kitchens. This action results in General Fund savings for core program services.

#### Staff Recommendation

Subcommittee staff recommends approval of the requests for reappropriation of bond funds and denial of the requests for reappropriation of General Fund for both the Napa and Patton State Hospitals (conforming with the Senate's actions).

#### ISSUE 3: SEX OFFENDER COMMITMENT PROGRAM

The Sex Offender Commitment Program (SOCP) evaluates individuals to determine if they meet the statutory criteria, enacted in 2006 by Proposition 83 (Jessica's Law), for civil commitment as a sexually violent predator. The California Department of Corrections and Rehabilitation refers these individuals to DMH for evaluation. The current-year budget for this program is \$21.6 million General Fund. The May Revision proposes to reduce SOCP funding by \$10.3 million General Fund.

The LAO raises no concerns with the proposed \$10.3 million reduction. According to the Department, it is the result of a number of factors, but mostly reflects a change in the mix of individuals referred for clinical evaluation. In recent years, an increasing share of the individuals referred for clinical evaluations has already been evaluated by DMH, and, since the evaluations of "re-referrals" are less costly than initial evaluations, this has resulted in program savings. DMH estimates that in the current year 70 percent of individuals being evaluated are referrals. According to the Department, these individuals are typically parole violators returned because of a technical violation. The reduced funding also reflects lower than anticipated workload, and reduced rates for related contract costs.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposed reduction of the SOCP by \$10.3 million.

# 2400 DEPARTMENT OF MANAGED HEALTH CARE

#### ISSUE 1: INCREASED WORKLOAD FROM NEW REGIONAL CENTER REQUIREMENT

This request was first heard by the Subcommittee on April 19, 2010. The DMHC is requesting expenditure authority of \$910,000 for FY 2010-11 and \$910,000 for FY 2011-12, for nine 2.5 year limited-term positions to handle increased workload resulting from ABX4 9 which prohibits Regional Centers (RCs) from providing services to consumers unless the consumer can demonstrate that their health insurer has denied coverage for the services provided by the RC.

As a result of ABX4 9, insured RC consumers will need to obtain formal denials from their health plans, and therefore DMHC anticipates a significant increase in complaints and Independent Medical Review applications as consumers seek to secure the required coverage denial documentation. However, as of the April 19<sup>th</sup> hearing, neither the DMHC nor the DDS had provided the Legislature with evidence of an increased workload as a result of this new statute. The DMHC states that if this request is denied and the workload materializes later this year, they will not be able to administratively establish positions to handle the workload, due to the Governor's executive order to maintain a 5 percent staff vacancy rate, and could only acquire additional positions through a BCP in next year's budget process.

#### **Staff Recommendation**

**Subcommittee staff recommends denial of this request.** The Department has yet to experience any increase in workload almost a full year after implementation of the new requirement on Regional Centers. Should this workload materialize in the next year, the DMHC should explore internal options for meeting the workload demand until a request to the Legislature for increased positions can be considered and acted upon.

### 4260 DEPARTMENT OF HEALTH CARE SERVICES

#### ISSUE 1: ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

#### May Revise Issue

The DHCS is requesting 11 positions and \$575,000 in contract funds to implement the Medi-Cal Electronic Health Record (EHR) Incentive Program in accordance with an implementation plan developed by a consultant for DHCS. The EHR program is intended to incentivize Medi-Cal providers to adopt and use electronic health records in a meaningful way and by doing so advance patient safety and quality of care. This program has the potential to provide incentive payments of approximately \$1.4 billion to 435 hospitals and 10,000 Medi-Cal providers. The administration is proposing to have the California Health Care Foundation (CHCF), an independent philanthropy, pay the state share, or 10 percent of the total cost for these staff and contractors. The federal government is providing a 90 percent match.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposal.

#### **ISSUE 2: LOCAL EDUCATIONAL AGENCY MEDI-CAL BILLING OPTION**

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 10, 2010. The DHCS is requesting an increase of \$1.6 million (\$819,000 from local entities and \$819,000 Federal Funds) to support 14 new State positions (two-year limited-term) to perform financial oversight requirements of the "Local Educational Agency" (LEA) billing option provided under the Medi-Cal Program. The DHCS states that two positions within the Fiscal Audits Branch are presently conducting audits of LEA billing option information but due to workload increases, these additional 14 positions are needed.

Full implementation of the LEA billing option was delayed by the DHCS for almost two-years due to claims and billing problems with the Medi-Cal Fiscal Intermediary (Electronic Data Systems). Because of these technical problems as well as the need to conduct more audits, the federal CMS has deferred \$85 million in federal payments for the LEA billing option. The DHCS states that two-years worth of "Cost and Reimbursement Comparison Schedule" forms must be reviewed and validated by the DHCS before federal payment can be obtained.

In addition, the DHCS would utilize the positions to provide training and to improve existing procedures. The requested staff is as follows:

- Ten Health Program Auditor III positions;
- Two Health Program Auditor IV positions; and,
- Two Health Program Audit Manager positions.

As California's lead state agency for the Medicaid Program (Medi-Cal), the DHCS is required to perform financial oversight responsibilities for the LEA billing option to ensure that federal Medicaid funds are being appropriately expended. The DHCS states that if these positions are not provided, the LEA billing option may be in jeopardy and it is very likely the \$85 million in deferred federal funds would not be obtained.

#### **Background**

There are 485 LEA providers participating in the LEA billion option. The LEA billing option provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment.

The billing option program provides early and periodic screening, diagnosis, and treatment services such as physical therapy, occupational therapy, speech and audiology, physician and nursing services, and school health aid services.

When this proposal was heard on May 10<sup>th</sup>, the Subcommittee voted down a motion to approve the positions but fund them with General Fund, rather than through LEA funding. The original legislation that created the LEA billing option in California prohibits the use of General Funding on the program.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the proposed BCP, including 7 of the 14 requested positions

#### **ISSUE 3: CA-MMIS REPLACEMENT**

On May 10<sup>th</sup>, 2010, the Subcommittee approved the DHCS request for 34 positions to implement the replacement of the Fiscal Intermediary Medi-Cal Management Information System (CA-MMIS). The new CA-MMIS is to be implemented in system component phases over a five year period. In 2010 work is to begin on the Business Rules Extraction of the existing CA-MMIS and the design, development and implementation of several components will proceed with the final replacement CA-MMIS in place by 2015.

#### **Staff Recommendation**

#### Subcommittee staff recommends the following actions:

- 1. In order to facilitate the Legislature being informed on its progress, the following "placeholder" trailer bill language is proposed:
  - "The Department of Health Care Services (DHCS) shall provide the appropriate fiscal and policy committees of the Legislature with quarterly reports on the transition and takeover progress efforts of the Medi-Cal Fiscal Intermediary Contract. These quarterly reports shall be provided within 30-days of the close of each quarter, commencing July 1, 2010 and continuing through the life of the contract. These quarterly reports shall contain the following information:
  - a. A project status summary that identifies the progress or key milestones and objectives for the quarter on transition and takeover efforts.
  - b. A description of how the vendor is meeting the eleven separate areas of the contractual requirements, including whether the vendor is meeting the time frames and milestones provided to the Legislature and whether the project is on budget.
  - c. Copies of any oversight reports developed by contractors of the DHCS for the California Medi-Cal Management Information System (CA-MMIS) project and any subsequent responses from the DHCS."
- 2. The following additional project oversight is also recommended for Subcommittee approval:
  - a. Upon request from the Chair of the Joint Legislative Budget Committee, the DHCS shall provide updates on the Implementation Advanced Planning Document provided to the federal Centers for Medicare and Medicaid Services pertaining to the CA-MMIS project.
  - b. The OCIO shall include the CA-MMIS project, over the life of the contract, as part of its IT Project Tracking.
  - c. The Bureau of State Audits shall provide oversight, over the life of the CA-MMIS contract, over the implementation of the contract to ensure that the project performs as required, that it is meeting the time-frames and milestones provided to the Legislature and the at the project is on budget.

#### ISSUE 4: ICF-DD ADMIN AND QA FEE REIMBURSEMENT

The Administration is proposing trailer bill that would authorize the Department of Developmental Services (DDS) to make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services. Under a proposal developed by DDS, beneficiaries who reside in an ICFDD would receive active treatment services and transportation from providers located offsite from the ICF-DD.

To realize the savings associated with increased federal funds for ICF-DD day treatment and transportation services, the DHCS has requested an increase of \$30.6 million (\$15.3 million General Fund) to reimburse ICF-DD nursing facilities due to the state assessing a quality assurance fee on these facilities. However, this assessment would generate \$24.4 million in new revenue for the General Fund. The net General Fund benefit would be approximately \$9 million.

#### Staff Recommendation

Subcommittee staff recommends approval of this issue, which conforms to an action approved by this Subcommittee on May 12, 2010 in the DDS budget.

### 4265 DEPARTMENT OF PUBLIC HEALTH

# **ISSUE 1: UMBILICAL CORD BLOOD BANKING (SFL)**

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 10, 2010. The DPH requests an increase of \$471,000 (one-time federal grant funds) to support the collection and storage of publicly donated and ethnically diverse umbilical cord blood in California for use in transplantation. These grant funds are provided through a Congressional Special Initiative grant award and can only be used for this purpose. This is one-time funding and is to be expended in 2010-11.

Of the total federal grant amount, \$120,000 would be used to engage a contractor to: 1) develop a "Request for Proposal" for the cord blood bank; 2) oversee all implementation and evaluation activities; and, 3) monitor the contract with the established cord blood bank.

The \$120,000 amount is the maximum the federal grant allows for this purpose. According to the DPH, this contractor will consult with the federal Health Resources and Services Administration (HRSA) on the following:

- Developing cord blood collection protocols;
- Assisting with reviewing the contract bids;
- Implementing the contract agreement with the selected cord blood bank;
- · Overseeing and managing the grant activities;
- Serving as the subject matter expert for the DPH;
- Providing status reports to HRSA as required; and
- Developing and implementing the grant performance evaluation.

The remaining amount of \$351,240 would be used to contract with a selected cord blood bank to collect, process, and store the cord blood from minority populations to diversify the national inventory of umbilical cord blood stem cell units that are available for transplantation.

The DPH states that the cord blood bank's collection and storage fee is a one-time fee inclusive of long-term storage. This is consistent with existing federal requirements. The DPH states that given the high cost associated with cord blood banking, the grant award will only enable collecting a limited number of cord blood units by the selected cord blood bank.

#### **Summary of State and Federal Law**

AB 34 (Portantino, Chapter 516, Statutes of 2007) established the Umbilical Cord Blood Collection Program for the purpose of collecting and storing umbilical cord blood for use in research and to add genetically diverse cord blood units to the national inventory. It requires, among other things, that any funds available for these purposes to be deposited into the Umbilical Cord Blood Collection Program Fund. The current AB 52, also authored by Assemblymember Portantino, seeks to provide a detailed structure for implementation of the Umbilical Cord Blood Collection Program.

The federal Stem Cell Therapeutic and Research Act of 2005 established a national umbilical cord blood network and authorized funding to collect and maintain cord blood stem cells for the treatment of patients and for research. As of 2009, there are nine banks contracted by HRSA to

collect cord blood for the national inventory. This includes StemCyte, Incorporated located in Arcadia, California.

As described above, Assemblymember Portantino has authored substantial legislation in this area, including AB 34 in 2007 and AB 52 this year. Therefore, the Assemblymember has taken a keen interest in this BCP and has expressed concerns to Subcommittee staff about some of the details included in the BCP narrative submitted by the DPH. Of most significance, the Assemblymember and his staff have raised the following concerns:

- The DPH proposes to engage a contractor for one full year on a full-time basis, at a cost of \$120,000. Assemblymember Portantino states that standard contracts already exist for entities that collect cord blood in compliance with federal guidelines, and therefore this workload could be completed with one half-time position, for one year, at half the cost.
- 2) The DPH proposes to contract with an "umbilical cord blood bank" for these purposes. Assemblymember Portantino states that the term "bank" is an inappropriately narrow term that will disqualify other types of "entities" that are equally qualified, such as the University of California.
- 3) The DPH proposal is silent on the role of the selected "bank" (or entity) in making cord blood samples that do not have sufficient cell dose for transplantation available for research. Assemblymember Portantino believes that it is critical to the future of cord blood research that the state do all that it can to encourage or even require, when possible, that cord blood units that cannot be used for transplantation be provided for research purposes.

Assemblymember Portantino has been in discussions with the DPH about his concerns; the DPH has explained that the specifics of the BCP have been dictated by HRSA requirements. The DPH states that they agree with the goal of making unusable cord blood samples available for research if it can be done without violating the HRSA requirements of this grant. The DPH submitted questions to HRSA to clarify these issues and is still awaiting a response.

#### **Staff Recommendation**

Subcommittee staff recommends approving of this request for expenditure authority of \$471,000 in federal funds, and approving of the proposal with the following modifications:

- Approve of one half-time position, for one year, rather than the requested full-time position; and
- 2) Adopt the following Budget Bill Language:

"Budget item 4265-004-0890 --- For transfer by the Controller from the Federal Trust Fund to the Umbilical Cord Blood Collection Fund for expenditure in accordance with the federal Health Resources and Services Administration (HRSA) Special Congressional Initiative: Cord Blood Education and Public Cord Blood Banking in California grant guidance. Cord Blood entities, in addition to banks, shall be considered eligible to submit proposals under this RFP; and the winning contractor shall make cord blood units that cannot be used for transplantation available for research purposes, at their own expense, provided that neither of these requirements violate the HRSA grant requirements or jeopardize California's receipt of this funding."

#### ISSUE 2: FEDERAL RYAN WHITE GRANT FUNDS—LOCAL ASSISTANCE (ISSUE 560)

#### **Governor's May Revision Issue**

DPH requests a *net* increase of \$668,000 (federal funds) in budget authority due to adjustments in the Health Resources and Service Administration (HRSA) Part B HIV Care Grant as noted below. These funds were awarded to DPH based on a formula by HRSA.

- Current 2010-11 Budget Authority \$123,035,000
- Increase in Base Grant \$692,000
- Increase in Emerging Communities Grant \$9,000
- Decrease in Minority AIDS Initiative Grant -\$33,000
- Adjusted Authority \$123,703,000
- May Revision Request for Authority \$668,000

DPH states the net increase of \$668,000 will be used to support certain Local Health Jurisdictions and a small number of community-based organizations to provide HIV care program services for medical care, such as physician visits and laboratory tests. The Office of AIDS allocates HIV Care Program funds to Local Health Jurisdictions via a formula allocation process. In addition, the DPH states they received recent clarification from HRSA that the award also includes Minority AIDS Initiative (MAI) funds. Previously MAI funds were awarded as a separate grant with a different budget period, not as part of the Ryan White award. Kern County is the only county in California that meets HRSA's statutory requirements for Emerging Communities. These funds are awarded to DPH but are allocated separately to Kern. The goal of the Emerging Communities funding is to enable emerging communities that do not qualify for Ryan White Act Part A funding, but have 500 to 999 cumulative AIDS cases, to receive a separate formula funding ward to provide HIV care.

DPH allocates MAI funds to 19 Local Health Jurisdictions with the highest number of nonwhite living with HIV/AIDS cases. The goals of this are to: 1) evaluate and address disproportionate impact of HIV/AIDS on African Americans and other minorities; and 2) provide outreach and education services to increase minority participation in ADAP.

#### Background

California has been receiving these funds for 20-years. These funds are used to fill in gaps in care not covered by other sources. Specifically, these funds will enable people living with HIV/AIDS to utilize services such as: 1) outpatient and ambulatory health services; 2) case management services; 3) early intervention services; 4) health insurance premium and cost sharing assistance; 5) home and community-based heath services; 6) home health care; 7) hospice services; 8) housing services; 9) local pharmaceutical assistance; 10) mental health services; 11) treatment adherence counseling; and many other life saving services.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the May Revise request for approval of Ryan White Act federal funds expenditure authority of \$668,000.

# ISSUE 3: LOAN REPAYMENT: OCCUPATIONAL LEAD PREVENTION ACCOUNT & DRINKING WATER OPERATOR CERTIFICATION SPECIAL ACCOUNT (ISSUES 401 AND 402)

#### **Governor's May Revision Issue**

The Governor's May Revision proposes a series of Special Fund transfers and loans to assist in General Fund relief. For the DPH, the Department of Finance proposes the following Budget Bill Language for this purpose:

Occupational Lead Poisoning Prevention Account Item 4265-401. Nothwithstanding Provision 1 of Item 4265-011-0070, Budget Act of 2008, the \$1,100,000 loan authorized, shall be full repaid to the Occupational Lead Poisoning Prevention Account by July 1, 2012.

Drinking Water Operator Certification Special Account Item 4265-402. Nothwithstanding Provision 1 of Item 4265-011-0247, Budget Act of 2008, the \$1,600,000 loan authorized, shall be fully repaid to the Drinking Water Operator Certification Special Account by July 1, 2012.

The effect of this language is to defer the repayment of money loan from these two special funds to the General Fund for one-year. This action will save General Fund.

#### Staff Recommendation

Subcommittee staff recommends approval of both loan repayment deferral proposals.

# ISSUE 4: AMYOTROPHIC LATERAL SCLEROSIS/LOU GEHRIG'S DISEASE RESEARCH (ISSUE 502)

#### **Governor's May Revision Issue**

SB 1502 (Steinberg), Statutes of 2008, created the ALS/Lou Gehrig's Disease Research Fund to benefit the ALS Association. This enabling legislation created a tax check-off. Funds from this check-off are appropriated in the DPH as a "pass-through" to directly to the ALS Association. The May Revision proposes to appropriate a total of \$521,000 (tax check-off) for this purpose. This proposal is consistent with the enabling legislation.

#### Staff Recommendation

Subcommittee staff recommends approval of this proposal.

# ISSUE 5: GENETIC DISEASE TESTING PROGRAM—MODIFICATION TO PROJECT (ISSUE 556)

#### **Governor's May Revision Issue**

The DPH proposes an increase of \$868,000 (Genetic Disease Testing Fund) to fund a System Software Specialist III position (18-month limited-term) and to reflect changes in scope to the Business System Upgrade Project (Project) which the DPH contends will result in decreased expenditures in 2011-12 through 2014-15. Of the proposed amount, a net of \$608,000 (Genetic Disease Testing Fund) is reflected in the contract line item.

This is composed of the following:

- Increase of \$792,000 Oracle Contract
- Increase of \$13,862 One-Time Project Costs (contract)
- Decrease of \$198,000 Continuing IT Project Costs (contract)
- Net increase of \$103,519 Data Center Services (DHCS hosting)

The DPH states this approach reflects going from a replacement system to a more straightforward system upgrade which would decrease the project costs from \$3.5 million (Genetic Disease Testing Fund) to \$2.8 million (Genetic Disease Testing Fund). This is due to a shorter project time-line as well as module variations.

### **Background—Business System Upgrade Project**

The Genetic Disease Screening Program is fee support and the program is seeking to upgrade its accounting and revenue collection, order and inventory management functions that will integrate into its "Screening Information System."

#### Staff Recommendation

Subcommittee staff recommends approval of this request.

# ISSUE 6: ADJUST LICENSING & CERTIFICATION PROGRAM FOR LTC OMBUDSMAN (ISSUE 553)

#### **Governor's May Revision Issue**

The Administration is requesting two adjustments to the Licensing and Certification Program, including: 1) a decrease of \$973,000 (Federal Health Facilities Citation Penalties Account for 2010-11 (one-time); and 2) a reduction of \$680,000 in the General Fund transfer to the Licensing and Certification Fund so that these funds can be appropriated to the CA Department of Aging (CDA) to support the Long-Term Care Ombudsman Program in 2010-11. This General Fund transfer to the L&C fund is a portion of the reimbursement paid by State facilities to the DPH for licensing and certification activities.

These two actions result in a net reduction of \$1.653 million for 2010-11 which would be redirected to support the Ombudsman Program for 2010-11. The L&C Program has stated unequivocally that this short-term fix will not adversely impact health and safety. The DPH Licensing and Certification Program (L&C Program) is seeking this adjustment as a short-term fix for the shortfall in the Long-Term Care Ombudsman Program which resulted from insufficient funds in the Federal Health Facilities Citation Penalties Account (0942-605). This special account serves as a funding source for L&C's Temporary Manager Program and for the CDA's Long-Term Care Ombudsman Program. The DPH notes that funds coming into this special account are inconsistent and unpredictable and not sufficient to support ongoing activities of these programs in 2010-11. This is a one-time fix to continue the CDA's Long-Term Care Ombudsman Program. The Office of the State Long-Tem Care Ombudsman in the CDA develops policy and provides oversight to 35 local Long Term Care Ombudsman Programs statewide. As advocates for residents of LTC facilities, local Ombudsman representatives promote resident's rights and provide assurances that these rights are protected. About 1,000 State-certified Ombudsman volunteers and paid staff in the local programs identify, investigate and seek to resolve complaints and concerns on behalf of about 296,000 residents in nearly 1.400 nursing facilities.

#### **Federal Health Facilities Citation Penalties Account**

This special account derives its revenues from Civil Penalties paid by Long-Term Care heath facilities to the federal CMS. The L&C Program, as the designated State agency for the federal CMS, conducts federal certification surveys through a federal grant. The federal CMS has its own prescribed process for review and issuance of deficiencies and assessment of penalties. Once settled, if the outcome is that the federal CMS receives a payment from a health care provider, they remit a portion back to the DPH via an electronic transfer. As such, the L&C Program is not a participant in the federal process, or is not apprised of the status of deficiencies and penalties. As such, the L&C Program contends it is difficult to project the level of revenues and the frequency with which these revenues will be remitted to the State.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this request.

# **VOTE ONLY ITEMS**

### 4440 Managed Risk Medical Insurance Board

#### ISSUE 1: INCREASE PREMIUMS IN HEALTHY FAMILIES PROGRAM

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 20, 2010. The Governor's May Revision proposes to increase monthly premiums paid by families with incomes between 200 and 250 percent of the federal poverty level, for increased revenue, and therefore General Fund savings, of \$13.3 million. The premium would increase by \$18 per child (\$54 maximum per family with 3 or more children).

#### **Background**

The Governor's January budget proposal included a proposal to increase premiums for children in families with incomes between 150 to 200 percent FPL. The proposal did not include a premium increase for children in families between 200 and 250 percent FPL because the January budget proposed to reduce eligibility in the Healthy Families Program from 250 to 200 percent FPL. However, this eligibility reduction proposal has been rescinded by the Governor as it would be a violation of federal health care reform. Therefore, the Governor's May Revision includes this proposal to increase premiums for the 200 to 250 percent FPL group of children in Healthy Families.

The Subcommittee discussed and rejected the January premium increase proposal at its hearing on April 19<sup>th</sup> (April 19<sup>th</sup> agenda, pages 16-17). At its hearing on May 10<sup>th</sup>, the Subcommittee approved a motion to redirect AB 1383 (hospital fee) revenue, designated for children's health services, to cover the cost of rejecting the various reductions to the Healthy Families Program proposed by the Governor in January, including the proposed premium increase.

#### **Staff Recommendation**

**Subcommittee staff recommends rejection of this proposal.** The Subcommittee rejected all of the Governor's January cost-savings proposals for the Healthy Families Program, including the proposed premium increase for the 150-200 percent FPL families. There is reasonable evidence that premium increases violate the federal health care reform MOE. Finally, this Subcommittee took an action on May 10, 2010 to augment the Healthy Families Program with sufficient AB 1383 (hospital fee) funds to avoid reductions or policy changes such as this one.

# ISSUE 2: HEALTHY FAMILIES CO-PAYMENTS FOR ER AND IN-PATIENT HOSPITAL CARE

This proposal was first heard by the Subcommittee on May 20, 2010. The Governor's May Revision includes a proposal to increase the Healthy Families co-payment for emergency room visits from \$15 to \$50, for General Fund savings of \$2.5 million and, to institute a new co-payment on in-patient hospital stays of \$100 per day with a \$200 maximum, for General Fund savings of \$0.7 million. These co-payments are consistent with those proposed by the Governor for the Medi-Cal program.

#### **Staff Recommendation**

**Subcommittee staff recommends rejection of this proposal**. The Subcommittee rejected all of the Governor's January cost-savings proposals for the Healthy Families Program. It is clear that increased and new co-payments would reduce access and therefore negatively impact the health of children in the program. Finally, this Subcommittee took an action on May 10, 2010 to augment the Healthy Families Program with sufficient AB 1383 (hospital fee) funds to avoid reductions or policy changes such as this one.

#### **ISSUE 3: HEALTHY FAMILIES CASELOAD ESTIMATE**

#### **Governor's Proposal**

The MRMIB projects a June 2010 caseload estimate of 909,648 and a June 2011 caseload estimate of 964,864 for the HFP. The budget-year caseload estimate is higher than that proposed in January, since the May Revision proposal reflects the administration's withdrawal of a proposal to reduce income eligibility for the HFP to 200 percent of the FPL. However, caseload trends over the current and budget years for all income groups are adjusted significantly downward from January caseload trends, due to lower-than-expected enrollment since the program was opened to new enrollment in September 2009 after two months of closure.

#### Staff Recommendation

Subcommittee staff recommends approval of the May Revise Healthy Families caseload estimate.

#### ISSUE 4: ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

#### **Governor's May Revision Issue**

The MRMIB budget for the Access in Infants and Mothers (AIM) Program proposes technical adjustments to reflect a 1.8 percent annual growth rate which results in a total annual enrollment of 11,276 pregnant women (monthly average of 940). Due to a continuing decline in revenues from Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds), there are less revenues to transfer into the Perinatal Insurance Fund for the AIM Program.

Total expenditures are \$60.9 million (\$25.4 million Perinatal Insurance Fund and \$35.6 million federal funds) for 2010-11 and are estimated to provide coverage for the year. The LAO has also reviewed the AIM estimate and recommends its approval.

#### Background

The AIM Program covers uninsured and underinsured pregnant women in families between 200 percent and 300 percent of the federal poverty level if they have no other insurance. Beginning July 1, 2004, infants born to AIM women were being automatically enrolled in the HFP at birth. Infants born to AIM mothers who enrolled in AIM prior to July 1, 2004, remained in AIM through two years of age.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the May Revise AIM caseload estimate.

# ISSUE 5: MINOR ADJUSTMENTS TO THE COUNTY HEALTH INITIATIVE MATCHING PROGRAM (CHIM)

#### **Governor's May Revision Issue**

The MRMIB proposes an increase of \$476,000 (\$167,000 in County Health Initiative Funding-from the Counties, and \$309,000 in federal S-CHIP funds) This adjustment reflects increased caseload of 443 children among the three pilot counties of San Francisco, Santa Clara and San Mateo. This is a standard adjustment for May Revision.

#### **Background**

Existing statute provides for county governments and public entities to provide local matching funds to claim federal S-CHIP funds (Healthy Families) for county children's health expansion programs to serve children otherwise eligible for State Children's Health Insurance Programs (S-CHIP) (Healthy Families in CA) who have incomes between 250 and 300 percent of the federal poverty level. Three counties participate in this program—San Francisco, Santa Clara and San Mateo. This proposal adjusts the level of federal funds provided to these counties as provided in existing State statute.

#### Staff Recommendation

Subcommittee staff recommends approval of this May Revision proposal.

### 4440 DEPARTMENT OF MENTAL HEALTH

# ISSUE 1: MENTAL HEALTH SERVICES FOR SPECIAL EDUCATION PUPILS (AB 3632) PROGRAM

The Subcommittee first discussed the AB 3632 program during its May 3<sup>rd</sup> hearing (see May 3<sup>rd</sup> agenda, page 33), and then again on May 20, 2010 to consider the Governor's May Revise proposal to suspend the mandate.

The federal government mandates that schools provide mental health services to special education students who need them. Specifically, the federal Individuals with Disabilities Education Act (IDEA) entitles all pupils with emotional and physical disabilities to a free, appropriate public education that prepares them to live and work in the community. The IDEA entitlement includes mental health treatment for children in need of them in order to benefit from public education; children can receive services irrespective of their parents' income level.

California, through AB 3632 (Statutes of 1984), chooses to meet this federal mandate by requiring counties to provide these mental health services to pupils who qualify for them. However, the state has not fully reimbursed counties for these services. According to the DMH, total claims submitted for the past three fiscal years amounts to a total of \$211.9 million, and the state paid counties \$51.2 million from the 2009-10 appropriation. This leaves a remaining balance of \$160.7 million still owed to counties. According to the State Controller's Reports on mandates, the State owes counties \$133 million for unpaid claims in this program. The Assembly Democrat's proposed budget plan includes \$1 billion to pay for mandates and therefore Subcommittee #4 staff will be recommending an action to include \$133 million in the budget to cover the unpaid claims for the past three years for AB 3632.

Counties point out that while these mental health services to special education students are critical services, this federally-mandated program is not a "means-tested" program, meaning a family's income or other resources have no bearing on the student's qualification for free mental health services. Therefore, as a result of the state not reimbursing the counties fully for providing these services, counties must redirect realignment funds for this purpose, thereby reducing resources and services available specifically for low-income populations.

#### **Staff Recommendation**

Subcommittee staff recommends rejection of the May Revise proposal to suspend the mandate and eliminate \$52 million in funding. Further, it is recommended to adopt Budget Bill Language that clarifies that this \$52 million is to be used for 2010-11 claims, to offset future mandate future claims to be submitted to the State Controller. AB 3632 was passed in California as a way to implement the federal mandate on schools to provide mental health services to specified students, in order to ensure their access to public education. Prior to passage of AB 3632, school were failing to meet this mandate, and therefore failing to meet the needs of many children. If the AB 3632 mandate were to be suspended, the federal mandate simply returns to the schools.

#### **ISSUE 2: SHIFT OF COUNTY MENTAL HEALTH REALIGNMENT FUNDS**

This proposal was first heard by the Subcommittee on May 20, 2010. In the May Revision, the Governor proposes to shift \$602 million in county realignment funds to various social services programs. Specifically, these funds would pay for social service costs that would be shifted from the state to the counties. This proposal would increase the county share of cost for food stamp administration and child welfare services, resulting in General Fund savings of \$602 million in 2010-11.

Under this proposal, counties would retain approximately \$450 million in mental health realignment funds in 2010-11. According to the Legislative Analyst's Office (LAO), the use of these funds would be limited to paying for federally required benefits, namely the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the Mental Health Managed Care Program. The LAO explains that this proposal might violate the Mental Health Services Act maintenance of effort provision.

#### **Staff Recommendation**

**Subcommittee staff recommends rejection of this proposal**. Taking \$602 million in county realignment funds would decimate community mental health services leading to significant cost shifts to state hospitals, jails, and other social services as crime and homelessness would increase.

#### **ISSUE 3: DMH REQUEST FOR LEGAL POSITIONS**

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 3, 2010. The DMH sent the Legislature a Spring Finance Letter (SFL) requesting 6 new legal positions at a cost of \$3,076,000 General Fund. The SFL also proposes to redirect this amount of General Fund, in the form of savings, from the Sex Offender Commitment Program (SOCP) to the DMH Legal Office. DMH explains that the increased legal workload is due to the Attorney General's Office (AGO) changing its policies and discontinuing performing legal work for various state departments, including the DMH.

#### Background

Up until recently, the DMH has been represented by the AGO for litigation and court appearances. In September of 2009, the AGO informed DMH of policy changes that will substantially reduce the amount of legal services provided by the AGO to DMH. According to the Administration, there is significant work that can be done by the DMH Legal Office at less cost and staff than required by the AGO.

Historically, the state Department of Justice has performed legal work for the Department. Unlike many other departments, DMH is not billed by DOJ for legal work performed by its staff. Rather, DOJ is provided General Fund monies to cover the staff costs associated with all "non-billable" departments. Due to recent budget reductions at the state Department of Justice, the Attorney General's office has reduced the total number of hours of legal work it will perform for DMH by 8,000 hours (5,000 hours of attorney work, and 3,000 hours of paralegal work). In response, the department now proposes to establish in-house positions and contract with private counsel for its legal workload at an estimate cost of \$3.1 million.

#### Legislative Analyst's Office

The LAO estimates that at current DOJ rates (\$170/hour for attorneys, and \$120/hour for paralegals), it would cost only \$1.2 million for the department to contract with DOJ to continue providing legal services. Accordingly, the LAO recommends the Legislature reduce the redirection to \$1.2 million.

#### **Staff Recommendation**

**Subcommittee staff recommends adoption of the LAO recommendation**: reduce the proposed redirection for DMH legal work from \$3.1 million to \$1.2 million and require DMH to continue contracting with DOJ for legal services.

### ISSUE 4: FUNDS FOR EVALUATION OF MHSA (ISSUE 479)

#### **Governor's May Revision Issue**

The DMH is requesting an increase of \$1 million (MHSA Funds) to contract with the Petris Center, located at UC Berkeley, to provide an independent evaluation of the effectiveness of MHSA programs and services. The DMH states they will coordinate with various entities, including the OAC Commission.

#### **Background—OAC Commission**

The Mental Health Services Oversight and Accountability Commission (OAC) was established in 2005 and is composed of 16 voting Members who meet criteria as contained in the MHSA Act. The (OAC) provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The OAC holds public systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency and ensuring positive outcomes for individuals living with serious mental illness and their families.

Among other things, the role of the OAC is to:

- Ensure that services provided pursuant to the Act are cost-effective and provided in accordance with best practices which are subject to local and State oversight;
- Ensure that the perspective and participation of Members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations:
- Provide for a comprehensive evaluation of the MHSA (two phases);
- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the Act.

With respect to the evaluation of the MHSA, the OAC has established a two phase process as follows:

- Phase I. As of July, 2010, the OAC will have completed Phase I, a 10-month assessment to design the scope of work of the evaluation. This assessment has incorporated significant stakeholder input and review, which consists of broad stakeholder representation from mental health consumer and family advocates, County Mental Health, and community mental health agencies.
- Phase II. An evaluation contractor will be selected by the OAC in Fall 2010 through a
  competitive bidding process. Phase II is the evaluation implementation to be conducted
  over a two-year period by the contractor to be selected. The Petris Center and other
  contractors may apply to conduct this evaluation through the competitive process. The
  OAC has \$500,000 (MHSA Funds) for the next two-years in its baseline budget for this
  purpose.

This \$1 million would augment the \$500,000/year for two years currently budgeted for this substantial, multi-year evaluation to ensure a more robust evaluation of the impact of the voterapproved MHSA to improve mental health service delivery and provide public accountability.

#### **Staff Recommendation**

Subcommittee staff recommends appropriating the \$1 million (MHSA Funds), identified in the May Revision for the DMH, to the OAC's budget (Item 4560—MHSA Oversight and Accountability Commission) – conforming to the Senate's action. As noted above, the OAC Commission already has responsibility to provide an evaluation of the MHSA and has already commenced with an evaluation framework and process to be built upon.

### ISSUE 5: BACKFILL EPSDT & MHMC WITH GENERAL FUND

The Governor's May Revision proposes to backfill the EPSDT and Mental Health Managed Care (MHMC) Programs with General Fund, in order to compensate for the lack of adoption by the Legislature, and voters, of the Governor's January proposal to replace \$452 million in General Fund (2010-11) in these two programs with Proposition 63 (MHSA) funding. Both of these programs are Medicaid-funded programs and therefore entitlement programs.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the May Revise proposal to backfill the EPSDT and MHMC programs with General Fund.

### **ISSUE 6: STATE HOSPITALS-ESTIMATE**

Governor proposes an increase of \$5.7 million (General Fund) for the State Hospitals to fund Level-of-Care staff for projected increases in the State Hospital patient population. DMH states this increase reflects an overall net increase of 95 patients in the Judicially Committed/Penal Code population.

This net 95 estimate assumes an increase of 158 Incompetent to Stand Trial (ISTs) patients, a decrease of 42 Mentally Disordered Offenders (MDO), and a net decrease of 21 patients in other categories of commitment.

DMH directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton, and two acute psychiatric programs at the California Medical Facility at Vacaville and the Salinas Valley State Prison. Governor's May Revision for the State Hospitals provides a total of \$1.343 billion (\$1.3 billion General Fund) which reflects an increase of \$172.4 million (General Fund) as compared to the revised 2009-2010 budget. A total of 6,477 patients are estimated to be treated at the facilities in 2010-11.

The LAO contends the May Revision over-estimates caseload for 2010-11, as well as for the current-year. Specifically, the LAO recommends a reduction of \$6 million (General Fund) for the current-year, and a reduction of \$14.7 million (General Fund), for a total reduction of \$20.7 million (General Fund). The LAO estimate reflects caseload adjustments primarily associated with Mentally Disordered Offenders and Sexually Violent Predators (SVPs).

#### Legislative Analyst's Office Analysis of Caseload Estimate

The LAO has reviewed the May Revision and recommends state hospital caseload funding adjustments in the current year and budget year. For the current year, the LAO recommends a reduction of \$6 million General Fund, which is \$4 million less than they recommended in March. According to the LAO, the reduced current-year savings is the result of recent developments related to the *Mille* case, which requires accelerated admittance to the state hospitals of the Incompetent to Stand Trial population. For the budget year, the LAO recommends a reduction of \$14.6 million General Fund. These recommended adjustments primarily reflect lower than budgeted caseload in the Mentally Disordered Offender and Sexually Violent Predator populations.

#### **Deletion of Budget Bill Language for Conditional Release Program**

Governor proposes a decrease of \$750,000 (General Fund) and related Budget Bill Language since the patient population is not expected to materialize.

Historically, this funding provides for: 1) outpatient services to patients into the Conditional Release Program (CONREP) via either a court order or as a condition of parole; and 2) hospital liaison visits to patients continuing their in-patient treatment at State Hospitals who may eventually enter CONREP. The patient population includes: 1) Not Guilty by Reason of Insanity, 2) Mentally Disordered Offenders, 3) Mentally Disordered Sex Offenders, and 4) Sexually Violent Predators. LAO *concurs* with the DMH reduction.

Staff Recommendation: Subcommittee staff recommends approval of all of the DMH proposed estimates, including the state hospital caseload estimate modifications proposed by LAO.

#### ISSUE 7: ADJUSTMENTS FOR MENTAL HEALTH MANAGED CARE

Governor proposes a net decrease of \$530,000 (increase of \$61.2 million General Fund) to reflect *deletion* of January's proposal to seek voter approval to amend Proposition 63 to backfill for General Fund support, as well as minor technical adjustments.

California's Medi-Cal Specialty Mental Health Services Waiver covers two programs within the DMH: (1) the Early and Periodic, Screening Diagnosis and Treatment (EPSDT) Program for children; and (2) Mental Health Medi-Cal Managed Care Program.

The Administration was informed by the federal Centers for Medicare and Medicaid (CMS) in September 2009 that California's comprehensive Medi-Cal Specialty Mental Health Services Waiver would *only* be approved for one year, to September 30, 2010, instead of the requested two year renewal period which is standard. Changes to the Waiver and California's State Medi-Cal Plan need to be made and several of these changes are due to continued federal audit concerns related to State administration of the program. A State Plan Amendment is to be provided to the federal CMS by June 30, 2010.

#### Staff Recommendation

Subcommittee staff recommends approval of the May Revision.

# ISSUE 8: ADJUSTMENTS TO EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM.

Governor proposes a series of adjustments for EPSDT for a net increase of \$145 million (\$30.7 million General Fund) as compared to January for 2010-11. This net increase is due to the following *key* factors:

- Increase of \$391.2 million (General Fund) to reflect the deletion of the redirection of Proposition 63 Funds.
- Increase of \$31.5 million (General Fund) and corresponding federal funds to reflect a revised projection for EPSDT claims which are mainly due to projected cost, utilization, and caseload increases in the Mental Health Services category of EPSDT.
- Increase of \$20.8 million (General Fund) for cost settlement amounts for 2007-08.
- Decrease of \$11.1 million (General Fund) to reflect increased participation by the County contribution of local Proposition 63 Funds contributed to the EPSDT Program for new or expanded EPSDT services based on updated claims data.
- Increase of \$69.5 million to reflect adjustments to the EPSDT County baseline for reimbursements which had not been included in previous estimates, according to the Department of Finance.

EPSDT is a federally mandated program that requires States to provide Medi-Cal enrollees under age 21 any health or mental service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a State's Medi-Cal plan. EPSDT operates under California's Medi-Cal Specialty Mental Health Services Waiver. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling. County Mental Health Plans are responsible for the *delivery* of EPSDT mental health services to children. Counties must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on Counties through a Governor Davis administrative action in 2002. This equates to about \$90 million or so in County Realignment Funds. The State and federal governments have primary financial responsibility for EPSDT funding. Due to several court cases over the years, California was required to expand its penetration rate for providing services, as well as the types of services it provides.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the May Revision.

# ISSUE 9: SUPPLEMENTAL MENTAL HEALTH SERVICES IN HEALTHY FAMILIES PROGRAM

Governor proposes a *net* decrease of \$6.2 million (federal funds) for supplemental mental health services for children in the Healthy Families Program. DMH states this decline in federal reimbursement provided to County Mental Health Plans is *primarily* due to a decrease in forecast of approved claims. It is believed this decrease is attributable to the fact that the Managed Risk Medical Insurance Board stopped enrollment of children in the Healthy Families Program for a brief period in 2009 due to the State's fiscal condition. Minor technical adjustments are also reflected.

Medically necessary mental health services are provided for children who are seriously emotionally disturbed beyond the basic mental health benefit provided within the Healthy Families Program. County Mental Health Plans provide these services and use County Realignment Funds to obtain the federal match (66 percent match provided under the federal States-Children Health Insurance Program).

#### **Staff Recommendation**

Subcommittee staff recommends approval of the May Revision.

### 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

### **ISSUE 1: ADDITIONAL 1.25% REDUCTION**

The Governor's January 2010-11 Proposed Budget, included a \$48.2 million (\$25 million GF) reduction to the DDS. To achieve this savings, the Governor is now proposing increasing the 3 percent reduction on both the Purchase of Services and Regional Center Operations by another 1.25 percent, for a total reduction of 4.25 percent.

#### **BACKGROUND**

The 2010-11 Governor's Budget extended, by one-year, a three percent reduction to Regional Center funding, both for the Purchase of Services and for Operations. The proposal was adopted in the Eighth Extraordinary Session by both the Senate and the Assembly.

**Additional Reduction**. The additional 1.25 percent reduction would yield the desired savings of \$48.2 million, of this total, \$25.3 million is GF. Of the \$25 million reduction, \$20.7 million will be made to regional center POS and \$4.6 million would be made to regional center Operations.

Although the reduction is made to RC Operations and POS, in discussion with the Department, a proposal to implement a provider relief program, based after a 1992 model implemented by SB 485 was shared with staff. The Trailer Bill Language for the additional 1.25 percent reduction is now provided by the Department.

#### STAFF COMMENT

**General Impact.** The \$25 million GF savings is achieved after excluding those in the original 3 percent trailer bill language (SSI, SSP and upholding the "health and safety of a consumer"), Capitol People First settlement agreement, Independent Living Supplement, Supported Employment, Usual and Customary Services, and payments consumers.

This item was heard three times in the Subcommittee. An alternative proposal to achieve this savings was proposed by advocates. This proposal would use funds from the Prevention Program to backfill the reduction. The Prevention Program was established when eligibility for infants and toddlers 0-3 years of age was eliminated from the Early Start Program (all in an effort to save \$15.5 million GF). The Department has testified that although expected caseloads have not been achieved, using these funds would create a deficit in the Prevention Program and the Early Start Program, as this population is constantly moving between the two programs.

A valid point is made that the estimated 13,400 infants and toddlers from October 1, 2009 through June 30, 2010 has not been met. Actually, as of April 30, 2010 caseload is 4,100 for the current year. This is due to the confusion of implementing this program. In fact, more children remained in the Early Start Program because regional centers reviewed the status of each child whose Early Start Report suggested eligibility for Prevention Program. Population has delayed from July 2009 – October -2009. Having said, these factors are not expected to be present in the budget year.

Overall, given the multiple Health and Human Services programs proposed for elimination by the Governor, it is important to note that a reduction across the board spreads impact throughout the developmental disabilities system. However, this is also a system that incurred a \$334 million unallocated reduction and a 3 percent reduction to regional centers in the last fiscal year.

Staff Recommendation: Reject the Governor's Proposal.

#### ISSUE 2: TECHNICAL REDUCTION FOR "GAP" FUNDING

#### **BACKGROUND**

The 2010-11 DDS regional center estimate for the Purchase of Services contains a \$1.4 million (General Fund) assumption regarding "gap" funding due to the time period of when an Intermediate Care Facility for DD (ICF-DD) is in a transition period and may not be certified to be a Medi-Cal provider due to a change in ownership.

DDS reflects \$1.4 million in General Fund support to backfill for the perceived loss of federal matching Medicaid (Medi-Cal) funds during this transition period.

#### **STAFF COMMENT**

Certain administrative processes have now been clarified and there is no longer a period (or gap) of time whereby federal matching funds are not applicable, as long as all federal CMS requirements are otherwise being met. The DDS and the Department of Public Health (DPH) have reached a compromise and believe this assumption is no longer necessary.

There is no affect on any health or safety issue here. It is just deleting an old, no longer applicable assumption.

Staff Recommendation: Conform to Senate and delete the \$1.4 million (GF) for the "gap" funding from item 4300-101-0001.

# 4120 EMERGENCY MEDICAL SERVICES AUTHORITY

#### ISSUE 1: PHARMACEUTICAL CACHE (STAND BY) FOR MOBILE FIELD HOSPITALS

#### **Budget Issue**

The Subcommittee first heard this request at its hearing on April 12, 2010. The EMSA requests an increase of \$448,000 (General Fund) to fund a pharmaceutical cache for the Mobile Field Hospitals (total of three). The EMSA states that this funding would ensure a fresh supply of pharmaceuticals to be on hand and delivered within 48 hours of the deployment of a Mobile Field Hospital (MFH). Pharmaceutical caches consist of medications, treatment kits, intravenous solutions, and other medical supplies. An allocation of \$18 million (General Fund, one-time only) was provided in 2006 for the purchase of pharmaceutical drugs, maintenance, medical supplies and related materials. In addition, \$1.7 million (General Fund, ongoing) was provided for pharmaceutical drugs, storage, staff and maintenance. The EMSA contends that only \$24,000 of the \$1.7 million (General Fund) is available for ongoing pharmaceutical supplies.

EMSA states that an integral part of the operational readiness, response and successful deployment of each MFH is a pharmaceutical drug cache, for which the original budgeted amount was \$23,000. Now, EMSA estimates the cost of the cache to be \$471,000, and therefore is requesting the difference of \$448,000. EMSA states that the original estimate of \$23,000 was simply a very inaccurate under-estimate.

At the April 12<sup>th</sup> hearing, EMSA indicated that it was in on-going discussions, along with the Department of General Services, with the state's preferred vendor about what they can do for the state and at what cost to the state. EMSA thought that they might have more detailed cost information as part of May Revise; however, they are still waiting for an estimate from the preferred provider.

#### **Staff Recommendation**

**Subcommittee staff recommends approval of this request.** In the event of a major disaster or public health emergency, either in California or elsewhere, the mobile field hospitals may be critical to saving thousands of lives, but only if they are adequately furnished with pharmaceuticals and other supplies. The state already has made a substantial investment in these hospitals.

#### 4270 CALIFORNIA MEDICAL ASSISTANCE COMMISSION

#### **ISSUE 1: REASSIGN GMC CONTRACT NEGOTIATIONS TO DHCS**

#### May Revise Issue

The Governor's May Revision proposes the following changes related to CMAC:

Transfers Authority for Geographic Managed Care (GMC) Contract Negotiations to DHCS. The Governor proposes to transfer GMC health plan contract negotiation responsibilities to DHCS for total savings of \$680,000. Furthermore, the administration indicates that some unknown number of CMAC staff will transfer to DHCS. The DHCS is not requesting additional position authority. It is not clear if DHCS would need additional staff to take on these responsibilities.

According to the LAO, this action will likely achieve savings and may administratively streamline these contract processes. This transfer also appears consistent with other transfers of responsibilities to DHCS regarding County Organized Health System managed care plans.

• Authorizes Other Changes to CMAC by Department of Finance. The administration proposes budget trailer bill language that would give the Director of the Department of Finance (DOF) authority to transfer responsibilities for determining the allocation of hospital supplemental payments, such as the Emergency Services Supplemental Payment program, to DHCS. This language would also authorize the Director to reduce or eliminate appropriations made to CMAC.

The LAO has concerns with the Governor's proposal to shift other responsibilities to DHCS and allow the Department of Finance to reduce or eliminate CMAC appropriations in the budget year. Given the significant potential changes to the hospital financing landscape, the LAO believe that it is reasonable for the Legislature to consider the future role and value of CMAC.

#### **Background**

The California Medical Assistance Commission (CMAC) negotiates for certain hospitals inpatient hospital rates and supplemental payments as well as Geographic Managed Care health plan contracts on behalf of DHCS. To support these activities, CMAC has 23 full-time staff and a board with seven voting and two ex-officio members. Total budgeted expenditures are \$2.6 million (\$1.3 million General Fund) in 2010-11.

#### **Staff Recommendation**

The Subcommittee staff recommends actions consistent with the LAO analysis, including approval of transferring GMC contract negotiations to DHCS and denying authorizing CMAC changes to be made by the Department of Finance.

#### 4260 DEPARTMENT OF HEALTH CARE SERVICES

#### **ISSUE 1: MEDICAID SECTION 1115 WAIVER**

#### **Budget Issue**

At last week's hearing on May 20<sup>th</sup>, 2010, the Subcommittee discussed and considered a related request for increased positions at the DHCS to implement the new 1115 Waiver, and the Subcommittee denied the request. This related request is for the adoption of proposed trailer bill language to implement the actual waiver. The trailer bill language covers the following four broad categories: 1) enrollment of seniors and people with disabilities into managed care; 2) enrollment of children with special health care needs into managed care of other similar medical home model; and, 3) better coordination of dual-eligibles (Medi-Cal/Medicare).

#### **Background**

As a result of federal policy changes several years ago, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal CMS which was completed as of September 1, 2005 and expires as of *August 30, 2010*. This Waiver is to provide over \$2 billion in annual reimbursement to hospitals.

The federal requirements for this Hospital Finance Waiver are contained in the "Special Terms and Conditions" document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny, Chapter 560, Statutes of 2005), provides the state statutory framework for implementing it.

Under this Waiver, Public Hospitals certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals use Intergovernmental Transfers (IGT's) on a limited basis to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distressed Hospital Fund, and Medi-Cal per diem and cost-based payments.

With the existing Hospital Financing Waiver scheduled to sunset as of August 2010, trailer bill legislation — AB 4X 6, Statutes of 2009 — was adopted last year to commence with the framework for a new, more comprehensive Waiver for California. As established in this bill, the goals of this new Waiver are:

- Strengthening California's health care safety net;
- Reducing the number of uninsured individuals:
- Optimizing opportunities to increase federal financial participation;
- Promoting long-term, efficient and effective use of State and local funds;
- Improving health care quality and outcomes; and,
- Promoting home and community-based care.

The statute also directs for the Waiver to provide Medi-Cal enrollees with access to better coordinated and integrated care to improve outcomes and help slow the long-term growth in program costs. Among other things, it provides for the more comprehensive enrollment of individuals into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model. The DHCS has developed a concept paper and an implementation plan for the Waiver and has been convening workgroups of stakeholders over the past several months.

AB 4X 6 requires the Administration to provide an implementation plan to the fiscal and policy committees of the Legislature prior to implementation of the Waiver, and at least 60-days prior to an appropriation by the Legislature for this purpose. The DHCS provided this plan on May 7<sup>th</sup>, 2010.

#### Staff Recommendation

Subcommittee staff recommends denying approval of all proposed 1115 Waiver trailer bill, without prejudice, and directing the Administration to pursue development and establishment of the new 1115 Waiver through policy bills and through the legislative policy process.

#### **ISSUE 2: MEDI-CAL COST-CONTAINMENT PROPOSAL**

This proposal was first heard by the Subcommittee on May 20, 2010. In January, the Governor proposed legislation to authorize the Department of Health Care Services (DHCS) to negotiate with the federal government to implement various changes to Medi-Cal for a reduction of \$2.388 billion (total funds). This proposal would require federal law changes and other federal approvals. The amount of General Fund savings attributed to this action is contingent upon the Federal Medical Assistance Percentage (FMAP) provided for California. The January budget assumed a General Fund savings of \$750 million. The Governor's May Revision proposes detailed policies under the umbrella of this cost-containment proposal including:

- 1. Utilization Controls (\$90.2 million in General Fund savings)
- 2. Cost Sharing (\$218.8 million in General Fund savings)
- 3. "Other Program Changes" (\$213.7 million in General Fund savings)

#### **Staff Recommendation**

**Subcommittee Staff recommends rejection of this proposal, with one exception --** Adopt the proposal to freeze CMAC-negotiated hospital rates for one year.

# ISSUE 3: HOSPITAL PROVIDER RATE STABILIZATION & QUALITY ASSURANCE FEE PROGRAM (AB 1383) – PROPOSED 6 MONTH EXTENSION

#### **Budget Issue**

The Subcommittee discussed AB 1383 (created hospital quality assurance fee) at its hearing on May 10, 2010, and approved of the Department's BCP requesting additional positions in order to implement the program. The Subcommittee also took an action to utilize AB 1383 revenues that were specifically designated in AB 1383 for children's health services, to fully fund the Healthy Families Program. The Governor's May Revision proposes to extend the AB 1383 hospital quality assurance fee for two quarters, conforming to an assumed two-quarter extension of ARRA, and therefore the enhanced FMAP.

#### Background

AB 1383 (Jones, Chapter 627, Statutes of 2009) authorized the implementation of a Quality Assurance Fee (QAF) on General Acute Hospitals for the period of April 2009 through December 2010. Implementation of the QAF requires federal CMS approval which is pending. The Governor's January budget proposes to appropriate these revenues within the Medi-Cal Program. Currently, AB 1653 (Jones) seeks to extend this hospital fee for six months. AB 1653 is currently awaiting the hearing in the Assembly Appropriations Committee.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposal and denial of proposed TBL, without prejudice, and direct the Department to pursue through a policy bill. The AB 1383 hospital fee is still awaiting approval by the federal CMS, which this proposal is contingent upon.

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

#### **Budget Issue**

This proposal was first heard by the Subcommittee on April 26<sup>th</sup>, 2010. 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 Recommendation**

Subcommittee staff recommends approval of this proposal and adoption of "placeholder" trailer bill, in light of the state's fiscal crisis.

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

#### **Budget Issue**

This proposal was first heard by the Subcommittee on April 26<sup>th</sup>, 2010. 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 Recommendation**

Subcommittee staff recommends approval of this proposal and adoption of "placeholder" trailer bill, in light of the state's fiscal crisis.

#### **ISSUE 6: MANAGED CARE RATES IN TWO-PLAN COUNTIES**

This proposal was first heard by the Subcommittee on May 20<sup>th</sup>, 2010. Beginning for the 2009-2010 rate year, the DHCS administratively implemented a risk-adjustment factor for the Two-Plan Model managed care capitation rates. The effect of this change was not fully recognized until December 2009 by many of the affected plans.

The DHCS contends the purpose of this risk-adjustment is to distribute Medi-Cal payments to health plans based on the health risk of the Medi-Cal enrollees in their plan. They state that it requires a county-wide rate because these rates represent the best estimate of the average cost of a Medi-Cal beneficiary that can enroll in the plan.

DHCS states they did not implement the full impact of their risk adjustment factor in 2009-2010. But instead, implemented a 20 percent risk-adjustment factor and a no risk factor to 80 percent of a health plans' specific rate. The DHCS proceeded with this rate-adjustment in a "budget neutral" manner. As such, Medi-Cal capitation rates were reduced for some, and increased for others, based solely on this factor.

Key concerns are: 1) the methodology does not factor-in safety net provider payments appropriately; 2) it shifts \$7.2 million away from Local Initiatives who are core providers in Two-Plan Model counties and reallocates these funds to commercial health plans participating in the Two-Plan Model; and 3) the DHCS did not fully communicate this change in its budget materials presented to the Legislature.

When questioned as to why a 20 percent risk-adjustment was chosen, the DHCS contends it was to demonstrate their clear intent to move toward an entire county specific risk adjustment rate. No other rational has been provided. The DHCS intends to increase this risk-adjustment factor in subsequent years.

The Local Health Plans of California (Local Initiatives) support a risk-adjustment factor. But they believe an additional factor needs to be included in the equation for determining Medi-Cal capitation rates in the Two-Plan Model system.

Specifically, the Local Initiatives are seeking adoption of trailer bill language to include a safety net adjustment factor within the risk-adjustment calculation for county-wide rates. The Local Initiatives have provided data to the DHCS which they contend illustrate the considerable network arrangements they have with Federally Qualified Health Centers (FQHCs) and designated Public Hospitals.

Medi-Cal capitation payments to Local Initiatives have in the past recognized that a portion of their reimbursement is needed to account for the Local Initiatives network arrangements with safety net providers. These safety net providers utilize these payments to support uncompensated care costs for the uninsured and for high volume Medi-Cal providers, among other public-focused expenditures such as medical training, certain case management for involved Medi-Cal enrollees, and access enhancements.

Under the DHCS 20 percent risk-adjustment factor, the Local Initiatives would be reduced by about \$7.2 million in Medi-Cal capitation payments. These funds would be shifted to the commercial health care plans participating in the Two-Plan Model.

Local Initiatives are a core component of the Medi-Cal Managed Care Program and need to be viably sustained as California proceeds through its development and implementation of its 1115 Medicaid Waiver. Health plan network expansion to address federal health care reform and the potential enrollment into managed care of vulnerable populations will be reliant upon safety net providers to provide specialty care, care coordination, and access to outpatient services.

#### **Staff Recommendation**

Subcommittee staff recommends adoption of "placeholder" trailer bill that has been agreed to by the Local Initiatives, Health Net and Molina. The proposed trailer bill is as follows:

"Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan."

#### ISSUE 7: FAMILY HEALTH ESTIMATE PACKAGE FOR CCS, CHDP & GHPP

#### **Budget Issue**

The May Revision for the CA Children Services (CCS) Program, the Child Health Disability Prevention Program and the Genetically Handicapped Persons Program proposes the following:

- CCS increase of \$ 5 million (General Fund)
- CHDP decrease of \$91,000 (General Fund)
- GHPP increase of \$5.4 million (General Fund)

This May Revision reflects changes that pertain to caseload; no policy changes are proposed. Caseload projects are estimated to be: 1) 44,345 children for CCS-only (a 2.6 percent increase over the current year; 2) 23,732 people for the CHDP (an insignificant difference over the current years; and 3) 1,430 people for the GHPP (a 2.9 percent increase).

#### **Staff Recommendation**

**Subcommittee staff recommends approval the May Revision**. The Family Health estimate for the CCS, CHDP and GHPP contains no new policy issues, only caseload and technical adjustments.

#### ISSUE 8: ELIMNATION OF PROP 99 FUNDING FROM EAPC

#### **Budget Issue**

This proposal was first heard by the Subcommittee on April 26<sup>th</sup>, 2010. Proposed in January as part of the Governor's package of "trigger" proposals, 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. On April 26, 2010, this Subcommittee took an action to restore the \$20 million that was vetoed by the Governor last year.

#### Staff Recommendation

**Subcommittee staff recommends rejecting this proposal.** Significant reductions were made to Community clinics last year, both directly and indirectly, such as through the elimination of dental services for adults in Medi-Cal. The safety net, including community clinics, has an increasingly critical role to play given both the weak economy and the imminent demands of federal health care reform.

#### **ISSUE 9: MEDI-CAL CASELOAD ESTIMATE**

The LAO's review of the most recent available enrollment data indicates that the Medi-Cal May Revision caseload estimate for 2010-11 is reasonable. However, there is uncertainty in the caseload estimates given in the potential impact of the recently enacted federal Patient Protection and Affordable Care Act of 2010 (PPACA) on Medi-Cal caseload. The PPACA would require all individuals to maintain health insurance coverage beginning in January 2014. The increased awareness of this requirement may prompt some individuals that are currently eligible for Medi-Cal, but not enrolled, to enroll in Medi-Cal at an earlier date including in 2010-11. The LAO estimates that more than 600,000 individuals are currently eligible, but not enrolled. In addition, the rate at which the economy will recover is unknown and will have an impact on the growth of caseload in Medi-Cal. A rapid recovery would be likely to moderate caseload growth somewhat, while a delayed recovery could result in caseload continuing to grow at a somewhat greater rate than it has during periods of economic stability.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the proposed May Revise Medi-Cal caseload estimate.

#### ISSUE 10: FEDERAL HEALTH CARE REFORM CONTROL SECTION

This proposed Budget Control Section 23.25 would give the Director of Finance broad authority to adjust any item of appropriation in the budget act for the purpose of implementing the federal Patient Protection and Affordable Care Act of 2010.

#### Staff Recommendation

**Subcommittee staff recommends rejection of this proposal**. The authority of this language is too open-ended and does not allow for appropriate legislative oversight. In addition, the Department of Finance has not identified any specific examples of how it would use this authority that could not be addressed through existing budget control sections.

#### **ISSUE 11: NEW CONTROL SECTION 8.65**

The Governor proposes new a Control Section 8.65 as follows: Notwithstanding any other provision of law, each item of appropriation in this act shall be adjusted, as determined by the Director of Finance, to reflect changes to the General Fund, Federal Trust Fund, and Reimbursement expenditures resulting from the following:

- 1. Continuation through June 30, 2011, of enhanced funding currently provided to Health and Human Services Agency programs pursuant to the American Recovery and Reinvestment Act of 2009:
- Additional federal flexibility or support in a number of targeted areas, including federal reimbursement for the cost of incarcerating undocumented immigrant felons, monies owed to the State for incorrect Medicare disability determinations, recalculation of State Medicare Part D Clawback payments, and General Fund relief through the new comprehensive Section 1115 Medi-Cal Waiver; and,
- Adjustments authorized pursuant to this section shall not be implemented before
  notification is provided to the chairpersons of the Committees in each house of the
  Legislature that consider appropriations and the Chairperson of the Joint Legislative
  Budget Committee.

The federal government has provided California with considerable assistance in the Medi-Cal Program and additional discussions are ongoing with: 1) the pending federal ARRA extension to June 30, 2011; 2) monies owed for Medicare disability claiming; and, 3) the pending 1115 Medi-Cal Waiver. As such, a Control Section is probably necessary to facilitate the management of these funds over the next fiscal year and to offset General Fund support where applicable.

#### **Staff Recommendation**

**Subcommittee staff recommends adoption of placeholder language**. The proposed Control Section is broadly crafted and therefore the language needs to be further clarified.

#### ISSUE 12: REINSTATEMENT OF ADULT OPTOMETRIC SERVICES IN MEDI-CAL

As required by ABX3 5 (Chapter 20, Statutes of 2009), the state discontinued the optional Medi-Cal optometry services for adults 21 years of age or older who are not in nursing facilities and excluding pregnant women.

Effective January 2011, the DHCS indicates that it needs to temporarily reinstate optometry services at a cost of \$3.7 million (\$1.8 million General Fund) to comply with federal law, which prohibits the elimination of optometrist services if physicians could still provide the services and the State previously funded these services. The DHCS states that it is performing a legal review to determine what steps are necessary to allow the Administration to reinstate the discontinuance of optional optometry services.

AB X3 5 specified that the reductions could only be made to the extent allowed by federal law. Therefore, this reinstatement can be made without a statutory change.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this proposal.

#### **ISSUE 13: FEDERAL FLEXIBILITIES**

Savings of \$1.6 billion is assumed from additional federal flexibility or support in a number of targeted areas, including federal reimbursement for the cost of incarcerating undocumented immigrant felons, monies owed for incorrect Medicare disability determinations, recalculation of the base Clawback payment, and possible General Fund relief available through the new hospital financing waiver.

Federal Flexibilities – May Revise Proposals/Assumptions (Dollars in Thousands)					
Department	Issue	2009-10	2010-11		
DHCS	FPACT Undocumented Factor	\$50,829	\$58,240		
DHCS	Safety Net Care Pool (ARRA)	\$298,597	\$125,172		
DHCS	Managed Care: Prior Year Funds	\$115,000	\$245,000		
DHCS	ARRA Extension		\$1,501,000		
DHCS	Clawback (ARRA)	\$447,253	\$234,978		
DDS	ARRA Extension		\$165,449		
DDS	IDEA, Part C Grant		\$32,894		
DDS	ICF-DD/SPA	\$39,023	\$14,518		
DMH	ARRA Extension		\$86,535		
Statewide	SCAAP, Disability Determinations,				
	Clawback, Waiver		\$1,600,000		
DADP	ARRA Extension		\$11,400		
DCSS	Extend ARRA Child Support Incentive		\$18,900		
DSS	Extend ARRA CalWORKS Funding		\$45,600		
DSS	ARRA Extension – IHSS		\$136,000		
DSS	Extend ARRA for Foster Care/Adoptions		\$27,800		
TOTAL		\$950,702	\$4,303,486		

#### **Staff Recommendation**

The Subcommittee staff recommends approval of the May Revise federal funding assumptions.

#### **ISSUE 14: TIMELY FILING RULE**

Federal law requires that when a Medicaid beneficiary has third-party health coverage or insurance, the state Medicaid agency shall be the payer of last resort. Accordingly, the state is mandated to identify and to recover from liable third parties the costs of claims paid by Medi-Cal. To comply with this mandate, the Third Party Liability and Recovery Division of the Department of Health Care Services (DHCS) utilizes internal processes, as well as competitively procured vendors, to identify Medi-Cal recipients having "other coverage."

Federal and state law authorizes DHCS to seek reimbursement for claims up to three years after the date of service. Upon notification of claims subject to other coverage, providers should submit claims for payment to the insurer. However, some insurers are denying claims based on "timely filing" provisions/restrictions – typically 30 to 180 days – delineated in each individual contract with the provider. When an insurer denies a claim as untimely, DHCS loses revenue due to its inability to recoup Medi-Cal monies from the provider.

The Administration is proposing trailer bill that would protect and increase third-party liability recoveries by requiring insurers to honor a three-year "look back" when providers submit claims which were originally paid by Medi-Cal. If DHCS, beyond the insurer/provider contractual timely filing period, notifies the provider of other coverage, providers will still be authorized to submit claims up to three years after the date of service and insurers will be required to pay the claims.

Due to privacy considerations surrounding the Medi-Cal rates DHCS pays to contract hospital providers, the DHCS is effectively prevented from seeking reimbursement directly from the insurer for these claims.

Although there are no costs or savings "scored" in the budget associated with this trailer bill proposal, the Administration indicates that the state risks losing an estimated \$10 million in annual Medi-Cal recoveries if this language is not approved.

#### Staff Recommendation

Subcommittee staff recommends supporting this proposal.

#### **ISSUE 15: RATE STUDIES ON MAIC AND PAD**

#### May Revise Issue

In the May Revise, the Administration has also requested \$800,000 (\$400,000 General Fund) to fund contractors to perform rate studies to establish the maximum allowable ingredient cost on generic drugs and to ensure the adequacy of a proposed change in the reimbursement rate for physician administered drugs.

The Physician Administered Drug reimbursement issue was first heard and left open in this Subcommittee on May 10, 2010. The current rate of reimbursement for physician administered drugs is the Average Wholesale Price (AWP) minus 5%. As a result of a federal lawsuit settlement against First Data Bank, the information supplier of AWP, the Department must change this reimbursement methodology.

Beginning in 2010-11, the DHCS is proposing trailer bill legislation that will change the physician administered drug reimbursement methodology to the lower of the Medi-Cal pharmacy reimbursement rate, which is the AWP minus 17%, or the Medicare rate, which is the Average Sales Price (ASP) plus 6%. The new methodology is expected to generate a savings of \$12.8 million (\$6.4 million General Fund).

The Department is conducting a study of the acquisition costs for drugs purchased by non-pharmacy providers prior to implementation of this reimbursement change, as well as the staffing needed to implement the rate adjustment.

In April, the Administration requested funding for one two-year limited term Pharmaceutical Consultant II Specialist position, at a cost of \$169,000 (\$44,000 GF), to develop and maintain reimbursement policy for Physician Administered Drugs.

It should take several months to complete the study, but the Administration expects the rate change to be implemented by February 2011.

#### Staff Recommendation

Subcommittee staff recommends approval of \$800,000 (\$400,000 General Fund) to conduct these studies.

#### ISSUE 16: PHYSICIAN ADMINISTERED DRUGS REIMBURSEMENT POLICY

#### **Budget Issue**

The Subcommittee first heard this proposal at its hearing on May 10, 2010. The DHCS requests funding for one two-year limited term Pharmaceutical Consultant II Specialist position, at a cost of \$169,000 TF (\$44,000 GF, and \$125,000 FF), to develop and maintain reimbursement policy for Physician Administered Drugs. The DHCS will redirect an existing position for this purpose. This workload results from a change in the reimbursement policy contained in the 2010-11 budget, which resulted from a federal lawsuit. The DHCS states that without this additional position, the DHCS will not be able to make the required change to reimbursement policy and therefore will not be able to achieve the anticipated \$26.3 million TF (\$13.17 million GF) in annual savings.

#### Background

Historically, the Medi-Cal program has calculated reimbursement policy for pharmacies using Average Wholesale Price (AWP), minus 17 percent. However, as a result of a federal lawsuit settlement against First Data Bank, the information supplier of AWP, AWP will no longer be published as of October 2011, and therefore the DHCS must change this reimbursement methodology. Therefore, the DHCS is proposing legislation to change physician reimbursement to the Medi-Cal pharmacy rate of reimbursement or the Medicare rate unless federal law requires a higher reimbursement level.

At this time, the DHCS has not yet developed or proposed a long-term solution to the problem created by the elimination of the AWP. Instead, they have proposed to simply reduce the rates paid to providers, who directly administer drugs, for those drugs. Few provider groups administer drugs directly; the primary provider type that administers drugs directly to patients is oncologists, very few of whom are Medi-Cal providers, according to the California Medical Association. A reduction to the rates for very expensive drugs is not likely to encourage more oncologists to participate in the Medi-Cal program.

#### **Staff Recommendation**

**Subcommittee staff recommends denial of this request.** State statute requires the state to perform an evaluation of anticipated impacts of rate reductions prior to implementing a rate reduction. As discussed in the previous issue, the DHCS is requesting additional funding to perform such an impact study, which should be completed before proposing this rate reduction. Moreover, it is recommended that DHCS develop a proposed solution to the imminent elimination of the AWP prior to submitting a new request on this to the Legislature.

# ISSUE 17: MEDI-CAL MANAGED CARE BASELINE ADJUSTMENTS AND CAPITATION RATES

The Governor proposes several adjustments to Medi-Cal Managed Care, including: 1) baseline adjustments due to anticipated enrollment; and 2) rate adjustments to reflect cost trends.

<u>Baseline</u>. An increase in expenditures for the base are due to the transition of Medi-Cal enrollees moving from Fee-for-Service to Managed Care, as noted above (more Seniors and People with Disabilities), along with the increase in caseload of traditional Medi-Cal enrollees (woman and children). An increase of \$404.4 million (total funds) is projected for this baseline adjustment (comparing 2009 to 2010).

Rate Adjustment. May Revision provides an increase of \$348 million (\$174.2 million General Fund) to provide an estimated 3.7 percent average rate increase for health care plans participating in Medi-Cal Managed Care.

DHCS is the largest purchaser of managed health care services in California with almost 3.5 million Medi-Cal enrollees, or about 48 percent of the Medi-Cal population enrolled in these arrangements. DHCS annually reviews, more frequently when warranted, the rates paid to Medi-Cal Managed Care plans. Their analysis is based on actual data regarding utilization trends and financial information provided by the plans. DHCS then applies a trend analysis, which is to be verified as actuarially sound, to discern the final rates.

The Administration states that this rate increase would take into consideration a pharmacy pricing adjustment which is a proposed policy change requires manage care companies to prescribe generic drugs in order to receive Medi-Cal reimbursement.

#### **Staff Recommendation**

Subcommittee Staff recommend approval of the May Revise managed care baseline adjustments and capitation rate

# ISSUE 18: MEDI-CAL PROGRAM ELIGIBILITY PROCESSING: METHODOLOGY CHANGE ON ELIGIBILITY GROWTH

The Governor proposes to re-calculate the County Administrative Baseline for Medi-Cal caseload growth by changing the methodology. Specifically, DHCS is proposing to change the existing method for determining baseline funding and growth funding (to account for new Medi-Cal caseload) and to trend them differently by only accounting for one year of caseload growth instead of trending over a two-year period as has been done historically. Use of this new methodology would result in a reduction of about \$84 million (\$42 million General fund). *In addition*, the Governor proposes to *continue* two reductions from 2009 forward, and to *not* provide a cost of doing business increase for 2010-11. These adjustments are shown below:

- Reduction of \$121.1 million (total funds) from a Governor's veto in the Budget Act of 2009.
- Reduction of \$49.3 million (total funds) from not providing the cost of doing business in 2009-2010.
- Reduction of \$21.7 million (total funds) from not providing a cost of doing business in 2010-11.

County Welfare Departments serve as the surrogate for the State in administering the Medi-Cal eligibility determination process for all individuals applying for enrollment and all aspects of enrollment redeterminations.

Funds allocated to counties for caseload growth enable counties to hire staff to handle increased workload due to increases in Medi-Cal eligible persons and enrollment. The accuracy and timeliness of the decisions made by eligibility workers are important for maintaining an upto-date listing of Medi-Cal enrollees (which is tied to the payment of services).

DHCS has proposed a completely *new methodology* at the May Revision for calculating caseload growth-related funding for staffing purposes. At this point in time, it is unclear as to how this methodology is calculated or how it is applicable to the considerably increased caseload in Medi-Cal resulting from the Great Recession.

#### **Staff Recommendation**

Subcommittee staff recommends rejection of the proposed methodology change on eligibility growth.

#### 4265 DEPARTMENT OF PUBLIC HEALTH

#### **ISSUE 1: AB 32 POSITION REQUEST (SFL)**

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 10, 2010. The DPH is requesting budget authority and funding (\$299,000 in 2010-11 special funds) for 3 positions to provide expertise and assistance in the implementation of AB 32. The funding for these positions will be a direct appropriation from the California Environmental Protection Agency (Cal/EPA), Air Resources Board (ARB) AB 32 administrative fees. The 3 positions will be redirected from within DPH, therefore no new positions are being requested.

#### **Background**

AB 32 (Nuñez, Pavley, Chapter 488, Statues of 2006), the Global Warming Solutions Act of 2006, sets a greenhouse gas emissions reduction goal into law – to reach 1990 emission levels by 2020. Under Executive Order, the Governor directed the Cal/EPA to coordinate multi-agency efforts to meet the AB 32 goal and created the Climate Action Team (CAT) for this purpose. Recently, the Cal/EPA invited the DPH Director to participate in the CAT, and to create a CAT Public Health Work Group in order to provide public health input into the AB 32 implementation process, as well as other public health issues related to climate change. This Work Group has met over the past year and has developed a work plan for public health activities. This proposal seeks to fund the activities within the work plan that pertain specifically to AB 32.

The AB 32 Administrative fee will be levied against industries responsible for producing greenhouse gas emissions, and, according to the DPH, will begin in 2010. Cal/EPA is in support of this proposal.

#### **Staff Recommendation**

Subcommittee staff recommends approval of the Spring Finance Letter to fund new positions at the DPH to implement public health activities related to AB 32.

#### ISSUE 2: REDUCTIONS FROM BREAST CANCER ACCOUNTS (CD-06, CD-07)

#### **Budget Issue**

This proposal was first heard by the Subcommittee on May 10, 2010. The Administration requests decreased expenditure authority of \$393,000 in the Breast Cancer Research Account, and of \$5,212,000 (\$4,075,000 in local assistance and \$1,137,000 in state support) from the Breast Cancer Control Account.

#### Background

As described earlier in the agenda under Issue #4 on the Every Woman Counts Program, AB 478, the Cigarette Tax Increase: Breast Cancer Act of 1993, was enacted adding a 2 cent per cigarette pack tax to the existing taxes. The Breast Cancer Fund was established to receive revenue from this 2-cent tax and it is divided evenly between two sub-funds:

- The Breast Cancer Research Account (BCRA) This fund receives 50 percent of the revenue, of which 90 percent funds University of California tobacco-related research and 10 percent funds the California Cancer Registry (CCR) – a collection of breast cancerrelated data and epidemiological research by the DPH.
- The Breast Cancer Control Account (BCCA) This fund receives 50 percent of the revenue, all of which is statutorily directed to fund the Every Woman Counts Program.

Tobacco taxes in general are a declining revenue source. Consequently, these two proposals reflect an anticipated decline in revenue in the Breast Cancer Fund. The BCRA reduction of \$393,000 is proposed to be reduced from funding for the CCR, not to UC research.

#### California Cancer Registry

According to the DPH, the CCR is "award winning" and one of the leading cancer registries in the world. CCR data helps identify where disparities exist and to identify disproportionately-affected populations, critical for prioritizing prevention strategies, early detection programs and cancer research. CCR data is also used to evaluate the effectiveness of cancer control programs.

#### University of California Tobacco Research

While there may be a vast array of tobacco-related research being done throughout the state, country and world, UC's research is unique in that it focuses specifically on California-specific aspects of tobacco-related diseases.

#### Every Woman Counts Program

As described in detail under Issue #4 specifically on this program, the EWC program provides breast and cervical cancer screenings to uninsured and under-insured women, not covered by Medi-Cal, up to 200 percent FPL.

#### Staff Recommendation

Subcommittee staff recommends approval of these two proposals to reduce expenditure authority in the Breast Cancer Research Account and the Breast Cancer Control Account.

#### **ISSUE 3: EVERY WOMAN COUNTS PROGRAM**

#### May Revise Proposal

The Department of Public Health (DPH) states that the Every Woman Counts program will be operating at a deficit in the budget year if cost containment measures are not implemented. In order to reduce costs in the program, the DPH proposes to continue restricting eligibility to women 50 and older on a permanent basis (previously, women between the ages of 40 and 49 were eligible). The DPH also proposes two primary cost containment mechanisms beginning July 1, 2010: 1) implementing a tiered case management payment system instead of the current system, which pays \$50 to providers to follow up on both normal and abnormal screening exams (savings of \$9.8 million annually); and, 2) limiting screening mammograms to once every two years instead of once every year (savings of \$2.4 million annually). The new proposed case management payment system would pay providers \$10 for case management services for normal screens, and \$50 for abnormal screens.

However, because of the time lag in submittal and payment of claims, DPH states that cost savings attributable to these proposals likely will not fully materialize in the budget year and will take from 6 to 24 months to be fully realized. Thus, DPH proposes to continue the freeze on new enrollment until cost savings are realized, and to allow limited new enrollment thereafter based on available funds.

#### Legislative Analyst's Office

The LAO believe the Administration's cost containment proposals for tiered case management and biennial screenings are reasonable and recommend modifying the proposed tiered case management payment schedule to make no payment for follow-up on normal screens, as opposed to the \$10 payment proposed by DPH. A normal screen should not require follow-up beyond notification to a patient that a test was normal. The DPH projects that this change would save an additional \$1.6 million annually that could be used to pay for direct clinical services. The LAO notes that the DPH has the authority to make these changes administratively. However, several Members of the Legislature were disappointed and uncomfortable with the administrative changes that the DPH made to the program earlier this year.

#### **Background**

The Every Woman Counts (EWC) program provides free breast cancer screening and diagnostic services to women aged 50 (40 until the beginning of this year) and over whose income is below 200 percent of the federal poverty level (FPL) and uninsured or under-insured. It also provides cervical cancer screening and diagnostic services to women aged 25 and over who meet similar eligibility criteria.

California began receiving federal funds for this purpose in 1991 through the National Breast and Cervical Cancer Early Detection Program administered through the federal Centers for Disease Control and Prevention (CDC). Subsequently, AB 478 (Friedman, Chapter 660, Statutes of 1993) created California's state program, to be funded by a two-cent per pack increase in the cigarette tax. This two cent tax revenue is collected and deposited into the Breast Cancer Fund, half of which is appropriated to DPH for the EWC program and the other half supports the California Cancer Registry and the University of California for California-specific breast cancer research.

According to DPH, an estimated 1.2 million Californians are eligible for breast cancer services through EWC and an estimated 3 million are eligible for cervical cancer services. DPH also estimates that approximately 350,000 women would request breast cancer services in 2010-11. The caseload has increased steadily over the life of the program.

When women who are screened through the EWC program are diagnosed with breast cancer, they are referred to the state's breast cancer treatment program, under Medi-Cal, for treatment. This program has a state-only component for women who do not qualify for federal financial participation due to immigration status; treatment for women in the state-only program is limited to 18 months.

#### **EWC Budget**

The EWC receives no General Fund support and has three funding sources: 1) Prop 99 – its primary funding source; 2) the Breast Cancer Control Account – the secondary two cent tobacco tax revenue, described above; and, 3) a federal CDC grant.

The program is currently facing an extreme funding shortage which DPH states is the result of two concurrent trends over the past several years: 1) increasing caseload; and, 2) decreasing tobacco tax revenue. Also, the 2009 Budget Act shifted \$4.5 million of Proposition 99 funds from the EWC to backfill General Fund in Medi-Cal.

In order to address the projected funding shortfall in the program, DPH announced the following two significant policy changes to the program which were put into effect on January 1<sup>st</sup>, 2010:

- 1) A permanent increase in the minimum age eligibility for breast cancer screening services from age 40 to age 50; and,
- 2) A temporary six month enrollment freeze for all women seeking breast cancer screening services from January 1 through June 30<sup>th</sup>, 2010.

#### **Subcommittee Actions on May 10, 2010:**

The Subcommittee took the following actions on May 10, 2010:

- Rejected the Governor's proposal to shift all Proposition 99 funding out of the EWC program to Medi-Cal for General Fund Savings;
- 2) Required the DPH to provide a semi-annual estimate package on the EWC as part of the Governor's January and May budget proposals; and
- 3) Augmented the EWC with sufficient General Fund (approximately \$38 million) to ensure that no new policy changes or eligibility restrictions would be necessary in order to fully fund the program.

#### **Staff Recommendation**

#### Subcommittee staff recommends:

- 1) Adopting the LAO alternative related to provider rates in the EWC program;
- 2) Denying the proposals to provide mammograms only every other year and to continue the enrollment freeze into 2010-11; and
- 3) Modify the prior action of the Subcommittee to augment the program with General Fund by instead augmenting the program with the \$36 million Proposition 99 reserve that the Governor has proposed to use to backfill General Fund in Medi-Cal.

#### **ISSUE 4: ASTHMA PUBLIC HEALTH INITIATIVE**

This proposal was first heard by the Subcommittee on May 10, 2010. Included in the package of "trigger" proposals, the Governor proposed shifting all \$1.2 million in remaining Proposition 99 funds in the California Asthma Public Health Initiative (CAPHI) to backfill General Fund dollars in Medi-Cal, for General Fund savings of \$1.2 million. According to the DPH, this would eliminate the CAPHI.

#### May Revise Proposal

The Governor's May Revision proposes eliminating \$106,000 in Proposition 99 funding for a study within the DPH's Environmental Health Investigations Branch, and eliminating \$1.2 million in Proposition 99 funding for the CAPHI, including grants to Central Valley health departments.

#### **Background**

Asthma affects nearly 3 million people in California. The state's Strategic Plan for Asthma indicates that costs for asthma-related hospitalizations totaled over \$763 million in 2005. Approximately 150,000 emergency department (ED) visits and 36,000 hospital discharges were attributed to asthma in California in that year. Rates of asthma-related ED visits, hospitalizations, and mortality are significantly higher among minorities and low-income communities. Most hospitalizations and severe adverse health outcomes related to asthma are preventable with proper clinical care and education, and through minimizing exposure to asthma triggers.

The goal of CAPHI is to reduce the impact of asthma and eliminate related health inequities in California. This proposal would eliminate core public health functions related to asthma such as promotion of best practices in asthma care and management, policy analysis and development, convening of quality improvement collaboratives, partnering with other state, local, and non-profit entities (including the California Department of Education), and provision of statewide technical assistance and expertise.

The CAPHI used to provide local assistance to ten community health centers serving a combined population of approximately 9,000 children with asthma in underserved communities. All ten of these contracts were cancelled as a result of this fund shift. The program also administers a local assistance program with central valley health departments designed to reach as many people with asthma, of all ages, as possible. Until this past year, the program worked with five counties (Fresno, Stanislaus, Kern, Tulare, and Madera); however this budget cut resulted in Tulare and Madera pulling out of the program. The three remaining counties reach an estimated 365,000 people.

The program also conducts four clinical collaboratives to promote improved pediatric asthma care. DPH states that these collaboratives have directly impacted over 25,000 children resulting in significant clinical care improvements, reduced morbidity, decreased emergency visits and hospitalizations. Finally, CAPHI provides statewide asthma clinical expertise to health care providers and individuals affected by asthma.

Funding for the program was reduced last year in the amount of \$438,000 million, and has been reduced by approximately half from the 2008-09 funding level of \$2.6 million.

#### Legislative Analyst's Office

The LAO states that the proposal to eliminate the CAPHI is problematic for several reasons. First, the CAPHI provides core public health expertise and technical assistance statewide on a public health issue that affects a significant portion of the state's population. Second, although the LAO has not conducted a formal cost-benefit analysis of the program, they acknowledge that asthma disproportionately impacts low-income populations likely to be served by other state health programs, and believe it is likely that clinical quality improvements and better management of asthma that result from this program may lead to lower ER visitation and hospitalization rates among this population. Finally, the LAO believes that the small amount of funding provided to the program leverages a fairly large impact, since clinical collaboratives and partnerships with other entities result in in-kind contributions towards the public health goals of the program.

#### LAO Recommendation

The LAO recommends modifying the proposal to preserve \$1.2 million in funding for the CAPHI and eliminate \$106,000 for a study within the Environmental Health Investigations Branch.

#### **Staff Recommendation**

Subcommittee staff recommends the LAO proposal to reject the Governor's original proposal to eliminate all \$1.2 million in Proposition 99 funding for CAPHI, and approve of the Governor's May Revise proposal to eliminate \$106,000 for an environmental health study.

#### **ISSUE 5: AIDS DRUG ASSISTANCE PROGRAM (ADAP)**

#### **Governor's May Revision Estimate**

Over 38,000 people with HIV/AIDS will receive drug assistance through the ADAP for 2010-11. The May Revision proposes a *reduction* of \$28.6 million (decrease of \$32.7 million General Fund) as compared to January as shown in the table below. The Office of AIDS states this reduction does not reflect any additional programmatic changes beyond the jail coverage change proposed in the Governor's January budget.

Comparison of Governor's January Budget and May Revision for ADAP  Dollars in Millions					
Fund Source	January 2010	May Revision	Difference		
General Fund	\$158.3	\$125.6	-\$32.7		
AIDS Drug Rebate	\$210.9	\$210.3	-\$0.6		
Federal Funds – Ryan White	\$92.9	\$97.6	\$4.7		
TOTAL	\$462.1	\$433.6	-\$28.6		

The key differences pertain to prescription drug costs and the Pharmacy Benefit Manager (PBM) Operation expenditures. Specifically, the Office of AIDS states the proposed net reduction is attributable to the following:

- Updated drug expenditure data which results in a reduction in the linear regression expenditure estimate (as modeled by the Office of AIDS).
- Reduction in projected drug expenditures resulting from the federal settlement with First Data Bank regarding the value of the Average Wholesale Price (AWP).
- Change in the Medicare Part D True Out-Of-Pocket (TrOOP) through federal health care reform legislation which enables ADAP client's to count expenditures to move from the "donut hole" to catastrophic coverage.
- Continuation of the Administration's change in coverage for incarcerated individuals;
- Increase in the Ryan White Part B Grant award of \$4.7 million (federal funds) for ADAP.
- Increase in ADAP due to the Governor's proposal to eliminate Newly Qualified Legal Immigrants and Persons Residing Under the Color of Law (PRUCOL) from the full-scope Medi-Cal benefits.
- Change in the reimbursement structure of the next Pharmacy Benefit Manger contract. Each of these key changes is discussed below.

#### A. Updated Data for Basic Prescription Costs and Liner Methodology

The Office of AIDS utilized updated actual data through February 2010 for both expenditures and revenues (rebates) in their Linear Regression Model. This updated data provided seven more data points (data from August 2009 through February 2010) than available for the January budget development. This is the same methodology and model as used for the January budget. According to the Office of AIDS, the change in this trend reflects a *Reduction of \$8.8 million*, or a reduction of 1.88 percent.

#### B. Average Wholesale Price Rollback from Federal Settlement

ADAP, as does the Medi-Cal Program, uses a drug reimbursement rate based on the Average Wholesale Price of drugs. Through a federal settlement related to First Data Bank and the published prices of AWP for certain drugs, a *one-time* adjustment factor is to be made which

lowers the value of AWP for certain brand drugs. ADAP implemented this change as of March 10, 2010.

The Office of AIDS states that a savings of \$4.6 million (General Fund) is to be achieved in the current-year, and an estimated savings of \$16.2 million (General Fund) is projected for 2010-11 from this adjustment.

The Office of AIDS acknowledges this calculation is based on existing data but that it is an estimate with several moving variables since ADAP clients (ADAP-Only, ADAP-Medicare Part D, ADAP-with insurance) vary and the AWP rollback calculation is affected by this variation.

**C. Medicare Part D and "True-Out-Of-Pocket (TrOOP).** California's ADAP interacts with the federal Medicare Part D drug benefit, implemented in 2006. The income level and assets of federal Medicare Part D enrollees determines the level of prescription assistance they receive under the federal program. The ADAP is the payer of last resort and serves as a *wrap-around* for enrolled clients because it is cost-beneficial to the State.

A Medicare Part D enrollee's TrOOP spending— a person's prescription payment obligation during the Medicare Part D coverage gap, or "donut hole"—determines how one advances through the various Part D coverage levels. This rule typically leads to ADAP clients (who are also in Medicare Part D) to remain "stuck" in the Part D coverage gap, and thus shifting more to ADAP coverage for this period.

The new federal Patient Protection and Affordable Care Act allows for ADAP expenditures to count towards a person's "TrOOP effective as of January 1, 2011. As such federal Medicare Part D coverage will provide more support, and ADAP will experience savings from this action.

This issue was discussed in the Subcommittee hearing of April 15, 2010, and it was believed a savings would result in ADAP due to this federal law change. The Office of AIDS calculated this adjustment to result in a *savings of \$3.2 million* (General Fund) in 2010-11 (effective January 1, 2011) due to a cost-shift to the federal Medicare Program which results from the federal law change.

#### D. Reduction of \$10.2 million to Discontinue ADAP in Jails

As discussed in Special Session and in Subcommittee on May 10, 2010, the Administration proposes a reduction of \$10.2 million (\$8.3 million General Fund and \$1.9 million in lost ADAP Rebate Fund) by eliminating funding for county jails effective as of July 1, 2010. The reduction amount was updated at the May Revision and reflects about \$1 million (total funds) less in savings than January due to updated calculations.

The Administration states that the \$8.3 million (General Fund) saved from this action are invested within the ADAP to assist in meeting State expenditures in 2010-11. They note that Local Health Jurisdictions are responsible for inmate care in jails as referenced in existing State Statue (Section 29602 of Government Code and Section 4011, et seq and 4015(a) of Penal Code).

The Office of AIDS administratively began funding county jails for inmates needing AIDS antiretroviral drugs in 1994 due to the increasing fiscal impact on Local Health Jurisdictions in meeting their mandate to provide medical services to their incarcerated populations. Presently, thirty-six counties receive funding from the State to serve incarcerated individuals in 44 jails, or about 2,093 people. The Office of AIDS states the existing process for reimbursing these 36 counties is as follows:

- 1. Jail pharmacy submits claim of \$100 (drug cost) to Pharmacy Benefit Manager.
- 2. Pharmacy Benefit Manager submits invoice of \$110.05 for payment to State ADAP. This invoice consists of \$100 drug cost + \$6.00 transaction fee and \$4.05 pharmacy dispensing fee.
- 3. State ADAP pays Pharmacy Benefit Manager \$110.05.
- 4. Pharmacy Benefit Manager reimburses Jail pharmacy at \$104.05 (drug cost and pharmacy dispensing fee).
- 5. State ADAP invoices drug manufacturer \$100, and the drug manufacturer pays State a drug rebate of \$32 (average rebate for ADAP jail clients) to ADAP.

The Office of AIDS notes that five counties—San Francisco, Santa Clara, San Diego, Contra Costa and Los Angeles— support their own jail programs. Santa Clara County is able to access 340b federal pricing through their county hospital (Valley Medical Center). As such, other counties may be able to establish relationships through their Local Health Jurisdictions to access this low-cost pricing via hospitals or applicable clinics.

When the Subcommittee heard this proposal on May 10<sup>th</sup>, the Chair requested the Department and legislative staff to explore what barriers may exist for counties to access 340b federal pricing as has been done in Santa Clara County, thereby reducing the costs of HIV/AIDS drugs.

**E. Update on Ryan White HIV/AIDS Federal Funding.** In April, the federal HRSA informed the DPH of California's award of federal Ryan White HIV/AIDS grant funds. The ADAP received an increase of \$4.7 million from this grant which is then used as an off-set to General Fund expenditures for 2010-11.

#### F. Proposed Shift of Newly Qualified Legal Immigrants and PRUCOLS to ADAP.

The ADAP May Revision reflects the Governor's Medi-Cal Program proposal to eliminate Newly Qualified Legal Immigrants and PRUCOL Individuals. Two adjustments are shown for ADAP, including: 1) \$1.9 million for drug expenditures; and 2) \$33,000 for PBM processing fees, for a total increase of \$1.937 million.

The Subcommittee has already rejected the Governor's May Revision proposal in Medi-Cal to remove these individuals from full-scope coverage. Therefore, the ADAP increase of \$1.937 million is not necessary.

Further, because the Office of AIDS calculates ADAP Drug Rebate revenues off of expenditures, including the augmentation of \$1.937 million, the ADAP Drug Rebate revenue needs to be *reduced by \$191,000* to appropriately reflect this adjustment.

#### G. Change in Non-Approved Transaction Fee

As discussed in Subcommittee on April 15, 2010, the Office of AIDS is proceeding with a new Request for Proposal for the ADAP Pharmacy Benefit Manager (APBM). The new contract is to be effective July 1, 2010 and includes *two changes* that the Office of AIDS states will save ADAP funds.

First, it will have a lower reimbursement for "non-approved" transaction fees (will now be \$3.00 per transaction versus the present \$6 per transaction). Due to prescribing aspects, sometimes a

pharmacist needs to revise a prescription before it is "approved". The PBM must conduct administrative work on all claims, including those not approved ("nonapproved").

Second, there will be a limit of five times for which a non-approved transaction and be submitted. These actions are to save \$3.3 million.

**H. ADAP Rebate Fund—Reserves Limited and Rebates Still Being Negotiated.** Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including *both* mandatory (required by federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with 14 drug manufacturers through ADAP Taskforce).

Generally, for every dollar of ADAP drug expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates). First, the ADAP May Revision is *only* reflecting a reserve of **\$7.4 million** (ADAP Rebate Fund). Subcommittee staff does *not believe* this is a "prudent" reserve for the following reasons:

- ADAP Fund Condition Statement at May Revision reflects revenues of \$192.7 million.
   Typically a lower end "prudent" reserve is at least 5 percent of the revenues generated which would be at least \$9.6 million.
- Interest rates are low now and all State Special Funds, such as ADAP, are not capturing
  as much "earned interest income" as they once did and they could drop further during
  the course of the budget year.
- According to the Office of AIDS, there is a historic seasonal trend to drug expenditures, and therefore rebate revenues, in that the first half of the fiscal year is lower as compared to the second half (i.e., July to December expenditures and revenues from rebates is lower); However the existing revenue estimate method does not take this fluctuation into account (Page 16 of ADAP Estimate). This normally would not be significant, but given the very low reserve margin of \$7.4 million, Subcommittee staff believes it could become a concern later in the fiscal year.

Second, new supplemental rebate negotiations with each of the eight antiretroviral drug manufacturers took place on May 5-7, 2010. Only three of the eight manufacturers finalized supplemental rebates with the ADAP Crisis Task Force (i.e., "supplemental" rebates negotiated nationally). The Task Force hopes to complete the remaining supplemental rebate agreements by July 1, 2010, but the Office of AIDS of course cannot be certain that this will indeed occur.

Third, the federal Patient Protection and Affordable Care Act, signed by President Obama in March, makes changes to the federal mandatory Medicaid rebate calculation which *may* impact ADAP. Specifically, the federal Medicaid rebate calculation was increased for *both* brand name drugs (from 15.1 percent to 23 percent of "average manufacturer price"), and generic drugs (from 11 percent to 13 percent), effective as of January 1, 2010 (retroactive). The Office of AIDS notes they are seeking additional information regarding the increased rebates under Medicaid to discern how ADAP may be affected. The Office of AIDS states they *do not anticipate* any reduction in rebates from this federal action, but it is not yet resolved.

Fourth, the minimal May Revision reserve of \$7.4 million assumes that all of the ADAP assumptions will indeed, hit the mark. Though the Office of AIDS has prepared an earnest, data-driven Estimate for ADAP, there are several moving parts, including the Average

Wholesale Price (AWP) rollback (discussion "B", above) which is to save \$4.6 million in the current-year and \$16.2 million in 2010-11 (total of \$20.8 million across the two years).

The Estimate notes (page 4) that this savings assumption relies on several "hypothetical" savings calculations in order to develop the estimate. This is completely understandable for a "new" assumption. However, it is a considerable savings and if it does not hit its mark, then a draw on the reserve may be needed.

#### **Pharmacy Benefit Manager**

The AIDS Drug Assistance Program was established in 1987 to help ensure that HIV-positive uninsured and underinsured individuals have access to drug therapies. The state provides reimbursement for drug therapies listed on the ADAP formulary (over 180 drugs). The formulary includes antiretroviral (about 30), opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and antibiotics. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol calls for inclusion of at least three different anti-viral drugs for patients.

#### Background

Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the state, whereas only 30 percent of ADAP costs are borne by the state.

Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person's health and productivity.

#### **Staff Recommendation**

Subcommittee staff recommends approving the ADAP estimate with modifications (conforming to the Senate's actions) as follows:

- 1) Reject the Administration's ADAP assumption regarding Newly Qualified Legal Immigrants and PRUCOLS. The Subcommittee's prior action on April 26, 2010 continues to provide full-scope Medi-Cal benefits to these individuals. Therefore a reduction of \$1.937 million (GF) from expenditures and a reduction of \$119,000 in ADAP Drug Rebate revenues should be reflected (i.e., net reduction of \$1.8 million due to revenue loss aspect).
- **2)** Provide an increase of \$10 million (General Fund) to increase the reserve to a total of \$19.2 million (i.e., net adjustment of \$1.8 million, plus existing \$7.4 million reserve and \$10 million augmentation). This would provide a 10 percent reserve. This seems more "prudent", particularly given the level of risk in two key assumptions. The Governor's May Revision provides a very modest reserve of only \$7.4 million. The potential risk of the pending supplemental rebates (Taskforce still working), and the AWP rollback issue, could sway ADAP into a precarious situation during the course of the budget year if these assumptions do not fully occur.

#### ISSUE 6: FEDERAL CMS GRANT FUNDS FOR LICENSING & CERTIFICATION PROGRAM

#### **Governor's May Revision Issue**

The L&C Program requests an increase of \$17.6 million (federal funds) to permanently establish 124.8 positions to enable the L&C Program to complete as much of the federal certification activities (related to Medicare and Medi-Cal) as possible given the level of federal grant funds made available (federal fiscal years from October 2009 through September 2010).

With respect to the current-year, a total of \$9.4 million (federal funds) and authority to administratively establish 93.6 positions was reviewed by the Joint Legislative Budget Committee, chaired by Senator Ducheny, and no issues were raised.

The federal CMS grant requires completing *specific prioritized* workload for multiple facility types. This workload is prioritized into Tiers 1 through 4, with Tier 1 being the highest priority. L&C Program notes that historically, the federal CMS has only provided enough resources for them to accomplish most of Tier 1 activities and a portion of Tier 2. The L&C Program proposes to expend the \$17.6 million (federal grant funds) in the following key areas:

- L&C Program Staff. A total of 124.8 staff as noted below. Extensive workload information has been provided to the Subcommittee regarding all of these positions.
  - o Medical Consultant I 1.0
  - o Health Facility Evaluators—Nurses 76.0
  - o Health Facility Evaluator I's 5.75
  - o Health Facility Evaluator Supervisors 17.0
  - o Pharmacy Consultant II, Specialist 1.0
  - o Nutrition Consultant II 1.0
  - o Program Technicians (key Evaluator support) 17.0
  - o Staff Counsel 1.0
  - o Various Professional Staff Support 5.0
- Contract with Los Angeles County—Increase by \$2.5 million. The State has always contracted with Los Angeles County for this purpose and provides funding to them based upon specified standards and costs.
- State Contract for "Recruitment" \$48,000: This contract will facilitate the hiring of L&C Program staff, particularly the clinical staff (it should also be noted that the L&C Program also uses many other personnel recruitment tools for hiring).
- Minor Equipment \$706,000: This is for lap-top computers and related items used in the field by the Survey Teams to enter data and conduct survey work.

The L&C Program has been working on efficiencies and meeting regularly with the federal CMS regarding federal grant compliance and federal survey activities, including compliance with existing workload mandates. Federal CMS has recognized a marked improvement over the last few years in L&C Program workload accomplishments. As a result of this work, the federal CMS has significantly increased California's federal grant for this purpose.

Even with the increased federal funds, L&C Program acknowledges they will not be able to complete 100 percent of the Tiered federal workload requirements for the budget year because

the federal grant does not provide *full funding* for California. But full expenditure of this federal grant increase, coupled with continued improved performance by California will be critical to further discussions and negotiations with the federal CMS to cover even more of the L&C Program workload as appropriate.

Finally, the L&C Program has revised its training schedule to ensure that the requisite training of new Health Facility Evaluator Nurses can be completed promptly and effectively.

#### **Background—Federal CMS Tiers**

The federal CMS requires specific activities to be conducted by the L&C Program as noted below.

- Tier 1. This includes extensive activities related to periodic Skilled Nursing Facility surveys, Home Health Agency surveys, and surveys for Intermediate Care Facilities for Developmentally Disabled.
- Tier 2. This includes "targeted" surveys for selected facility types and validation surveys for facilities that are certified by a federally-recognized accrediting organization.
- Tier 3. This includes increased periodic inspection of Non-Long Term Care facilities.
- Tier 4. This includes initial certification activities of all facility types.

The federal CMS's rationale for this tiered priority ranking is that States should not be certifying new provides unless there is the ability to provide some basic level of assurance to the public that the facilities that are already certified are undergoing quality review.

The L&C Program must meet federal CMS state agency performance requirements and can be penalized (reduced award in federal grants) for failing to meet the standards.

#### Overall Background—Purpose of Licensing & Certification

The DPH L&C Program conducts licensing and certification inspections (surveys) in facilities to ensure their compliance with minimum federal certification and state licensing requirements in order to protect patient health and safety. Encouraging provider-initiated compliance, quality of care improvement and promoting research regarding the quality and effectiveness of health care services is also a key component of the L&C Program mission.

The L&C Program is responsible for investigating complaints from consumers, consumer representatives, the Ombudsmen, and anonymous sources. L&C is a statutorily mandated enforcement agency.

Certification is a federal prerequisite for health facilities and individual providers wanting to participate in and receive reimbursement from both Medicare and Medicaid (Medi-Cal). The DPH is the designated entity under contract with the federal CMS to verify that health facilities meet certification standards. Federal grant funds are allocated to California to conduct work associated with Medicare. In addition, L&C fees are collected from the various facilities and are placed into the L&C Fund. General Fund support is also provided for some facilities to support L&C functions of State facilities (such as Developmental Centers). There are over 7,000 public and private health care facilities throughout the state, including hospitals, nursing homes, clinics and home health agencies.

The L&C Program should be acknowledged for achieving program efficiencies and making improvements recognized by the federal CMS and resulting in a considerable federal grant increase. This is well-earned. The L&C Program has provided appropriate information for the workload and the functions proposed clearly meet the purposes of the federal CMS federal fund grant.

#### **Staff Recommendation**

Subcommittee staff recommends approval of this request.

#### ITEMS TO BE HEARD

#### 4280 Managed Risk Medical Insurance Board

#### **ISSUE 1: CHIPRA BCP & TBL**

On February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA provides states with many opportunities to strengthen and expand programs that provide health coverage to low-income, uninsured children and pregnant women. CHIPRA is an expansive, complex statute with a multitude of new requirements and opportunities that must be addressed by California's Managed Risk Medical Insurance Board, primarily in its responsibilities to oversee and operate the Healthy Families Program. To this end, the Governor's May Revision includes three CHIPRA proposals. Altogether, MRMIB requests a total of \$7.164 million (\$2.507 General Fund) to implement the CHIPRA. Of this amount:

- State operations \$882,000 (\$308,000 General Fund) will fund 9 personnel years for 11 two-year positions within MRMIB for start-up activities in 2010-11; and
- Local Assistance \$6,282,000 (\$2,199,000 General Fund) is proposed for local assistance (incorporated into the overall Healthy Families estimate).

## 1. Prospective Payment System for Federally Qualified Health Centers & Rural Health Centers (FQHCs & RHCs)

#### **May Revise Request**

Under this proposal, the MRMIB requests a total of \$3,320 million (\$1.162 million General Fund) for the following:

- \$438,693 (\$153,543 General Fund) for 4.5 personnel years for 7 two-year positions within MRMIB, including: 2 AGPAs, 1 Staff Program Systems Analyst-Specialist, 0.5 Personnel Specialist, 0.5 Staff Counsel IV, 0.5 Associate Management Auditor, and 0.5 Associate Accounting Analyst;
- \$1.8 million (\$630,000 General Fund) to make interim payments to FQHCs/RHCs as required by federal law;
- \$583,000 (\$204,000 General Fund) for 5 personnel years, including 1 Health Program Auditor IV and 4 HPA III's at the DHCS; and
- \$498,000 (\$174,000 General Fund) for additional costs incurred by the DHCS Fiscal Intermediary contractor to implement this PPS requirement for MRMIB and to issue payment to the FQHCs/RHCs.

#### Background

This funding is needed to comply with the Section 503 of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This section requires MRMIB to:

- Ensure all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are compensated for their actual cost;
- Achieve end-to-end success in all systems modifications so that revenue flow is not interrupted;
- Validate auditing and reconciliation processes to avoid overpayments; and
- Establish a system to measure increased utilization and delivery of services resulting from the enhanced revenue stream to FQHCs and RHCs.

#### The DHCS's supporting role will include:

- Gather cost and statistical utilization data for each FQHC and RHC that will participate (approximately 873 clinics);
- For each clinic, establish an "interim rate", which is the approximate difference between what the Healthy Family plans (HFP) pay the clinic and the clinic's Prospective Payment System (PPS) rate;
- Perform annual reconciliations of each clinic to compare what has been paid by the interim rate to the PPS rate; and
- Determine if an overpayment/underpayment has been made and recover or make payment accordingly.

Section 1902(bb) of CHIPRA implemented a Prospective Payment System (PPS) for FQHCs/RHCs under the Medicaid program beginning in 2001. In order to comply with Section 1902(bb) of the CHIPRA, MRMIB needs to incorporate the payment process for FQHCs/RHCs into the existing Prospective Payment System (PPS) utilized by California's Medicaid agency, the Department of Health Care Services (DHCS).

Currently, providers serving Healthy Families Program (HFP) members are paid by the health, dental and vision plans with whom they contract to deliver health care services. Plans pay providers in various ways: monthly capitation, fee-for-service schedules, and in some cases specifically negotiated fee (e.g., immunizations). MRMIB must solicit this information from plans and determine an additional "interim rate" to be paid to the FQHCs and/or RHCs for the various types of services. In order to comply with the CHIPRA requirement, MRMIB will need to establish a contract with DHCS to include payment of interim rates for services provided to HFP enrollees by FQHCs/RHCs in the same process DHCS uses for payment to FQHCs/RHCs. In addition, MRMIB will have to contract with DHCS to be included in their FQHCs/RHCs reconciliation process. MRMIB will have to have staff to develop regulations to implements these changes, staff to develop the necessary contracts with DHCS and revise plan contracts, staff to analyze usage and cost trends and incorporate this information into the Estimate Process, etc. Please see position justifications for complete details of position duties.

#### 2. Medicaid Managed Care Standard (MMCS) Provisions of the CHIPRA

#### **May Revise Request**

The MRMIB requests \$733,133 (\$256,596 General Fund) to implement the MMCS provisions of CHIPRA. Of this amount:

\$233,133 (\$81,596 General Fund) is for the following two-year limited-term positions: 1
Research Program Specialist II, 0.5 Research Program Specialist I, and 0.5 Staff
Counsel IV; and

 \$500,000 (\$153,543 General Fund) for local assistance to contract MRMIB's Administrative Vendor for encounter data collection from plans and to maintain claim records and generate reports to MRMIB.

#### **Background**

This section extends Medicaid Managed Care Standards to CHIP programs. Among other things, section 403 requires the following:

- Makes significant changes to the processes for enrollment termination, and change of enrollment;
- Makes significant changes to the amount and type of information provided to subscribers;
- Requires beneficiary protections;
- Requires quality assurance standards;
- Requires protections against fraud and abuse; and,
- Requires sanctions for noncompliance

### 3. Quality Management and Consumer Assessment of Health Plan Service (CAHPS) for CHIPRA

#### **May Revise Request**

The MRMIB requests \$3,109,489 (\$1,088,321 General Fund) to begin startup activities to implement the child health and dental quality management and consumer assessment of health plan services required by CHIPRA. Of this amount:

- \$209,489 (\$73,321 General Fund) is proposed for 2.5 personnel years for 3.5 two-year limited term positions including: 2 Associate Governmental Program Analysts, 0.5 Research Program Specialist 1, and 1 Staff Services Analyst; and
- \$2,900,200 (\$1,015,000 General Fund) is proposed for local assistance to contract with the External Quality Review Organization to conduct plan performance, quality improvement, and health plan quality projects for MRMIB.

#### **Background**

Under CHIPRA, states are also required to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and report results in their annual reports which are due in December of each year. HFP has conducted CAHPS surveys periodically when funding was provided. A survey is now an annual requirement. Assuming funds are provided in the 2010-11 budget, MRMIB would conduct the CAHPS survey in the Fall of 2010.

This proposal will be top priority for MRMIB due to the requirement to implement the 1932(c) by January 2011. Section 401of CHIPRA requires HHS to develop child health quality measures for children enrolled in CHIP or Medicaid. By January 1, 2010, the Secretary, in consultation with States, providers, and consumer groups, will identify and publish an initial core set of child health quality measures for CHIP and Medicaid. The Secretary of HHS also will develop a standardized report format for reporting information and encourage States to voluntarily report on measures. The Secretary will disseminate to States best practices for measuring and reporting quality and will provide technical assistance to States to help them adopt and utilize quality measures.

#### **Staff Recommendation**

Subcommittee staff recommends approval of these three proposals, including adoption of "placeholder" trailer bill language to implement the three proposals.

#### 4265 DEPARTMENT OF PUBLIC HEALTH

#### ISSUE 1: THE SAFE, CLEAN, AND RELIABLE DRINKING WATER SUPPLY ACT OF 2010

#### **Governor's May Revision Issue**

The DPH is requesting expenditure authority for 2010-11 and 2011-12 to implement this bond measure (SB X7 2, Cogdill, Statutes of 2009) which will be on the November 2, 2010 ballot. Voters would need to authorize the issuance and sale of bonds to fund water improvements in the State. If it is approved, the measure specifies that it is to take effect immediately. State agencies are expected to move swiftly to distribute funds to eligible projects.

The 2010 Water Bond is an \$11.1 billion proposition intended to fund the overhaul of the State's water supply system. Among the water bonds' components are funding programs allocated to the DPH to administer, including \$80 million for drought relief (Chapter 5—Section 79720 of Water Code), and \$1 billion for Groundwater Protection and Water Quality (Chapter 10—Section 79770 of Water Code).

The DPH is responsible for overseeing the appropriation of grants and loans for infrastructure improvements to public water systems and related actions to meet safe drinking water standards under both State and federal law.

The DPH May Revision expenditure authority request includes the following:

- \$103 million in local assistance funds for 2010-11;
- \$501,000 for State support in 2010-11 (seven staff);
- \$208.3 million in local assistance funds for 2011-12; and,
- \$5.3 million for State support in 2011-12 (45 staff).

Specifically, the DPH is proposing to use \$80 million in pending bond funds for the meeting the State's 20 percent match requirement to leverage federal funds under the Safe Drinking Water Program (as described below and discussed in detail in the Subcommittee hearing of April 15th). These funds will provide about \$126 million in federal capitalization grants.

Chapter 5 of the Water Bond measure provides for this purpose. Chapter 10 of the measure provides \$1 billion in funding to DPH to provide grants and loans for projects that prevent or remediate contamination of groundwater that serves as a source of drinking water. DPH expects that it could use *up to* \$93 million of the pending bond measure for 16 water projects in 2010-11 using *existing* Proposition 84 criteria (this criterion was discussed in detail in the Subcommittee hearing of April 15th).

DPH also desires to work with stakeholders, particularly disadvantaged communities, to address modifying the strict criteria and deadlines in the Proposition 84 program. These discussions are to occur during the course of 2010-11. Upon passage of the pending bond measure, the DPH intends to solicit pre-applications, create priority lists, evaluate applications, conduct technical evaluations of projects, and issue funding agreements and process reimbursement claims.

In addition, the DPH wants to re-examine its existing emergency grant program (water needs based upon unforeseen occurrences) operated under Proposition 84 with the intent to provide more assistance to disadvantaged communities here as well. The pending water bond would provide for the allocation of funds in this area as well. DPH expects to allocate at least \$10 million annually for this purpose.

#### **Background—Safe Drinking Water Program**

Enacted in 1997, under this program California receives federal funds to finance low-interest loans and grants for public water system infrastructure improvements. In order to draw down these federal capitalization grants, the State must provide a 20 percent match. Further, the State must submit an annual "Intended Use Plan" which describes California's plan for utilizing the program funding.

The program is comprised of five set-aside funds, as well as a loan fund. The set asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent); and,
- Administrative costs (up to 4 percent).

California will be receiving *increased federal grant funds* due to a change in the federal allocation, and from *increased Congressional funding* (H.R. 2996).

With respect to the 20 percent State match, General Fund support was used for a period of time, then a portion of Proposition 13 bonds (until fully expended), then a portion of Proposition 50 bonds, and now a portion of Proposition 84 bonds.

#### **Background—Public Drinking Water**

The DPH has statutory authority to administer California's public Drinking Water Program and has since 1915. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur. They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 34 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the administration of the federal Safe Drinking Water Act for California. California's total need for water system infrastructure improvements is in excess of \$39 billion, as reported through a needs-assessment conducted in 2007. The majority of public water systems are not able to finance necessary improvements on their own and require State and federal assistance.

#### **Prior Subcommittee Hearing**

In the Subcommittee hearing of May 10<sup>th</sup>, the DPH administered Drinking Water Program was discussed extensively, including all funding sources and the various criteria components. As noted above and as discussed in the Subcommittee hearing on May 10<sup>th</sup>, California has extensive water infrastructure needs for our public drinking water system. The DPH has operated a well managed, well established program for many years. Given the timing of the Water Bond measure, and the existing project lists, it is recommended to provide an appropriation for 2010-11 only. This one-year appropriation will enable the DPH to implement immediately upon approval by the voters in the November election, and will enable the Legislature to further discuss and review criteria and projects for the 2011-12 fiscal year.

QUESTIONS	
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The Subcommittee has requested the DPH to provide an overview and explanation of this proposal.

# 4260 DEPARTMENT OF HEALTH CARE SERVICES 4265 DEPARTMENT OF PUBLIC HEALTH

# ISSUE 1: AB 1629: RATE INCREASE, REAUTHORIZATION, QUALITY ASSURANCE, POSITIONS IN DHCS & DPH

## Summary --- Freestanding Nursing Home Reimbursement and Quality and Accountability Proposal

Considerable change is proposed for the method in which DHCS reimburses Freestanding Nursing Homes (NFs). A phased-in approach over *three years* is proposed.

#### Key components are to:

- 1. Modify existing QAF in several ways to obtain increased revenues to match with federal funds to increase rates paid to NFs by an average of 3.93 percent, effective August 2010. No General Fund impact. Current QAF structure sunsets as of June 30, 2011.
- 2. Establish a "Quality and Accountability" (Q&A) special fund to be used in 2011-12 as a supplemental payment pool for rewarding NFs that meet identified quality measurements.
- 3. Cap NF reimbursement for professional liability insurance at 75th percentile and place savings into Q&A Fund.
- 4. Disallow reimbursement for legal costs related to cases that have not been found in favor of facilities.
- 5. Review NF compliance with 3.2 nursing hours per patient ratio. Any penalties from this review will be placed into Q&A Fund.
- 6. Establish and publish quality and accountability measures and benchmarks in consultation with stakeholders.
- 7. Develop an overall framework to provide increased oversight of NFs and enforcement of penalties of noncompliance.
- 8. Develop an overall framework for NFs that meet performance targets to receive financial incentives of supplemental quality and accountability payments.
- 9. Makes other adjustments related to rates and the Q&A Fund in 2011-12, including adjustments to the Labor Driven Operating Allocation (contingency margin).

Certain Nursing Home (NF) rates are reimbursed under Medi-Cal using a combination of federal funds, General Fund and revenues collected from Quality Assurance Fees (QAF). Use of QAF has enabled California to provide reimbursement increases to NFs with *no* added General Fund support.

This existing reimbursement method established under AB 1629, Statutes of 2004, requires DHCS to implement a *facility-specific* rate system for certain Nursing Homes (NFs) and it

established the QAF. Revenue generated from QAF is used to draw federal funds and provide additional reimbursement to NFs for quality improvement efforts.

Current QAF structure sunsets as of June 30, 2011. If QAF sunsets, over \$400 in General Fund support is at risk. The Omnibus Health trailer (AB X4 5, Statutes of 2009) expanded the QAF to include Medicare revenue and lowered the allowable *overall* rate increase from five percent to zero for rate years 2009-10 and 2010-11. This DHCS proposal would provide for a 3.93 percent increase for 2010-11, in lieu of the freeze.

The Administration proposes: 1) comprehensive trailer bill legislation to enact changes to the existing Medi-Cal reimbursement structure; 2) changes to the QAF trending methodology; 3) lowering of licensing and certification fees to increase QAF for increased federal funds; and 4) extension of the QAF to Multi-Level Retirement Communities.

These revenues, coupled with federal ARRA funds (to June 30, 2011), would provide about \$160 million (total funds) for a 3.93 percent average rate increase for 2010-11, effective August 1, 2010. The QAF changes are contained within three May Revision proposals discussed on the next pages of this Agenda. Extensive stakeholder conversations have also occurred regarding quality assurance measures, or a pay for performance approach.

The Omnibus Health trailer bill of 2008 provided for an extensive stakeholder process for this purpose. An April 2009 report to the Legislature articulated the discussions from this stakeholder process.

Key concerns of consumer groups included the need to: 1) provide oversight regarding the 3.2 nursing hours staff to patient ratio; 2) develop a uniform data collection system to measure quality improvement; 3) create incentives to facilitate quality improvement and accountability measures; 4) develop and implement resident, family, and staff satisfaction measures; and 5) many other factors related to quality assurance.

The DHCS contends its proposal addresses many of the quality assurance components discussed in these meetings. *Each of the May Revision proposals is discussed individually below.* 

#### Medi-Cal Quality Assurance Fee (QAF): Changes to Trending Methodology.

DHCS proposes trailer bill to increase the amount of revenues upon which the QAF is assessed by using two-year old actual data as the base, and applying growth and trending adjustments to project the actual revenues expected for the fiscal year. Increased QAF revenues from this revised method, matched with federal funds, provides for increased rates. May Revision reflects the enhanced ARRA federal fund rate (61.59 percent). This change, coupled with the other changes, discussed below, would provide an average rate increase of 3.93 percent. This rate increase is expected to be cost neutral to the General Fund.

As noted above, there are many aspects to the Administration's proposal which will need to be discussed in-depth, including the trending factors used by the DHCS. The revised trending factors will also coincide with the following:

- Changes in how QAF is assessed and collected, including penalties for non-payment of QAF;
- Disallowance of reimbursement for legal costs related to cases that have not been found in favor of facilities;
- Capping of reimbursement for professional liability insurance at the 75th percentile; and
- Changes to the Labor Driven Operating Allocation.

DHCS needs to provide a further explanation of the various components for the Committee, and to continue various stakeholder discussions.

### Medi-Cal Quality Assurance Fee (QAF): Lower L&C Fees & Increase QAF for Rate Increase.

The QAF is comprised of a general quality assurance fee component, as well as a licensing and certification component and is capped at 5.5 percent of gross revenues.

The Department of Public Health (DPH), who conducts licensing and certification functions, is proposing to lower their fees for Nursing Homes. This will allow the DHCS to *increase* the QAF component, resulting in an increase in rates for these facilities effective as of August 2010. This requires trailer bill language and is another component to the Administration's proposed restructuring of Nursing Home rates and quality accountability.

AB 1629, Statutes of 2004, established the QAF under the Medi-Cal Program. Revenue generated from QAF is used to draw federal funds and provide additional reimbursement to, and support of, Nursing Home quality improvement efforts. DPH states that about \$4 million in Licensing and Certification Fees can be reduced, and therefore not counted towards the 5.5 percent QAF. This will provide for an increase in the QAF up to the 5.5 percent and more federal funds can be generated.

#### Medi-Cal Quality Assurance Fee (QAF): Include Multi-Level Retirement Communities.

DHCS proposes trailer bill legislation to expand the revenues upon which the QAF is assess to include revenue from MLRC facilities, resulting in *increased rates* for the Nursing Home-Level B component of these facilities.

The increase in rate payments is \$40.8 million (total funds), effective as of August 2010. There is no affect on the General Fund. DHCS states that about 50 percent of the MLRC facilities serve Medi-Cal enrollees. This is another component to the Administration's proposed restructuring of Nursing Home rates and quality accountability.

AB 1629, Statutes of 2004, established the QAF under the Medi-Cal Program. Revenue generated from QAF is used to draw federal funds and provide additional reimbursement to, and support of, Nursing Home quality improvement efforts. Presently, Multi-Level Retirement Communities (MLRC) are *exempt* from paying the QAF but do benefit from rate adjustments associated with this mechanism. It seems reasonable that these facilities should participate in QAF.

Resources for Freestanding Nursing Home Changes. (Relates to AB 1629 changes.) The Governor's May Revision requests an increase of \$3.9 million total funds (\$1.8 million General Fund), and 45.5 positions in the DHCS and DPH to improve quality of care and accountability of freestanding skilled nursing facilities. These positions would increase oversight of staffing standards and make changes to the payment methodology. The Administration states that the full cost of this proposal would be offset by proposed penalties on noncompliant facilities.

The Governor is proposing an increase of \$1.7 million (\$849,000 General Fund) to fund seven DHCS staff to implement various changes to Nursing Home reimbursement under the Medi-Cal program as referenced in the Governor's May Revision package for the Medi-Cal Program.

#### **QUESTIONS**

The Subcommittee has requested the DPH to provide an overview of all of the major components of the AB 1629 proposal.