AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER JERRY HILL, CHAIR

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

4270 CALIFORNIA MEDICAL ASSISTANCE COMMISSION

ISSUE 1: OVERVIEW OF CALIFORNIA MEDICAL ASSISTANCE COMMISSION

The California Medical Assistance Commission (CMAC) is an independent commission with ten commissioners appointed by the Governor and Legislature. The Commission negotiates contracts for Medi-Cal fee-for-service hospital inpatient services statewide and develops and negotiates per capita, at-risk managed care contracts for health care services to Medi-Cal beneficiaries with Geographic Managed Care plans in Sacramento and San Diego. The Commission also negotiates contracts for supplemental payments under special programs available to eligible contract hospitals.

All CMAC activities are eligible for a 50:50 state-federal match which is unaffected by the recent enhancement to the state's FMAP.

CMAC Expenditures By Fund:

Fund	Actual 2007-08	Estimated 2008-09	Proposed/Adopted 2009-10
General Fund	$1,342,000	$1,285,000	$1,293,000
Federal Funds	$1,144,000	$1,258,000	$1,264,000
Total Expenditures	**$2,486,000**	**$2,543,000**	**$2,557,000**

Comments and Questions:
The Subcommittee has asked the Commission to provide an overview of the Commission, its activities, and budget.

ISSUE 2: INCREASED REIMBURSEMENT AUTHORITY

Proposal:
CMAC is requesting increased reimbursement authority from the Department of Health Care Services (DHCS) in order to maximize receipt of federal funding. This would have no General Fund impact and would result in CMAC receiving an additional $29,000 in federal funds.

Background:
As stated above, CMAC activities are eligible for federal financial participation with a 50:50 match under the federal Medicaid program. In CMAC's budget, there is a difference of $29,000 between General Fund and Federal Fund expenditures, due to insufficient reimbursement authority.

If approved, this proposal will allow CMAC to receive an additional $29,000 in federal Medicaid funds, through DHCS, the single-state Medicaid agency. The state will not receive these funds in the absence of this proposal and these funds cannot be used for any other purpose.

Comments and Questions:
The Subcommittee has asked CMAC to respond to the following:

1. Please briefly explain this proposal.

2. Is there a cap on CMAC's "reimbursement authority" that may be reached again even after approval of this proposal?

Staff recommendation: Approve

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: OVERVIEW OF THE MANAGED RISK MEDICAL INSURANCE BOARD

Purpose and Description of Department:
The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the: 1) Healthy Families Program; 2) Access for Infants and Mothers (AIM) Program; and 3) Major Risk Medical Insurance Program (MRMIP).

AIM:
The AIM program provides health care to pregnant women who are between 200 and 300 percent of the federal poverty level. Once women in the AIM program give birth, the babies are enrolled in the Healthy Families Program. AIM is supported by Proposition 99 and federal funds, and receives no General Fund.

MRMIP:
MRMIP is a health coverage program for individuals who do not have employer-sponsored coverage and are considered uninsurable in the individual health care market, usually due to a "pre-existing condition." MRMIP is supported by revenue from fees on managed care companies imposed by the State, through the Department of Managed Health Care, Proposition 99 funds, and program participant premiums. No General Fund funds support this program. MRMIP has 7,100 individuals and a waiting list of approximately 200-300 people. Very little outreach is done for this program which suggests that there could be many more eligible, uninsured individuals in California, who are not enrolled, and are not on the waiting list. It costs approximately $3,300 annually to insure an individual through MRMIP.

***Summary of MRMIB Budget Appropriation**:*
The budget proposes total expenditures of just over $1.3 billion ($406.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2009-10 as shown in the chart below.

Summary of Expenditures (dollars in thousands)	**2008-09**	**2009-10**	**$ Change**
Program Source			
Major Risk Medical Insurance Program (including state support)	$54,858	$39,439	-($15,419)
Access for Infants & Mothers (with state support)	$133,695	$150,984	$17,289
Healthy Families Program (with state support)	$1,158,469	$1,130,900	$27,569
County Health Initiative Program	$2,420	$2,413	-($7)
Total Expenditures	**$1,349,442**	**$1,323,736**	**-($25,706)**
General Fund	399,916	$406,352	$6,436
Federal Funds	$808,470	$801,579	-($6,891)
Other Funds	$141,056	$115,805	-($25,251)

Comments and Questions:
The Subcommittee has asked MRMIB to provide an overview of the department, its programs, and budget.

ISSUE 2: OVERVIEW OF THE HEALTHY FAMILIES PROGRAM (HFP)

Overall Background:

The Healthy Families Program (HFP) is California's version of the federal Children's Health Insurance Program (CHIP) and was implemented in 1997-98. The HFP provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. Eligibility is conducted on an annual basis. In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 to 300 percent of poverty) are immediately enrolled into the HFP and can remain until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP. Please also see attachment 1 for a chart on eligibility.

Benefit Package:

The benefit package is modeled after that offered to state employees. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but historically consumer choice has been available. Children in the HFP also have access to the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. Finally, an HFP enrolled child is eligible to receive *supplemental* mental health services provided through County Mental Health Plans.

HFP Funding:

California receives a 66 percent federal match for each state dollar provided. Federal CHIP funding is an *"allotment,"* and as such, this program is *not* an entitlement. In addition to the federal allotment and State General Fund support, premium payments received from families for the enrollment of their children (i.e., subscribers) are used to offset expenditures.

Summary of Budget Appropriation:

The February budget agreement provides an appropriation of $1.121 billion ($403.9 million General Fund, $710.2 million Federal Title XXI Funds, $904,000 Proposition 99 Funds, and $6.5 million in reimbursements) for the HFP, excluding state administration. This reflects a *net reduction* of $27.6 million (total funds), or a 2 percent reduction as compared with the revised current-year. Most of this difference is attributable to implementation of the various cost-containment actions taken in the Budget Act of 2008. Therefore, the revised current-year reflects only 4 months of savings whereas 2009-10, captures a full-year of savings. In addition, HFP caseload is estimated to increase by 3 percent, as discussed further below. No other significant changes are proposed. Each of the previously enacted cost-containment issues and its estimated reduction amount is shown in Table #1, below. It should be noted that a total reduction of over $160 million ($57 million General Fund) is to be achieved over the two-year period.

Table #1: Summary of Reductions for Healthy Families Program Enacted in 2008

Description of Actions Taken in 2008	2008-09 Reduction Amount	2009-10 Reduction Amount	Two-Year Total Reduction
1. Increase premium by an average of $1 per member per month**	$10.7 million ($2.9 million GF)	$62.5 million ($23.2 million GF)	$73.2 million ($26.1 million GF)
2. Reduce plan rates by 5 percent	$24.8 million ($8.8 million GF)	$57.1 million ($20.2 million GF)	$81.9 million ($29 million GF)
3. Annual benefit limit for dental coverage	--	$5.3 million ($1.9 million GF)	$5.3 million ($1.9 million GF)
Totals	**$35.5 million ($11.7 million GF)**	**$124.9 million ($45.3 million)**	**$160.4 million ($57 million GF)**

***Premiums vary by income, family size and type of plan.*

Premium Increases (See #1, in Table #1):

Effective February 1, 2009, and as provided in the Budget Act of 2008, the MRMIB began applying the premium adjustments described below. The savings in Table #1, above, assume an enrollment reduction of almost 8,000 children in the current-year and about 44,000 children in 2009-10, as well as increased premium collections. However, due to the economic downturn, these disenrollment numbers are no longer expected to be realized. Nevertheless, MRMIB reports seeing some families disenrolling due to insufficient or non-payment of premiums. In most of these cases, the family paid the old, lower premiums, and one-third made up the difference once they were informed or reminded of the new higher premiums. The premium increases are as follows:

- **100-150% FPL**. There are no changes for families with incomes from 100 to 150 percent of poverty. Due to federal cost-sharing requirements, premiums cannot be raised. The premium is $7 per child with a maximum per family of $14 per month. If the "community provider" plan is chosen the premium is $4 per child with a maximum per family of $8. About 31 percent of the HFP subscribers are in this income bracket.

- **150-200% FPL**. Families with incomes from 150 percent to 200 percent will have their premiums increased from $9 per child per month to $12 per child per month. The family maximum amount for these subscribers will be adjusted from $27 per month to $36 per month. About 40 percent of the HFP subscribers are in this income bracket.

- **Over 200% FPL**. Families with incomes over 200 percent will have their premiums increased from $17 per child to $19 per child per month. The family maximum amount for these subscribers will be adjusted from $45 per month to $51 per month. About 29 percent of the HFP subscribers are in this income bracket.

HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include: 1) $3 per child per month

discount for enrollment in a “community provider plan;" 2) one month free for paying 3 months in advance; and 3) a 25 percent monthly discount for payment of premiums through electronic funds transfer.

***Plan Rate Reduction (See #2, in above Table)**:*
Effective February 1, 2009, MRMIB has negotiated and implemented an overall 5 percent rate reduction for plans participating in the HFP. Three plans dropped HFP coverage in certain geographic regions because of the rate reduction, resulting in 81,000 children needing to change plans. Of these children: 1) 82 percent were shifted from Anthem Blue Cross coverage to other plans; 2) 10 percent were shifted from Health Net; and 3) 8 percent were shifted from Blue Shield to other plans.

***Dental Benefit Limit (See #3, in above Table)**:*
Effective July 1, 2009, MRMIB will proceed with an annual benefit limit of $1,500 for dental coverage as directed in the Budget Act of 2008. MRMIB estimates that about 5 percent of the HFP enrolled children *may* hit this limit in 2009-10. In addition, since this proposal reduces total benefits to subscribers it also reduces dental plan costs, thereby allowing for a reduction in the rates paid to these plans. It is possible that this dental cap violates the new federal CHIP law ("CHIPRA," discussed later in the agenda) and MRMIB is in discussions about this with the federal Centers for Medicare and Medicaid Services (CMS).

2008 Shortfall:
Near the end of calendar year 2008, the HFP experienced a funding shortfall that resulted primarily from the delay in savings from delayed implementation of these 2008 cost containment measures due to the delay in passage of the state budget. The MRMIB board considered instituting a waiting list for the program. However, the State Prop 10 Commission provided approximately $17 million to MRMIB to make up the shortfall, and a waiting list has not been implemented. Prop 10 dollars may only be used for new enrollees who are 0-5 years old.

Budget Year Caseload Adjustments:
According to MRMIB, enrollment is booming, likely due to the recession. March 2009 saw the second highest monthly enrollment in the history of the program. The 2009-10 budget reflects HFP caseload increases. Specifically, it assumes enrollment of 941,786 children as of June 30, 2009, an increase of 36,200 children, or a growth rate of about 3 percent, over the revised current year enrollment. This estimated HFP enrollment of children for 2009-10 is summarized by population segment below:

• Children in families up to 200 percent of poverty:	701,496
• Children in families between 201 to 250 percent of poverty:	240,276
• Children in families who are legal immigrants:	17,592
• Access for Infants and Mothers (AIM)-Linked Infants:	18,698
• New children due to changes in Certified Application Assistance:	9,008
• Bottom-line adjustment attributable to enactment of reductions:	-45,284

Comments and Questions:

The HFP is now implementing the reductions contained in the Budget Act of 2008. These adjustments will be updated at the May Revision, along with a revised caseload estimate for the current-year and budget-year.

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

1. Please provide a *brief* summary regarding the implementation of the three reductions—i.e., the increase in premiums, negotiation of revised contract rates, and the capitation of dental services.

2. How has enrollment into the HFP been affected by these changes thus far, including the 81,000 children who had to shift plans due to the health plan rate reduction?

3. Please provide a *brief* summary of the existing budget and highlight *key* changes that have not already been referenced.

4. Due you anticipate another shortfall in funding in 2009-10 due to caseload increases or any other reasons?

ISSUE 3: FEDERAL REAUTHORIZATION OF CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Background:

The federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009, signed by President Barack Obama in February, is sweeping legislation. *First*, it was designed to "reauthorize" the financing of children's health insurance (Healthy Families in California) for the next 4.5 years (April 1, 2009 to September 30, 2013) and is financed largely by a $0.62 increase in the federal tax on cigarettes. *Second*, it makes several other changes to the program by offering states additional children's coverage options, as well as requiring certain other programmatic changes to improve quality assurance measures, data collection and other components of the program. Some of these federal CHIPRA changes will be addressed through California's budget process as needed. Other issues will require state policy discussions over the next year or so as components of the federal legislation are clarified by MRMIB working with the federal CMS, as well as with involved stakeholders and the Legislature. *Third*, it interacts with California's Medi-Cal Program in several areas. These issues were discussed in the Subcommittee's March 23, 2009 agenda on the Department of Health Care Services.

Due to timing, California's February 2009 budget package does *not reflect changes* contained within the federal CHIPRA. The MRMIB states that some CHIPRA issues will be forthcoming at the Governor's May Revision, to be received by the Legislature in late May. It is anticipated that fiscal changes, as well as trailer bill language proposals will be forthcoming. Key aspects of CHIPRA, likely to have a budget impact, are highlighted below:

California's Federal CHIP Allotment:

CHIPRA increases the federal allotment available to states and uses a three-part formula for states to determine their federal allotment amount. It also establishes a mechanism for "rebasing" state allotments every two years to ensure that federal funds are targeted to states that are using them, or the funds will be re-distributed. Based on an *initial* calculation, the MRMIB anticipates California to receive a federal allotment of $1.481 billion for federal fiscal year 2009 (October 1, 2008 to June 30, 2009). These federal Title XXI Funds (as the federal allotment is called) require a 35 percent General Fund match, *as needed*, to operate the HFP, as well as certain components within the Medi-Cal for Children Program.

According to the MRMIB and an independent consultant, this allotment of federal Title XXI Funds for California should be sufficient for the state to operate the HFP without any concern of a federal funding shortfall. Any unexpended federal Title XXI Funds can roll forward to the next federal fiscal year (two-years to expend). The law also outlines a system for redistributing unexpended federal funds to states facing any federal CHIP shortfall in future years. Finally, CHIPRA allows states to expand eligibility or benefits under CHIP beyond the federal funding methodology contained in the law. States can request these expansions only in federal fiscal years 2010 and 2012. To do so, a state

must submit a "State Plan Amendment" to the federal CMS by August 31st preceding the beginning of the applicable fiscal year (e.g., by August 31, 2009 for federal fiscal year 2010). Therefore, if California desired to expand the HFP enrollment from 250 to 300 percent of poverty, it would need to submit a State Plan Amendment by August 31, 2009. In addition, this would require State statutory changes and increased expenditures of about $58.5 million ($21.1 million General Fund and $37.4 million federal funds) to provide coverage to about 50,000 children who are estimated to be in this aspect of the population and would otherwise be eligible for the HFP.

Federal Financial Participation for Legal Immigrant Children:
CHIPRA gives states the *option* of providing coverage for legal immigrant children with less than 5-years in the United States and receiving federal funds for this purpose. California law has always offered enrollment in the HFP for legal immigrant children with less than 5-years in the U.S. if they otherwise meet all other HFP requirements. California has covered these children since inception of the HFP using 100 percent General Fund support. As such, this CHIPRA *option* would now enable the HFP to draw federal funds for this purpose and *save about $12.2 million in General Fund support* based on the 2009-10 February budget package. Presently the HFP expends about $18.8 million (General Fund) on this coverage. This federal financial participation is available to states that submit a State Plan Amendment by June 30th, 2009.

Citizenship Documentation:
The federal CHIPRA extends existing Medicaid citizenship and identity documentation requirements to CHIP (Healthy Families Program) which must be implemented by January 1, 2010. According to the MRMIB, about 92 percent of children enrolled in the HFP are born in California. Therefore, MRMIB could link to the vital statistics database created by the Department of Health Care Services for Medi-Cal citizenship documentation and could automatically identify children using California's birth certificate records (as maintained by the Department of Public Health). In addition, the MRMIB believes the "identity documentation" component of this new requirement can be addressed for most children through a revision to the "joint application" (an application used to enroll children who may be eligible for Medi-Cal or the HFP). Specifically, the revised joint application would allow a parent/guardian to attest to the identity of children *less than* 17 years of age. Federal law provides for a parent/guardian's declaration for this age group. However, it is not clear how to satisfy the new requirement for 17 and 18 year olds enrolled in the HFP. Further, it is unclear what these administrative changes will cost the HFP. The MRMIB states that changes to the HFP eligibility verification process will likely require emergency regulations. Currently, the HFP does not collect Social Security Numbers (SSNs) as part of its enrollment process.

Additional Issues:
Other CHIPRA issues the Subcommittee should be aware of are as follows:

- *Requires Dental Coverage*. CHIPRA requires States to include coverage of dental services as part of the benefit package. California has always provided

dental coverage within the HFP. However, three issues have been raised. First, it is not yet clear if California's orthodontia benefit meets the CHIPRA requirement since the HFP coverage for this specific dental procedure is limited. Second, CHIPRA requires certain encounter claims-based information for dental coverage and California does not presently collect this information; therefore, changes may be required. Finally, the annual dental benefits cap, to begin July 1, 2009, may not be allowed under CHIPRA. The MRMIB will provide an update on these issues at the May Revision.

- *Increased FMAP for Translation Services.* CHIPRA provides an enhanced federal matching rate (i.e., 75 percent) for translation and interpretation services in connection with enrollment of, retention of, and use of services for families whose primary language is not English. The MRMIB is presently assessing the cost-effectiveness of separating out these services from the Administrative Vendor contract and the Health Plan contracts where these services are presently provided and funded. The MRMIB states that more information should be available at the May Revision regarding this issue.

- *Additional Funds for Outreach & Enrollment "Grants."* CHIPRA provides $100 million for federal fiscal years 2009 to 2013 for outreach and enrollment "grants" designed to increase enrollment in CHIP (Healthy Families) and Medicaid (Medi-Cal). Of this amount, 10 percent is available to American Indian Reservations. MRMIB states that more information should be forthcoming from the federal CMS regarding these grants but noted that these funds can go to States, local governments and other organizations.

- *Prenatal Care for Pregnant Women—Unborn Option.* CHIPRA explicitly leaves intact an existing "unborn child" regulation whereby states can obtain federal CHIP funds for prenatal care provided to pregnant women. California presently has a federal Waiver for this purpose which enabled the state to save almost $200 million General Fund in the Budget Act of 2005 and forward (i.e., savings in the Access to Infants and Mothers Program and the Medi-Cal Program). The MRMIB states *no adjustments are necessary* to continue this existing approach.

- *Mental Health and Substance Abuse Parity.* CHIPRA makes recently enacted federal mental health parity laws applicable to CHIP, which may require changes to the HFP, which may increase costs, but this remains unknown at this time. Currently, mental health services for participants who are Severely Emotionally Disturbed (SED) is carved out and provided through counties.

- *Prospective Payment System for FQHCs and RHCs.* CHIPRA requires states to use a prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for CHIP services. It is unknown if this will increase costs in the HFP and by how much.

Comments and Questions:

The Subcommittee has requested the MRMIB to discuss each issue above and provide a brief summary and comment regarding the issue, including the potential need for budget action to be taken in 2009-10, and respond to the following questions:

1. Will the State submit a State Plan Amendment (SPA) in order to receive federal funds for recent legal immigrants? Will this SPA be submitted by June 30th?

2. If the CMS determines that the dental cap is not allowed under CHIPRA, what options will the State have to address this?