AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER PATTY BERG, CHAIR

MONDAY, MAY 7, 2007
STATE CAPITOL, ROOM 127
4:00 P.M.

ITEMS TO BE HEARD

ITEMS ON CONSENT

2400 DEPARTMENT OF MANAGED HEALTH CARE

The Department of Managed Health Care (DMHC) was established in 2000, when the licensure and regulation of the managed health care industry was shifted from the Department of Corporations and placed in a new, stand-alone, department. The mission of DMHC is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These 94 Health Care Plans provide health insurance coverage to approximately 64 percent of all Californians. Recent statutory changes also make DMHC responsible for the oversight of 240 Risk Bearing Organizations (RBOs), who actually deliver or manage a large proportion of the health care services provided to consumers. Within the Department, the Office of the Patient Advocate helps educate consumers about their HMO rights and responsibilities.

The Governor proposes $43.5 million (Special Funds) in total expenditures and 297.3 positions for the department–an increase of $72,000 and no change in positions.

The administration did not submit any budget change proposals for the department.

No issues have been raised regarding the department's budget.

4260 DEPARTMENT OF HEALTH CARE SERVICES

A. National Provider Identifier Trailer Bill Language

The administration is proposing trailer bill language to conform with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements to establish the "National Provider Identifier" as the single identifier for health care providers who utilize HIPAA-covered electronic transactions (such as for Medi-Cal and Medicare).

This HIPAA rule requires that providers obtain a single provider number from the federal CMS and requires that only *one number* be used by that provider for *all* billings for all business locations. All Medi-Cal providers will need to obtain a National Provider Identifier in order to receive Medi-Cal reimbursement. DHCS states that this is necessary because without this requirement, DHCS would have to maintain two separate databases—one using Medi-Cal provider numbers as required by state law and one using the National Provider Identifier under federal law. DHCS states that implementation of this federal HIPAA rule is to be effective May 23, 2007 and that the proposed statutory changes are needed to avoid the risk of litigation.

B. Intermediate Care Facility DD-CN —Positions & Sunset Extension (also DPH)

The budget provides an increase of $262,000 ($81,000 General Fund, $20,000 L&C Funds and $161,000 in federal funds) to fund four positions on a two-year limited-term basis (from January 1, 2008 to January 2010) to continue to comply with the Intermediate Care Facility for Developmentally Disabled-Continuous Nursing (ICF DD-CN) Wavier requirements, to close out the project, and to prepare an amendment to the state's Medi-Cal Plan to add this as a regular service to the Medi-Cal Program.

Three of the requested positions would be within the Department of Health Care Services (DHCS) and would be used to continue the management of the existing pilot, continue certain evaluation analyses, provide clinical monitoring and related activities. The other position would be used within the Department of Public Health (DPH) to continue monitoring of the pilot and to develop policies and procedures for licensing the facilities once they are added to the state's Medi-Cal Plan.

Trailer Bill Language. The administration is also proposing trailer bill language to extend the ICF DD-CN pilot to January 1, 2010. This is being proposed to allow sufficient time to fully evaluate the pilot and then to take steps to include this as part of the state's Medi-Cal Plan.

The purpose of the ICF DD-CN model is to explore more flexible and effective models of facility licensure to provide 24-hour skilled nursing in a residential community versus an institutionalized setting. The pilot was originally established as a two-year pilot but

the federal Centers for Medicare and Medicaid Services (CMS) has since approved two additional three-year Waiver periods and is expected to approve the fourth request (for October 2007 through September 2009).The administration notes that there has been consistently positive feedback from consumers, families and physicians regarding this pilot.

C. Third Party Health Plan Recoveries—Trailer Bill Language

The Governor's Budget proposes trailer bill language to modify state law to comply with recent changes in federal requirements regarding Medicaid (Medi-Cal) cost avoidance and cost recovery activities. These changes were made in the federal Deficit Reduction Act (DRA) of 2005.

According to DHCS, California law does not comply with DRA requirements that Medicaid third-party liability extends to pharmacy benefit managers and employer self-insured plans. As a result, Medi-Cal is unable to avoid costs and recover funds from these entities.

Under federal law, Medicaid programs are "payors of last resort," meaning that costs of providing care are first charged to any other health coverage that a Medi-Cal beneficiary may have, such as employer coverage. Often, the existence of third-party coverage is determined after-the-fact, and Medi-Cal later bills the insurer or health plan to recover its costs.

Historically, pharmacy benefit managers and self-insured plans have contended that they are not legally defined as health insurers and, therefore, not responsible for payment of claims, or subject to Medi-Cal's timely filing requirements and subrogation rights. Over the years, the Medi-Cal Program has had little success in recovering funds from these entities. The DRA specifies that self-insured plans, managed care organizations, pharmacy benefit managers, and other statutorily or contractually liable parties are included as legally responsible third parties for payment of a claim for a health care item or service. Additionally, the DRA requires insurers to submit eligibility and claims data for Medi-Cal enrollees on a regular basis to enhance identifying third party health coverage. It also reinforces the Medi-Cal Program's rights by requiring insurers to pay claims for Medi-Cal enrollees that are submitted within three years of the date of service, regardless of the format of the claim.

Specifically the language modifies state law to (1) revise the definition of "private health care coverage"; (2) expand the state's ability to submit claims to health insurance carriers by enabling follow-up action for a period of up to six years after the DHCS' original claim was submitted; and (3) restrict health insurance carriers from denying the state's claims based solely on timelines, claim format, or the state's failure to immediately provide documentation.

Savings Should Be Scored. The DHCS estimates that these state statutory changes will result in increased recoveries of about $2 million ($1 million General Fund)

primarily due to the inclusion and responsibility of pharmacy benefit managers, as a legally defined health insurer, to pay claims for health care items or services provided to Medi-Cal Program enrollees. However, the Governor's Budget inadvertently failed to count these savings. Consequently, the savings should be scored with this action.

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

A. Technical Corrections and Adjustments—Finance Letter

In a letter dated March 29th, the Department of Finance requested various adjustments to the support and local assistance appropriations for DHCS and DPS to correct technical errors or oversights. The net General Fund impact of these changes is a reduction of $547,000 due to an oversight in the Governor's Budget in which one-time spending in 2006-07 for office automation and equipment in DPH was not removed in the 2007-08 base. Other adjustments generally correct errors in the January Budget in the proper allocation of funding sources or savings between DHS and DPH. These adjustments do not represent any actual change in the proposed split of resources and programs between the two new departments, but merely correct errors and omissions.

This action includes direction to the Department of Finance to make any conforming adjustments necessary to be consistent with the actions of the subcommittee.

4265 DEPARTMENT OF PUBLIC HEALTH

A. Genetic Disease Testing Program

The budget proposes total expenditures of $118.9 million in local assistance for the Genetic Disease Testing Program, an increase of $20.7 million compared to the current year. This program is fully fee supported. Most of this increase is to implement SB 1555 (Speier) of 2006, as discussed below.

The Genetic Disease Testing Program consists of two programs—the Newborn Screening Program and the Prenatal Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers or private parties using a special fund—Genetic Disease Testing Fund.

The Newborn Screening Program provides screening of *all* newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $103 dollars. The Prenatal Screening Program provides screening of pregnant women who consent to screening for serious birth defects. The fee paid for this screening is $162 dollars. These fees may be paid by the family's insurance, the Medi-Cal Program, or out-of-pocket.

SB 1555 Implementation. The budget proposes an increase of $4.6 million in state support ($4.2 million in Birth Defects Monitoring Fund, and $475,000 in Genetic Disease Testing Fund) to (1) add six new positions across two programs, and (2) provide $4 million in contract funds to implement Senate Bill 1555 (Speier), Statutes of 2006. Trailer bill legislation to establish a special fund for this purpose also is proposed.

Specifically, SB 1555 does the following:

- Expands the Prenatal Screening Program by adding Inhibin screening (i.e., the fourth marker) to the program and by providing for first trimester screening. The fee for this program was increased by $40 for this purpose. This expansion of the program would increase the detection for neural tube defects, Down Syndrome, Trisomy 18 and Smith Lemli Optiz Syndrome to about 90 to 95 percent accuracy; The department is proposing expenditures of $475,000 (Genetic Disease Testing Fund) to fund four positions to carry out this function.

- Funds laboratory and supplies costs totaling about $13.2 million. The budget includes $8.5 million for system development in order to make the necessary changes to implement the changes required under SB 1555—namely the addition

of Inhibin and the First Trimester screening. The budget also includes an additional $4.7 million for reagents to screen for the new conditions and to develop the actual screens, along with quality control, pilot testing and implementation of the expansion statewide.

- Directs the California Birth Defects Monitoring Program to store and share pregnancy blood samples for the purpose of conducting research about causes, treatments, prevention strategies and screening tests for children's and women's diseases. The fee for the Prenatal Screening Program was increased by $10 for this purpose. The budget requests $4.2 million (CA Birth Defects Monitoring Fund) to contract with the March of Dimes for the oversight of the storage of blood samples, development and oversight of the sample retrieval protocol and coordination and racking of the use of the samples by researchers ($3.9 million) and for two positions ($320,000) that will (1) oversee peer review process to prioritize access to pregnancy blood samples; (2) write project plans and monitor contractor's work, and (3) collaborate with the scientific community and present findings.

- Requires the department to educate the public about the benefits of umbilical cord blood banking. The legislation specifies that these efforts are to be funded using private donations.

The proposed trailer bill legislation establishes the Birth Defects Monitoring Fund for deposit of the new $10 fee to support this program.

B. Implementation of Senate Bill 1312 (Alquist) of 2006 and Trailer Bill Language

The Governor's Budget includes an increase of $2.5 million (Licensing and Certification Fund) to support 16 positions and augment a contract the state has with Los Angeles County to implement the provisions of Senate Bill 1312 (Alquist) of 2006. In addition, the administration is proposing trailer bill language (April 12, 2007 version) to clarify and improve the efficiency of implementing this legislation.

Senate Bill 1312 (Alquist), Statutes of 2006, requires the Licensing and Certification (L&C) Division to do the following:

- Identify all state law standards for the staffing and operation of long-term health care facilities.

- Reinstate periodic licensing surveys for all long-term health care facilities.

- Impose administrative penalties for incidents occurring at facilities starting January 1, 2007.

Prior to SB 1312, the state had discontinued conducting state surveys in certified facilities where federal surveys were conducted. However, under SB 1312, regardless of the federal survey results, a state licensure survey is required.

Request for 16 positions of State Staff ($1.9 million). The proposal contemplates that the L&C Division will conduct joint federal *and* state surveys and inspect facilities' compliance with state standards "to the extent that those standards provide greater protection to residents, or are more precise than federal standards." The budget request estimates this would add 20 hours to the federal survey. This standard equates to 13 permanent L&C Division field positions. An additional evaluator position is requested to identify state standards for the staffing and operation of long-term care facilities and to begin using those standards for the reinstated licensing inspections. The remaining two positions are for legal services to implement the administrative penalties and handle legal issues that arise from conducting these additional surveys.

LA County Contract. The state contracts with Los Angeles County to conduct licensing and certification work in that region. As such, an increase of $559,000 (Licensing and Certification Fund) is necessary for the county to meet the requirements of the enabling legislation.

Trailer Bill Language. The administration is proposing trailer bill language to clarify a few aspects of SB 1312. First, the language clarifies that the L&C Division will inspect for compliance with provisions of state law and regulations during a state periodic inspection *or* at the same time as a federal periodic inspection. Second, it clarifies that the cost of the additional inspections and surveys may be recovered by an increase in initial license and renewal fees for long-term care facilities. Third, it clarifies the administrative penalties to be imposed on hospitals. This clarification was needed due to an overlap with other chaptered legislation (i.e., AB 774 of 2006).

C. Nursing Home Administrator Program

The budget proposes a net increase of $57,000 (Nursing Home Administrator's State License Examining Fund), along with a redirection of $110,000 (from operating expenses within the program) to fund 2.5 positions to investigate complaints and citations and to ensure that statutory and regulatory duties are met. The purpose of this program is to protect the health and safety of the public by ensuring that only qualified persons are licensed and appropriate standards of competency are established and enforced.

The department indicates that currently it has 2.5 staff for this program and there is a growing backlog that now stands at 83 complaints and over 800 citations. Other workload also is backlogged. The additional positions primarily would be used to: (1) conduct investigations and enforcement activities; (2) ensure that applicants meet standards for licensure; ensure the timely approval of continuing education providers and courses; and (3) maintain the relevancy of the state licensing examination.

The department believes that 40 complaint cases per year can be investigated and that the current backlog will be eliminated in about two years. Further, they intend to have

the program develop, monitor evaluate and update as necessary an annual work plan for accomplishing the program's statutory mandates. This annual plan is to identify goals and objectives, required activities, resources needed, timeframes, and expected outcomes that will result in the accomplishment of the defined mandates.

Reporting Language. Action to approve the budget request also would include adoption of the following reporting language to provide legislative oversight for Item 4265-001-0001 (this would conform to the Senate action on this issue):

> "The Department of Public Health shall provide the fiscal and policy committees of the Legislature, by no later than January 15, 2008, a copy of the annual work plan for accomplishing the mandates set forth in the Nursing Home Administrator's Act. This work plan will identify goals and objectives, required activities, resources needed, timeframes, and expected outcomes that will result in the accomplishment of the defined mandates."

D. Temporary Manager/Receiverships for Long-Term Care Facilities—Finance Letter

A Finance Letter dated March 29th requests a one-time increase of $1.9 million ($1.4 million state Health Facility Citation Penalty Account and $466,000 federal Health Facility Citation Penalty Account) to fund temporary manager/receiverships for long-term care facilities. With this increase, total funding for this program would be $5 million in 2007-08.

The department states that the $1.9 million increase is a one-time adjustment while they gather sufficient expenditure and revenue data to determine a more permanent and workable funding mechanism for temporary manager/receiverships. This is because the current funding sources are not adequate to finance this expenditure level on an ongoing basis.

State law requires the department to take action to protect the health and safety of residents of long-term care facilities. The L&C Division must fund Temporary Managers and Receiverships and maintain facility operations to protect the health and safety of residents of long-term care facilities when noncompliance with state or federal requirements places residents in immediate danger of injury or death.

The department states that the overall 2007-08 cost estimate is based on the availability of facility cash resources for ongoing operational costs, the number of beds in the facilities, whether the facilities are federally certified to receive Medi-Cal funding to offset operational costs, and whether the receivership will require the relocation of residents.

Funding for this program is from citation penalties levied against long-term care facilities and deposited into the Health Facilities Citation Penalties Account (state citation fund)

and the Federal Citation Penalties Account (federal citation account). Both of these funds provide immediate access to financial resources in emergency situations threatening the health and well being of residents in long-term care facilities.

Bureau of State Audits Report (April 12, 2007). The audit recommends that the L&C Division gain assurance from temporary management companies that the funds they request and receive are necessary. Documentation for expenditures needs to be obtained. In addition, the division should expand the pool of qualified temporary management companies to ensure that they have sufficient numbers of temporary management available and receive competitive prices.

Reporting Language. Action to approve this Finance Letter request also includes adoption of the following reporting language to provide legislative oversight for Item 4265-001-0001 (this would conform to the Senate action on this issue):

> "By no later than November 1, 2007, the Department of Public Health shall provide the fiscal and policy committees of the Legislature with an action plan to address issues related to fiscal accountability and the selection process for temporary management appointments as identified in the Bureau of State Audits Report (2006-106)."

4280 MANAGED RISK MEDICAL INSURANCE BOARD

A. Medicaid Payment Error Rate Measurement—Finance Letter

A Department of Finance Letter dated March 29th makes the following request.

Federal Medicaid Payment Error Rate Measurement Implementation (Issue 101) – It is requested that Item 4280-001-0001 be increased by $76,000 and Item 4280-001-0890 be increased by $140,000 to support two auditor positions. The Centers for Medicare and Medicaid Services came to agreement with the Managed Risk Medical Insurance (MRMIB) in February 2007 on the implementation of the Federal Medicaid Payment Error Rate Measures (PERM) regulations. These federal regulations require all states to implement new audit procedures for the State Children's Health Insurance Program (SCHIP) funds. Under PERM, reviews will be conducted in three areas: (1) fee for services, (2) managed care, and (3) program eligibility. The results of these reviews will be used to produce the national program's error rates, as well as state-specific error rates. CMS has developed a national contracting strategy for measuring the fee for services and managed care areas. States are responsible for measuring program eligibility and for coordination with the national contractors on the other areas.

California is among 17 states which are to begin these new audits in 2007. Each PERM audit continues over a three year period, with a new audit to begin immediately thereafter. This establishes a permanent, ongoing audit process. PERM also requires the use of an independent auditor contract in addition to duties performed by the MRMIB. Costs for this independent auditor will be reflected in the 2007 May Revision Estimate by the MRMIB. Assuming federal reauthorization of the SCHIP program beyond 2007, implementation of these audits will ensure that California continues to receive federal funding under this program, currently valued at approximately $800 million per year.

This request augments spending by a total of $216,000 ($76,000 General Fund) and two positions in order to comply with federal regulations.

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: REPORT ON MEDI-CAL PROVIDER RATES OVERDUE

AB 1807 Reporting Requirement for Comparison with Medicare Rates

Section 81 of the 2006-07 Health Budget Trailer Bill (AB 1807) requires the Department of Health Services to report to the Legislature **no later than March 15, 2007**, with a comparison of Medi-Cal provider rates to Medicare rates and also information on the need for adjustments to Medi-Cal—only rates. Specifically, AB 1807 requires the following information to be reported:

> (1) Where applicable, a percent comparison regarding the reimbursement rates paid under Medi-Cal as compared to the reimbursement rates paid under the federal Medicare Program, excluding rates applicable to dental services, pharmacy, federally-qualified health centers, rural health clinics, and health facilities.
>
> (2) Where applicable, an estimate of the cost for increasing all Medi-Cal reimbursement rates that are comparable to the federal Medicare Program rates, up to a minimum of 50 percent of the rate paid under the federal Medicare Program. The estimate shall take into account increases necessary to keep managed care rates comparable.
>
> (3) For those procedures reimbursed only under the Medi-Cal program, excluding dental services, a prioritized listing of services and procedure codes, as determined by the department, that may merit adjustment based on a review by the department or a contractor. The estimates shall take into account increases necessary to keep managed care rates comparable.

This report has not yet been provided to the Legislature.

- The department should inform the subcommittee as to when the report will be provided.

Staff notes that Budget Committee policy is that overdue reports must be submitted prior to approval of a department's budget.

Community Clinic Rates—Planned Parenthood

Planned Parenthood Affiliates of California (PPAC) operates community clinics that provide birth control, pregnancy, and sexual health services in 32 California counties. According to PPAC, the low level of Medi-Cal rates has had a drastic effect on the ability of PPAC and other safety-net providers to provide needed care. In particular, PPAC indicates that a lack of clinicians and staff is causing dangerous delays in care. A recent survey indicates the following:

- Nearly every one of the PPAC affiliates are currently turning away clients daily because they cannot afford to hire clinical personnel to handle the caseload. In San Diego and Riverside Counties, 4,600 patients are being turned away every month; more than 2,500 a month in Santa Barbara; 1,000 monthly in Orange County and another 250 in Pasadena; 600 in San Francisco; more than 150 at Shasta Diablo (Contra Costa/Santa Rosa) clinics and the most rural affiliate, Six Rivers (Eureka), currently is turning away more than 200 patients per month.

- ALL prenatal services at PPAC affiliates have been either curtailed, suspended or eliminated. Many families show up for prenatal care and cannot be seen.

- HIV Screening, STD screening, cervical cancer screening and other preventive health care services are either being curtailed, or the wait for an appointment can range from two to four weeks. In one case (Six Rivers), 50 patients per week who seek HIV testing are turned away. Six Rivers no longer provides colposcopy and cryosurgery to any patients, and Shasta-Diablo discontinued primary care services three years ago entirely because of cost issues. In many cases excessive wait times have resulted in a 50 percent no show rate for visits.

- Many affiliates have laid-off significant numbers of clinical staff, have shuttered clinics (Six Rivers closed its clinic in Trinity) and are unable to retain, attract and recruit doctors and other medical staff. The San Francisco affiliate currently has 16 positions open due to of lack of funding, and some have been vacant for more than a year because of the affiliate's inability to offer competitive wages.

Because costs severely exceed revenues, PPAC indicates that underserved populations are going without health care – and that this is having serious consequences. The inability to provide direct services is eroding the state's successful efforts at reducing teen pregnancy and protecting the public health from sexually transmitted diseases.

PPAC Seeks Increase to Medicare Rates. PPAC has requested DHS to estimate the cost of increasing Fee-for-Service Medi-Cal rates to a more adequate level—specifically to full Medicare-equivalent rates—for services provided by community clinics.

Questions for DHS. The department should respond to the following questions:

1. What would be the cost of the rate increase proposed by PPAC?

2. From a fiscal point of view, what would be the impact on Medi-Cal and other public programs if restricted access to clinic services results in higher levels of unintended pregnancies and delays in treatment of sexually-transmitted diseases?

3. Has DHS evaluated the findings of the PPAC survey? What is DHS's response to the contention that low Medi-Cal reimbursement rates are having a significant adverse effect on access to care?

Non-Emergency Medical Transportation (NEMT)

In the 2006-07 Budget Bill, the Legislature provided an augmentation of almost $5 million ($2.5 million General Fund) to increase Medi-Cal rates for non-emergency medical transportation. However, the Governor vetoed this funding.

The California Medical Transportation Association recently had a CPA review the costs and revenues for NEMT services provided to Medi-Cal beneficiaries by five firms. This review determined that only one of the firms was making any money on this business (but only 0.2 percent), and that, on average, the firms were losing 7.8 percent. Furthermore, ongoing increases in fuel and labor costs will exacerbate the losses. Rates for NEMT services were last increased in 2000, when costs were significantly lower.

The association points out that NEMT providers primarily transport Medi-Cal patients to and from dialysis treatment. These patients often are in weak condition and often have little or no access to alternative appropriate transportation. In some cases, NEMT providers have had to discontinue services with resulting hardship for patients and the potential for higher Medi-Cal costs if an ambulance must be used instead.

The association also points out that NEMT providers tend to predominantly serve Medi-Cal patients and, so, have little or no ability to shift costs to other payers.

Questions for DHS. The department should respond to the following questions:

1. What types of Medi-Cal beneficiaries receive NEMT services?

2. What are current expenditure trends for NEMT and what are some examples of current Medi-Cal rates for NEMT? When were those rates last adjusted?

3. Has DHS evaluated whether access to NEMT services is being curtailed due to low rates and, if so, what has it found?

4. What is the impact on Medi-Cal beneficiaries from any access limitations?

5. Would lack of access to NEMT service result in use of an ambulance instead in some cases? What would be the cost difference at current rates?

ISSUE 2: CRITICAL ACCESS HOSPITAL (CAH) RATES

The CAH designation is granted through the federal Health Resources and Services Administration, Office of Rural Health Policy and results in enhanced reimbursed payment under the Medicare program. There are 25 CAH-certified hospitals in California. These hospitals provide primary and acute care as well as emergency, home health, and skilled nursing care. CAHs are some of the smallest, most remote and most financially vulnerable hospitals. Both Medicare and Medi-Cal provide major sources of revenue for these facilities.

Although, CAHs receive cost-based *inpatient* rates, they are heavily dependent on low Medi-Cal *outpatient* rates. This is because a large share of their services are provided on an outpatient basis because of the scarcity of other health facilities and providers in many rural areas.

According to the California Hospital Association, over 60 percent of CAHs are operating in the red, and Medi-Cal outpatient rates are a significant reason for their poor financial condition since they cover only 25 percent of costs. Moreover, closures or service restrictions by CAHs would often would require Medi-Cal beneficiaries and other residents of those areas to travel much longer distances to receive health care.

Questions for DHS: The department should respond to the following questions:

1. Has DHS evaluated the adequacy of outpatient rates for CAHs and their impact on the financial viability of CAHs? If so, what were the department's findings?

2. What would be the cost of increasing outpatient rates for CAHs to Medicare-equivalent rates, for example?

ISSUE 3: IMPLEMENTATION OF SB 1755—ADULT DAY HEALTH CARE

There are three budget-year adjustments for this issue:

1. **DHCS Staffing.** DCHS is requesting an increase of $3.9 million ($1.8 million General Fund) to fund 46 positions primarily to implement SB 1775 (Chesbro) of 2006 related to the Adult Day Health Care (ADHC) Program within Medi-Cal.

2. **DPH Staff.** The Department of Public Health (DPH) is requesting an increase of $99,000 ($49,000 General Fund) to fund one position in the Licensing and Certification Division of the DPH.

3. **Medi-Cal ADHC Savings.** The Medi-Cal local assistance estimate includes a savings of $5 million ($2.5 million General Fund) resulting from the implementation of more restrictive medical necessity criteria for enrollment into the ADHC Program, effective January 1, 2008.

DCHS Staffing Request

- ***Audits and Investigations (A&I) Branch—35 Positions.***

  - ***A&I Financial Audits Section—31 Positions.*** This includes **(1)** 20 Health Program Auditor III's (three year limited-term); **(2)** 5 permanent Health Program Auditor III's; **(3)** 3 permanent Health Program Auditor IV's; **(4)** a permanent Health Program Audit Manager I; and **(5)** two Health Program Audit Manager I's (three-year limited-term). These positions would primarily be used to audit 350 ADHC cost reports by no later than January 31, 2010 in order to allow for the analysis and calculation of rates that must take place before the rates can be applied to each of the 350 ADHC providers. The DHCS contends that staff needs to be hired and trained, and to commence with audits as soon as feasible. The three Health Program Audit Manager I's (one permanent with two being limited-term) would supervise the audit staff.

  - ***A&I Medical Review Section—2 Positions.*** These positions (a Medical Consultant and a Nurse Evaluator) will focus on revisions to the medical necessity criteria and will assist in determining whether ADHC participants are receiving needed services.

  - ***A&I Investigations Section—2 Positions.*** These fraud investigator positions would perform criminal investigations in cases where fraud and abuse are suspected. The investigators would work closely with the Department of Justice in prosecuting fraud cases that may result.

- ***DHCS Office of Legal Services—9 Positions.***

- ***Office of Administrative Hearings and Appeals—4 Positions.*** The DHCS states that these positions will be needed to process audit appeals filed by ADHCs.

- ***Administrative Litigation Section—4 Positions.*** These positions will be handle potential litigation from the upcoming changes under SB 1755.

- ***Medi-Cal In-House Counsel.*** The DHCS contends that medical reviews resulting from the ADHC Program will result in negotiated settlement agreements. This position would be used for this purpose, as well as to provide legal advice in all aspects of the development of regulations to be developed for the changes.

- ***Medi-Cal—2 Positions.*** An existing position would be converted to a Nurse Consultant III position to be used in the Medi-Cal Policy section to coordinate the implementation of ADHC reforms. Second, a new research position in the Rate Development section would assist in the development of a new rate methodology.

- ***Department of Public Health, Licensing & Certification Division—1 Position.*** The budget includes a request for a permanent Associate Governmental Program Analyst position within the DPH's Licensing and Certification Division. This position would be used to update the current licensing regulations so they will conform to the reforms authorized in SB 1775.

Reduction in Benefit Costs. The budget estimates a reduction of $5 million ($2.5 million General Fund) in Medi-Cal costs from implementing the medical necessity criteria as of January 1, 2008. The reduction level assumes the following:

- 30 percent of new users will not meet the revised medical eligibility criteria. This means that 362 individuals will not be eligible to enroll in ADHC services.

- 15 percent of existing users will not meet the revised medical eligibility criteria. This means that 2,469 individuals will be terminated from ADHC services.

Key Provisions of SB 1755. This legislation was crafted in response to federal CMS concerns with California's ADHC Program. Specifically, the federal CMS notified the state that the existing ADHC program included some services not covered by Medicaid, did not require a finding of medical necessity for services, and did not adequately document the provision of specific services. In response, the state will be submitting a "State Plan Amendment" (SPA) to the federal CMS in 2009 to bring the ADHC program into compliance with federal law. SB 1755 authorizes DCHS to take the following actions over the next three years to accomplish this:

- Establish a set of definitions relating to ADHC services.

- Revise the standards for participant eligibility and medical necessity criteria.

- Set new standards for the participant's personal health care provider and the ADHC center staff physician.

- Require the ADHCs to provide a set of core services to every participant every day of attendance.

- Restructure the rate methodology to a prospective cost-based process requiring audited cost reporting.

Future Savings. The department indicates that the gradual implementation of SB 1755 reforms will generate savings of $121.8 million ($60.9 million General Fund) beginning in 2011-2012. Savings leading up to 2011-2012 are expected to be limited. Savings are expected to stem from a combination of the following factors:

- Post-payment reviews with subsequent audit recoveries;

- Tightening of medical necessity criteria, eliminating authorization for Medi-Cal enrollees that do not require ADHC services to remain in the community.

- Unbundling of the ADHC all-inclusive procedure code and requiring ADHCs to bill only for those specific services provided that were medically necessary.

- Development of prospective costs reimbursement that tie the ADHC rates to the actual costs of providing the services.

- Intensive and ongoing audits of ADHCs to prevent and resolve fraud and abuse.

Background—Adult Day Health Care Services

Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded in the Medi-Cal Program. The DHS (soon DPH) licenses programs and the Department of Aging administers the program and certifies each center for Medi-Cal reimbursement.

The baseline budget for the ADHC Program is $375.8 million ($187.9 million General Fund). The average monthly cost per ADHC user is $931.11. The projected average monthly user of these services is 33,633.

The current reimbursement rate for ADHC is 90 percent of the nursing facility level A rate. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. The budget assumes a 4.35 percent rate increase for these services which corresponds to existing law.

The bundled reimbursement rate pays for a day of ADHC services (defined as a minimum of four hours, not including transportation) regardless of the specified services actually provided on any given day. The bundled rate assumes that the required ADHC services will be provided to individuals as deemed medically necessary.

***ADHC Certification Moratorium*.** The Budget Act of 2004 and accompanying trailer bill legislation, resulted in a 12-month moratorium on the certification of new ADHC centers. This was done to diminish the growth of the centers due to concerns regarding the potential for Medi-Cal fraud, by a rapid proliferation of for-profit providers, and by the concerns expressed by the federal CMS regarding the compliance of California's program with federal Medicaid requirements. As discussed above, these concerns are being addressed through the implementation of SB 1755. With minor adjustments, this moratorium was extended for 2005 and 2006, and the budget assumes this continuation through 2007-08. Existing statute makes annual renewal of the moratorium subject to the decision of the Director of Health Services.

Legislative Analyst's Office (LAO) Recommendation

Approve 33 of the Requested 46 Positions. The LAO recommends approving only 33 of the requested 46 positions for savings of $1.37 million ($685,000 General Fund). The basis of the LAO recommendation is that much of the anticipated audit and appeal workload related to antifraud activities will not materialize until 2008-09.

The 13 positions recommended for deletion are: (1) five Health Program Auditor III's; (2) five Health Program Auditor IV's (three from the Financial Audits Branch, two from the Office of Legal Services); (3) one Research Analyst II; and (4) two Staff Counsel positions (from the Administrative Litigation Section).

No issues have been raised regarding the reduction to local assistance of $5 million ($2.5 million General Fund).

Late SB 1755 Report. SB 1755 included a provision requiring, effective January 1, 2007, the department to report annually to the relevant fiscal and policy committees as part of the Governor's budget in January on the impacts of the implementation of SB 1755 on ADHC programs. The department has not, however, issued the 2007 report at this time.

Trailer Bill Language Needed to Enable Relocation of Existing Center to Proceed

Humboldt Senior Services (an existing nonprofit ADHC provider) currently has a new facility under construction that will have a somewhat increased capacity. A number of other ADHC providers have closed in the area. The ADHC moratorium provision (in Section 14043.46 of the Welfare and Institutions Code) permits the Director of Health Services to approve exceptions to the moratorium for applicants that have been providers for at least four years and are expanding or relocating within the same county provided that they meet one of several additional enumerated conditions.

The Humboldt center qualifies under one of these conditions—it is located in a county ranked first or second for percentage of persons aged 65 or older in poverty. The department, is supportive of licensing the relocated Humboldt Center, but its legal staff has identified a need for the law to cite a data source. The department indicates that the California Long-Term Care County Data Book for 2002 (the most recent issuance) would be the appropriate data source for this purpose. Consequently, trailer bill language to specify this data source would allow the department to proceed with approval of the new center for Humboldt Senior Services.

STAFF COMMENTS

Staffing Proposal. Implementing SB 1755 will be a significant effort. However, the number of staff recommended by the LAO is still considerable, and it will take some time for the DHCS to hire and train them. The DHCS can request any necessary additional resources next year as workload grows. Further, the DHCS has considerable staff within the Audits and Investigations area and could, in certain cases, shift staff resources around to meet key priorities when necessary.

Late Report. Given that implementation of SB 1755 is just beginning, the 2007 report probably would be quite brief. However, the department should comply with this requirement prior to the closeout of the subcommittee process.

Humboldt Senior Services. The department indicates that the clarifying trailer bill language is needed in order to enable it to complete its approval of the new facility (which is currently under construction).

ISSUE 4: OFFICE OF LONG-TERM CARE PACE STAFFING

Programs of All-inclusive Care for the Elderly (PACE) combine Medicare and Medicaid services to provide intensive coordinated care to enable seniors in need of nursing home services to remain in their homes and communities. PACE programs provide a high level of coordinated care and they save the state money compared with providing nursing home care and medical services on a fee-for-service basis.

California currently has four operating PACE programs—two in the Bay Area, one in Los Angeles, and one in Sacramento. Existing law authorizes up to ten PACE programs in California. There is interest in providing additional PACE programs. In particular, Community Eldercare of San Diego has submitted an application to DHS to become a PACE provider. However, approval of PACE applications is complex, and DHS does not have staff available to move forward with the application or to work on an overall PACE expansion strategy for the state.

Two Positions Needed. Reinstatement of two positions that formerly were provided to work with PACE programs would enable these tasks to proceed. The cost of the two positions would be approximately $200,000 ($100,000 General Fund).

ISSUE 5: CONTRACT PURCHASING OF HEARING AIDS

Medi-Cal covers the provision of hearing aids for beneficiaries who need them, subject to pre-authorization through the Treatment Authorization Request (TAR) process. At present, hearing aid providers purchase hearing aids individually and bill Medi-Cal based on the wholesale cost plus an allowance for additional services, subject to a maximum cap.

Over the last several years, there has been a decline in the number of Medi-Cal hearing aid providers and in the number of hearing aids provided to Medi-Cal beneficiaries even though there has been a substantial growth in the number of elderly and disabled beneficiaries during this time. Some of this decline may reflect efforts by DHS to eliminate fraudulent or inappropriate claims. However, there have been increasing complaints from providers about delays in payment and the complexity of the claiming and authorization process for hearing aids.

Medi-Cal spends about $19 million annually (total funds) for hearing aids under the current reimbursement methodology. An alternative to the current approach would be to contract for hearing aids. This could be done in a number of ways. For example, the department could contract with specific manufacturers or distributors for their best price. Hearing aid dealers then would be required to obtain hearing aids from those sources. Another variant would be to use one or more purchasing intermediaries who would act as bulk purchasers for Medi-Cal and supply hearing aids to the individual dealers (somewhat similar to the function that pharmacy benefit managers play for drugs).

Contracting along the lines of any of these models offers two benefits. First, there would be potential cost savings of at least several million dollars annually due to better prices. Second, Medi-Cal would pay the contractor for the hearing aids directly, eliminating the need for the local provider to seek reimbursement for these devices. Local providers still would receive payment for their services related to fitting, adjustments, training and any repairs, but they would no longer have to "front" the substantial cost of the hearing aids themselves.

STAFF COMMENTS

Hearing aids are relatively expensive, and Medi-Cal purchases around 18,000 of them annually. Clearly, contracting for hearing aids rather than paying for them on an individual purchase basis offers the potential for significant savings. The department does not dispute the benefits of contracting, but argues that it wants to focus its contracting efforts on the broader categories of Laboratory Services and Durable Medical Equipment. These contracting areas do offer potential savings, and Laboratory Services represent almost $300 million of purchases. However, contracting in these categories is a complex matter because of the variety of equipment and laboratory

services that is purchased and the need for quick turnaround in some cases (particularly with Laboratory Services).

In contrast, hearing aids offer a much simpler contracting opportunity that should not require inordinate effort by DHCS. Adoption of the following trailer bill language would direct DHCS to proceed with contracting for hearing aids and result in savings of several million dollars annually after the contract purchasing arrangement is in place:

> Amend (add underlined provision) Section 14105.3 (b) of Welfare & Institutions Code as follows:
>
> (b) The department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services and with laboratories for clinical laboratory services for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the product or service. This subdivision shall not apply to pharmacies licensed pursuant to Section 4080 of the Business and Professions Code.
>
> (1) In order to ensure and improve access of Medi-Cal hearing aid beneficiaries to both hearing aid appliances and provider services, and to assure that the state obtains the most favorable prices, the department shall by January 1, 2008 enter into exclusive or nonexclusive contracts on a bid or negotiated basis for purchasing hearing aids.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: EMERGENCY PHYSICIAN PROPOSITION 99 FUNDING

The administration is proposing to appropriate $24.803 million (Proposition 99 Funds) to reimburse physicians, surgeons and hospitals for uncompensated emergency medical services. This appropriation is consistent with appropriations made for this purpose for the past several years, since 2000.

Trailer Bill Language. The administration's proposed trailer bill language which accompanies the appropriation is not consistent with language adopted in some prior years. In particular, it may not allow some existing reimbursement arrangements that have been negotiated locally to continue, including the existing agreement in Los Angeles County. In order to ensure that any county with an existing special fee schedule can allocate their funding to their hospitals and physicians accordingly. The added provision is as follows:

> (c) (2) If a county has an Emergency Medical Services Fund Advisory Committee that includes both emergency physicians and emergency department on-call back-up panel physicians, and if the committee unanimously approves, the administrator of the Emergency Medical Services Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients, provided that no more than 15 percent of the tobacco tax revenues allocated to the county's Emergency Medical Services Fund is distributed through this special fee schedule, that all physicians who render trauma are entitled to submit claims for reimbursement under this special fee schedule, and that no physician's claim may be reimbursed at greater than 50 percent of losses under the special fee schedule.

STAFF COMMENTS

The administration indicates that it is not opposed to this addition.

ISSUE 2: RADIOLOGICAL HEALTH AND NUCLEAR WASTE REGULATION

As an oversight issue, it has been brought to the Subcommittee's attention that DHS has apparently failed to implement a 2002 Governor's executive order requiring it to set new standards for the handling of low-level radioactive waste. The Radiological Health Branch within DHS (soon DPH) is responsible for these regulations.

In 2002, the Legislature passed SB 1970 (Romero), which would have banned even slightly radioactive materials being landfilled. But Governor Davis vetoed the bill on the basis that the prohibition would be "premature until the department assesses the public health and environmental safety risks." Soon after the veto, the Governor issued Executive Order D-62-02, placing a temporary moratorium on landfilling radioactive waste, and directing the department to "adopt regulations establishing dose standards for the decommissioning of radioactive materials by its licensees." At about the same time, a lawsuit challenging DHS existing regulations resulted in a court order to set aside those regulations and to require an environmental impact review under the California Environmental Quality Act prior to the adoption of any new regulations.

DHS indicates that the environmental-impact assessment still has not been completed and may not have been initiated.

STAFF COMMENTS

- DHS should provide the Subcommittee with a description of its activities related to the regulation of low-level nuclear waste and the status of the environmental review order by the court in 2002.

4270 CALIFORNIA MEDICAL ASSISTANCE COMMISSION

The California Medical Assistance Commission (CMAC) was established in 1983 to negotiate contracts for specific services under the Medi-Cal Program on behalf of the Department of Health Care Services. The commission is composed of seven voting members appointed to four-year terms.

Major Commission activities include the following:

- Negotiating contracts for Medi-Cal fee-for-service hospital inpatient services throughout the state in areas where there are multiple providers of hospital services.

- Negotiating contracts with private hospitals for supplemental payments under special programs available to contract hospitals under the Medi-Cal Program.

- Negotiating contracts for health care services to Medi-Cal enrollees with County Organized Health Care Systems (except Santa Barbara) and participating Geographic Managed Care Plans (Sacramento and San Diego).

Summary of Funding. The budget proposes total expenditures of $2.8 million ($1.4 million General Fund) to support 22 positions for 2007-08, essentially the same as in the current year.

ISSUE 1: MANAGED CARE NEGOTIATIONS—UPDATE

At its March 26th hearing, the subcommittee reviewed the rate setting process for Medi-Cal managed care plans with the Department of Health Services. The department indicated that rates for the upcoming plan year would be developed using a new methodology based on the recommendations made by Mercer Consulting in its recent report to the department. That methodology will focus much more on the actual encounter data and cost factors for each plan, rather than extrapolating from one plan to all others.

Under existing law, CMAC negotiates rates on behalf of Medi-Cal with four of the five County Organized Health Systems (COHSs) and with plans participating in the two Geographic Managed Care areas (San Diego and Sacramento). Plan rate years generally begin on July 1.

STAFF COMMENTS

- CMAC should update the subcommittee regarding the status of its negotiations with managed care plans for the 2007-08 rate year.
    - Has DHS provided any guidance to CMAC yet regarding rate parameters for the plans?
    - When does CMAC anticipate that it will finalize rates with the plans?
    - Since CMACs negotiations are confidential, how can the Legislature exercise appropriate oversight of CMAC ratemaking?

Negotiations work best when there is a competitive framework. This occurs when CMAC negotiates with multiple hospital providers who serve the same area or with the individual competing health plans in a Geographic Managed Care region. However, COHSs serve essentially all Medi-Cal beneficiaries within their area, and Medi-Cal generally is the sole (or very dominant) purchaser of their services. Consequently, the ratesetting process for COHSs is not a normal competitive type of negotiation. In some cases, COHSs feel that CMAC simply passes along DHS rate decisions

- CMAC should comment as to whether rate setting for the COHSs should be retained by it or shifted to DHCS (which sets rates directly for most Medi-Cal managed care plans).