

AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

**WEDNESDAY, MAY 23, 2012
1:30 P.M. - STATE CAPITOL ROOM 447**

VOTE-ONLY CALENDAR		
ITEM	DESCRIPTION	
4260	DEPARTMENT OF HEALTH CARE SERVICES	2
ISSUE 1	FAMILY HEALTH PROGRAMS – ESTIMATE	2
ISSUE 2	EVERY WOMAN COUNTS TECHNICAL ADJUSTMENT	3
ISSUE 3	FEDERALLY QUALIFIED HEALTH CENTERS AUDITS TECHNICAL ADJUSTMENT	3
ISSUE 4	ELECTRONIC HEALTH RECORDS – STATE MATCH FUNDING	4

ITEMS TO BE HEARD		
ITEM	DESCRIPTION	
4150	DEPARTMENT OF MANAGED HEALTH CARE	5
ISSUE 1	COORDINATED CARE INITIATIVE – RESOURCES REQUEST	5
ISSUE 2	PEDIATRIC DENTAL CARE – RESOURCES REQUEST	8
4260	DEPARTMENT OF HEALTH CARE SERVICES	10
ISSUE 1	MEDI-CAL – ESTIMATE	10
ISSUE 2	NON-DESIGNATED PUBLIC HOSPITALS – REIMBURSEMENT METHODOLOGY	14
ISSUE 3	DESIGNATED PUBLIC HOSPITALS – UNEXPENDED FEDERAL WAIVER FUNDS	17
ISSUE 4	PRIVATE HOSPITALS – HOSPITAL FEE REVENUE	18
ISSUE 5	SKILLED NURSING FACILITIES – RATES	20
ISSUE 6	COMMUNITY BASED ADULT SERVICES – RESOURCES REQUEST	23
ISSUE 7	COUNTY MEDICAL SERVICES PROGRAM – GENERAL FUND LOAN TRAILER BILL	26
ISSUE 8	LOW-INCOME HEALTH PROGRAM – CAPITATION PAYMENT TRAILER BILL	27
ISSUE 9	JUVENILE INMATES (AB 396) – CLEAN-UP TRAILER BILL	29
ISSUE 10	COORDINATED CARE INITIATIVE – MAY REVISE CHANGES	31

VOTE-ONLY**4260 DEPARTMENT OF HEALTH CARE SERVICES****VOTE-ONLY ISSUE 1: FAMILY HEALTH PROGRAMS – ESTIMATES**

The May Revision proposes an overall net increase of \$5.8 million General Fund (GF) in the Family Health Programs, which includes the Genetically Handicapped Persons Program (GHPP), the California Children's Services (CCS) Program, and the Child Health and Disability Prevention (CHDP) Program.

BACKGROUND

The May Revision proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

- *Genetically Handicapped Persons Program (GHPP)*. Total expenditures of \$99.7 million (\$68.2 million GF, \$23.1 million federal Safety Net Care Pool, \$8 million Rebate Fund, and \$452,000 Enrollment Fees) are proposed for 2012-13. This includes a \$2.4 million GF increase from the January budget due to the costs of Kalydeco for the treatment of patients, six years of age and older, with cystic fibrosis and a reduction of \$2.5 million in Safety Net Care Pool funds. Total caseload is 858 people.
- *California Children's Services Program (CCS)*. Total expenditures of \$230.4 million (\$68.9 million GF and \$161.5 million federal funds) are proposed for 2012-13. Total caseload is estimated to be 29,624 children.
- *Child Health & Disability Prevention (CHDP) Program*. Total expenditures of \$2.76 million (\$2.7 million General Fund, and \$22,000 Children's Lead Poisoning Prevention Funds) are proposed for 2012-13. Total caseload is estimated to be 42,228 children.

In addition, the May Revision proposes a reduction of \$41.1 million (\$10.2 million GF) by shifting children in the Healthy Families Program carve-out portion of the CCS Program to Medi-Cal to coincide with the Administration's proposal on merging the Healthy Families Program into the Medi-Cal Program based on a phase-in transition beginning October 1, 2012.

Staff Recommendation: Staff recommends approval of the Family Health Program estimates. Conforming adjustment will be assumed as outstanding proposals that affect the CCS program, including the Healthy Families transition and the Medical Therapy means testing proposals, reach resolution in the final budget package.

VOTE-ONLY ISSUE 2: EVERY WOMAN COUNTS TECHNICAL ADJUSTMENT

Department of Health Care Services (DHCS) is requesting authority to shift \$1,301,000 (\$1,251,000 Breast Cancer Control Account and \$50,000 federal funds) from State Operations to Local Assistance.

The Every Woman Counts (EWC) seeks to raise the quality and accessibility of cancer screening services for low-income under-insured and uninsured women. Women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvic exams, and Pap tests, with the goal of reducing breast and cervical cancer deaths. When women are diagnosed with cancer through the EWC, they are referred to the Breast and Cervical Cancer Treatment Program, operated by the DHCS. The EWC provides support services to recruit providers, conduct outreach, assure quality, collect, and analyze data through the support of Regional Contractors and other contracts. The Regional Contractors conduct health education and maintain provider networks. To be eligible for EWC services, women must be 25, and older for cervical cancer screening, and 40 and older for breast cancer screening and diagnostic services. The Department of Public Health (DPH) projects a screening caseload of 340,000 women in the current year.

The Governor's January budget proposes to move the EWC from the DPH to the DHCS, along with two other direct-service programs, a proposal that this Subcommittee heard on March 26, 2012 and took no action on. The current May Revise proposal is a technical adjustment to correct an error in the allocation of funding between State Operations and Local Assistance. This correction will make the EWC program budget consistent with usual Medi-Cal budgeting which incorporates fiscal intermediary costs in Local Assistance, rather than in State Operations.

Staff Recommendation: Staff recommends approval of this technical adjustment in order to correct an error in the Every Woman Counts budget.

VOTE-ONLY ISSUE 3: FEDERALLY QUALIFIED HEALTH CENTERS AUDITS TECHNICAL ADJUSTMENT

The May Revision inadvertently assumes no savings as a result of the reconciliation audits of provider payments at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by DHCS audit staff. DHCS notes that three limited-term auditor positions expire on June 30, 2012; and consequently, the estimate does not reflect any savings, as a result of these audits, in light of the positions expiring at the start of the Budget Year.

Nevertheless, the Administration's intent was to continue the audits, utilizing existing resources to manage the on-going workload, and therefore to assume savings as a result of the audits in 2012-13.

Staff Recommendation: Staff recommends redirecting existing staff at DHCS to perform this workload and recognize \$6.1 million (\$3.1 million GF) in savings in 2012-13 as a result of the audit findings.

VOTE-ONLY ISSUE 4: ELECTRONIC HEALTH RECORDS (EHR) – STATE MATCH FUNDING

The federal ARRA Stimulus Program, authorized in 2009, included funding for investments in health information technology (HIT) designed to modernize the delivery of health care services. Known as the HITECH Act, core elements of this program include incentive payments administered through Medicare (by the federal Centers for Medicare and Medicaid Services [CMS]), and Medi-Cal to encourage physicians, hospitals, and other providers to adopt EHRs. The Medi-Cal EHR incentive payments are 100 percent federally funded. In addition, CMS provides 90 percent of the funds to operate the program. Over 9,200 California providers have registered to receive these incentive payments totaling more than \$168 million. Additionally, 219 hospitals have also registered, and of these, 106 have already received federal incentive payments totaling \$212 million, and 34 others have been approved for payments totaling \$65 million.

While the incentive payments are 100 percent funded by the federal government, the operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. For the past year, the matching funds needed to startup the Medi-Cal EHR Incentive Payment program have been provided by the California HealthCare Foundation (CHCF) in anticipation that the State would determine a sustainable solution to obtaining the minimal funds needed to operate the program. CHCF has notified the state that effective July 1, 2012, it will no longer be able to provide funds to operate the program. Therefore, unless a minimum of \$188,529 is allocated by the state in 2012-13 to continue to operate the program, the State is in jeopardy of forfeiting hundreds of millions of dollars in federal funds. California providers are able to receive millions of dollars in federal funds as a result of this program.

DHCS indicates that they have been exploring other funding possibilities to cover the required 10 percent state match to cover the administration of this program, however have not yet secured new funding.

Staff Recommendation: Staff recommends conforming to the Senate's action of redirecting \$190,000 GF budgeted for Other Administration (postage and printing costs) to be used as the state match to operate the Medi-Cal EHR Incentive Payment Program.

ITEMS TO BE HEARD

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: COORDINATED CARE INITIATIVE – RESOURCES REQUEST

The Department of Managed Health Care (DMHC) is requesting 13.0 positions and \$1,097,000 (special funds) to address increased workload associated with the Governor's proposed Coordinated Care Initiative (CCI). DMHC also requests \$77,500 (special funds) for consultant services to conduct Independent Medical Reviews and to develop audit tools for new medical surveys.

BACKGROUND

In the January budget, the Governor proposed the CCI, which was the subject of the Subcommittee's joint hearing (with the Assembly Committee on Aging and Long-Term Care) on March 7, 2012. The CCI proposes to shift 1.1 million seniors and persons with disabilities (SPDs) who are beneficiaries of both Medi-Cal and Medicare ("dual eligibles") into managed care by integrating Medi-Cal and Medicare services and funding. As proposed, in up to ten demonstration counties, physical health care, behavioral health care, and long-term care services, currently provided under Medi-Cal or Medicare, would be coordinated by a single managed care plan, which would be paid through a capitated rate to be negotiated with the state and federal governments. This integration would include home and community based services, such as the In-Home Supportive Services (IHSS) program, nursing home care, and other home and community based services, all of which would become managed care benefits under the CCI. The CCI proposes to phase in this integration of services into managed care in the demonstration counties over nine months beginning March 1, 2013.

DMHC's request for positions and resources reflects the Department's anticipated increased workload associated with implementing the CCI. Specifically, DMHC will be responsible for the evaluation of plan readiness and oversight of health plans in counties participating in the CCI demonstration. Under an agreement between DMHC and DHCS, DMHC will be responsible for:

- Conducting a demonstration plan readiness review;
- Providing oversight of health plan financial solvency through financial audits and examinations;
- Providing oversight of quality of care through medical surveys of health plans;
- Ensuring provider network adequacy; and,
- Responding to dual eligible enrollees' grievances, appeals, and complaints regarding the services provided by the plans.

DMHC is planning to submit a subsequent BCP to the Legislature, as part of the January 2013 proposed budget, to seek authorization to make these positions and resources permanent. The requested positions include the following:

The Help Center (8 positions). The Help Center assists consumers with health care issues and seeks to ensure that patients in managed care plans receive the medical care that they should receive. The Help Center also evaluates and promotes health plan regulatory compliance and quality improvement in health care delivery systems by conducting on-site evaluations of licensed commercial and government health plans. This request includes the following positions for the Help Center:

- 1.0 Health Program Specialist II
- 1.0 Nurse Evaluator II
- 1.0 Associate Governmental Program Analyst
- 5.0 Consumer Assistance Technicians

Division of Licensing (4 positions). The Division of Licensing seeks to ensure that managed care plans provide health care services in an appropriately organized and financially stable managed health care setting. This division conducts reviews of new license applications, grants licenses to operate in California, and analyzes material modifications and amendments to existing licenses. This request includes the following positions for the Licensing Division:

- 2.0 Staff Counsels
- 1.0 Health Program Specialist I
- 1.0 Associate Health Program Adviser

Division of Financial Oversight (1 position). This division monitors and evaluates the financial viability of health plans to ensure continued access to health care services for patients. It reviews financial statements, analyzes financial arrangements and other licensing information, and by performing routine and non-routine financial examinations of licensed plans. This request includes 1.0 Corporation Examiner for this division.

Consultant Services. This proposal includes \$77,500 for consultant services to conduct Independent Medical Reviews and develop tools for new medical surveys. Pursuant to an inter-agency agreement between DMHC and DHCS, approved September 2011, DMHC conducts medical surveys and audits to track the transition of SPDs from fee-for-service to managed care, a transition that is in progress. These surveys and audits review plans' operations and processes for the SPD population, including: 1) utilization management; 2) continuity of care; 3) availability and accessibility; 4) member rights; and, 5) quality management. This proposal seeks to develop these types of tools that would be specifically tailored to Medi-Cal managed care plans.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DMHC to present this proposal and to describe the consultancy services that are needed.

PANEL

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this item open to allow time for resolution on the Coordinated Care Initiative prior to approving resources to implement it.

ISSUE 2: PEDIATRIC DENTAL CARE – RESOURCES REQUEST

DMHC requests 3.0 positions and \$295,000 (special funds) for 2012-13 to address increased workload anticipated as a result of the Department's expansion of oversight of licensed dental managed care plans participating in Medi-Cal, as well as increased workload as a result of the proposed transition of children from the Healthy Families Program to Medi-Cal. DMHC also is requesting \$83,000 (special funds) for consultant services to develop audit guides and survey tools to use in medical audits of the dental plans.

BACKGROUND***Dental Managed Care***

DMHC is requesting 2.0 positions for planning, preparation and development of the tools and documents required to conduct annual financial audits and dental surveys, replacing the normal three-year audit/survey schedule. New annual audits and surveys of nine dental managed care plans are part of an expansion of DMHC's oversight of dental managed care plans that participate in Medi-Cal in Sacramento and Los Angeles. The consultant services being requested are to develop audit guides and survey tools for surveying dental plans. DMHC licenses all Medi-Cal dental managed care plans pursuant to the Knox Keen health Care Service Plan Act of 1975.

This request is in response to substantial recent media and legislative attention to very low utilization rates, poor service, and inadequate access to care in Sacramento County's Geographic Managed Care (GMC) pediatric dental Medi-Cal program. Sacramento is the only county in the state for which all children in Medi-Cal receive dental care through dental managed care plans and there is no fee-for-service option. Los Angeles County is the only other county that offers dental managed care, but it is optional along with fee-for-service. Dental care in Medi-Cal is provided only to children as the adult benefit was eliminated in the 2009 budget package. The problems with Sacramento's GMC pediatric dental program were discussed at the Subcommittee's hearing on April 30th, 2012 and the subcommittee approved of trailer bill language to address these problems.

Healthy Families Transition

The third position being requested is to address anticipated new workload to be generated in the DMHC's Help Center as a result of the proposed transition of all children in the Healthy Families Program to Medi-Cal. This Subcommittee heard the proposal to transition all children in the Healthy Families Program to Medi-Cal on April 16, 2012 and approved of transitioning to Medi-Cal just children up to 133 percent of the federal poverty level (comprising approximately 25 percent of the Healthy Families population).

DMHC is planning to submit a subsequent BCP to the Legislature, as part of the January 2013 proposed budget, to seek authorization to make these positions and resources permanent.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DMHC to present this proposal and to describe the consultancy services that are needed.

PANEL

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends approval of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL ESTIMATE

Governor's May Revision. The May Revision proposes total expenditures of \$59.7 billion (\$14.4 billion GF) for 2012-13 which represents an increase of \$12.8 billion (total funds), or 27.4 percent more than the current-year.

Medi-Cal caseload is projected to be 8,246,300, which represents a 7.9 percent increase compared to current year (and reflects the full transition of Healthy Families Program [HFP] children into Medi-Cal).

Medi-Cal 2012-13 Local Assistance Funding Summary (Dollars in Millions)				
	2011-12 Revised	2012-13 Proposed	Difference	Percent
Benefits	\$43,917.9	\$56,282.6	\$12,364.7	28.2%
County Administration (Eligibility)	\$2,630.1	\$3,072.0	\$441.9	16.8%
Fiscal Intermediaries (Claims Processing)	\$318.9	\$350.5	\$31.6	9.9%
LOCAL ASSISTANCE TOTAL	\$46,866.9	\$59,705.1	\$12,838.2	27.4
General Fund	\$15,460.9	\$14,406.6	-\$1,055.3	-6.8%
Federal Fund	\$28,663.0	\$36,242.0	\$7,579.0	26.4%
Other Funds	\$2,743.0	\$9,057.0	\$6,314.0	230.2%

LAO Comment. Based on its review of recent caseload data, the Legislative Analyst's Office (LAO) finds that the Administration's revised estimates of Medi-Cal caseload are reasonable. The majority of the caseload changes reflect lower caseload for families with children enrolled in Medi-Cal. On average, individuals who are included in these eligibility categories are some of the least expensive Medi-Cal beneficiaries.

BACKGROUND

The following are significant adjustments being proposed for the Medi-Cal budget:

Current Year Shortfall

The Medi-Cal program faces a Current Year (2011-12) budget shortfall of approximately \$760 million. The Administration will seek a supplemental appropriation to cover this shortfall.

Copayments

The May Revision proposes to increase GF expenditures by \$555 million due to an erosion of savings from mandatory copayments for Medi-Cal services, pursuant to AB 97 (Budget Committee), Chapter 3, Statutes of 2011 that were not implemented because the state did not receive federal CMS approval. Nevertheless, as part of the May Revision, DHCS intends to seek CMS approval for two of the copayments adopted in AB 97 last year, as follows:

- **Revised Non-Emergency ER Copay.** DHCS will seek CMS approval to implement a \$15 copayment for non-emergency use of the emergency room (ER). AB 97 implemented a mandatory copayment of up to \$50 for non-emergency room use of the ER, and therefore no new statutory changes are needed for this proposal. This copay would result in \$7.1 million GF savings in the budget year.
- **Pharmacy Copay.** DHCS will seek CMS approval to implement a copay of up to \$3.10 for non-preferred drugs. AB 97 implemented a mandatory copay of \$3 per prescription for preferred drugs and a \$5 per prescription for non-preferred drugs. This copay would result in \$13.1 million GF savings in the budget year.

The DHCS estimates that both of these copayments would be implemented January 1, 2013.

Hospital Quality Assurance Fee Adjustment

The May Revision reflects a shift of \$85.0 million in hospital quality assurance fee revenue from the Current Year to the Budget Year.

County COLA Suspension

The May Revision proposes GF savings of \$43.1 million by not providing a cost-of-living adjustment (COLA) to the counties for a savings of \$13.1 million and recognizing \$30 million General Fund (\$60 million total funds) savings as a result of the reconciliation of county administrative expenditures from prior years.

Federal Medicaid law requires a governmental entity to finalize *all* eligibility applications. In California, County Human Services Departments serve as surrogate for the State to perform this important function.

Two years following the end of the fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quality administrative claim, which is used by DHCS for its reconciliation process.

State statute provides that counties shall receive cost-of-doing business (COLA) increases annually and these increases are linked to performance standards in law. As in prior years when this COLA has been suspended, penalties related to performance standards are proposed to be suspended as well. The last COLA was provided in 2007-08.

ACA Payments to Primary Care Physicians

The ACA, as amended by Section 1202 of the Health Care and Reconciliation Act of 2010 (Public Law 111-152.) requires Medi-Cal to increase certain physician primary care service rates to no less than 100 percent of the Medicare rate for specific services beginning January 1, 2013 to December 31, 2014. This enhanced reimbursement applies to physicians with a primary specialty designation of family medicine, general internal medicine, and pediatric medicine.

For services furnished during this time period, the federal CMS provides for 100 percent federal funding for the differential between Medi-Cal baseline rates (the level of payment in effect on July 1, 2009) and Medicare rates. Regular federal matching applies for any payment amounts

above the minimum requirement or for any increases necessary to achieve the July 2009 rate. Some Medi-Cal rates are currently below 2009 levels, and therefore this proposal would result in a \$77.5 million cost to the GF in 2012-13.

After December 31, 2014, CMS will no longer provide 100 percent federal funding for the difference between the level of payment in effect on July 1, 2009 and 100 percent of the Medicare rate. Maintaining the higher levels of payments after December 31, 2014 will require additional GF dollars. Per the proposed trailer bill language, the incremental increase in payments will sunset on December 31, 2014.

Medi-Cal Provider Payment Reductions

The May Revision proposes to increase GF expenditures by \$174 million to reflect a change in the implementation date from March 1, 2012 to October 1, 2012, due to current court injunctions barring implementation of rate reductions.

AB 97 requires the Department to implement a 10 percent provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospitals, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* and *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities and pharmacy services. In compliance with these injunctions, the Department is prohibited from implementing these reductions.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing AB 97 payment reductions for nonemergency medical transportation providers.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment. In compliance with this injunction, the Department is prohibited from implementing these reductions. Appeals in all four cases have been filed.

On February 22, 2012, the United States Supreme Court issued its decision in the *Douglas v. Independent Living Center* Medi-Cal payment reductions cases. The 5/4 majority opinion vacated all of the Ninth Circuit decisions that were before it and remanded the cases to the Ninth Circuit Court of Appeals to reassess the plaintiffs' preemption/Supremacy Clause claims in light of the Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendments (SPA) at issue in a number of those cases. The Supreme Court also strongly indicated that, on remand, the Ninth Circuit should show deference to CMS decisions to approve the SPAs, noting that CMS approval "carries weight".

First 5 Commission

The budget proposes to use \$40 million in Proposition 10 Funds to fund Medi-Cal services for children (aged five and under) to offset GF support in the program for 2012-13.

The California Children and Families Program (known as First 5) was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions and 20 percent is allocated to the State Commission.

County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: (1) Family Functioning; (2) Child Development; and, (3) Child Health.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DHCS to provide an overview of the Medi-Cal estimate, caseload projections, and the key adjustments that are highlighted above.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends approval of the Medi-Cal estimate, including the key adjustments highlighted above. Conforming adjustments will be assumed as outstanding Medi-Cal proposals reach resolution in the final budget package. Staff also recommends approval of placeholder trailer bill to suspend the county COLA for eligibility administration, including a suspension of the penalties associated with performance standards.

ISSUE 2: NON-DESIGNATED PUBLIC HOSPITALS – REIMBURSEMENT METHODOLOGY

In order to achieve \$75 million in GF savings in 2012-13, DHCS proposes to change the reimbursement methodology for Non-Designated Public Hospitals (NDPH). Currently, NDPHs receive either the California Medical Assistance Commission (CMAC) negotiated per diem rates if they are a contract facility or cost-based reimbursement if they are a non-contract facility for hospital inpatient costs for services rendered to Medi-Cal fee-for-services (FFS) beneficiaries. In addition, qualified NDPHs also receive supplemental reimbursement under the Non-Designated Public Hospital Supplemental Fund. Their current reimbursement for both their FFS rates and the NDPH supplemental fund is paid with 50 percent federal financial participation (FFP) and 50 percent GF. Additionally, NDPHs receive other supplemental payments under the Non-Designated Public Hospital Intergovernmental Transfer Program established in 2011 by AB 113 (Monning), Chapter 20, Statutes of 2011.

Under this proposal, DHCS will seek approval of a State Plan Amendment (SPA) to change NDPH reimbursement instead to a Certified Public Expenditure (CPE) methodology. Under the CPE methodology, the NDPHs would no longer receive State General Fund, and instead would have to certify the cost of providing inpatient services to FFS Medi-Cal beneficiaries in order to receive as reimbursement the federal share of those expenditures (50 percent under the current FMAP). This is the same reimbursement methodology under which the Designated Public Hospitals (DPHs) are reimbursed. Under this proposal, because NDPHs would no longer be funded with GF, they therefore would be exempt from the Diagnosis-Related Group (DRG) payment methodology that will replace the current inpatient reimbursement methodology effective July 1, 2013.

Under this proposal, DHCS will also seek approval of an amendment to the 1115 Bridge To Reform (BTR) Waiver from CMS to increase Safety Net Care Pool (SNCP) Uncompensated Care and Delivery System Reform Incentive Pool (DSRIP) funding available to NDPHs. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve.

This proposal implements these reimbursement methodology changes as a requirement for NDPHs through the end of calendar year 2013, and conditions this new reimbursement methodology on voluntary certification of the participating hospitals as of January 1, 2014.

BACKGROUND

NDPHs are publicly owned and operated facilities, the majority of which are operated by health care districts. There are approximately 47 NDPHs and the majority of them are considered to be both small and rural. Approximately sixteen of the NDPHs are designated as Critical Access Hospitals (CAH) under Medicare. To be designated as a CAH, a hospital must be located in a rural area; provide 24-hour emergency services; have an average length-of-stay for its patients of 96 hours or less; be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital, and have no more than 25 beds.

Medi-Cal reimbursement for hospital services changed significantly in 2005 under California's 1115 Medicaid Waiver (Hospital/Uninsured Care Demonstration Project). The NDPH designation was created under the Waiver's implementing legislation, SB 1100 (Perata), Chapter 560, Statutes of 2005, which outlined the Medi-Cal reimbursement methodologies for three distinct categories of hospitals: Designated Public Hospitals (DPHs), Non-Designated Public Hospitals, and Private Hospitals. The same reimbursement structure was continued under the 2010 1115 Medicaid Waiver (Bridge to Reform) and its implementing legislation, AB 1066 (Pérez), Chapter 86, Statutes of 2011. As noted above, AB 113 instituted an additional supplemental payment for NDPHs, funded through intergovernmental transfers (IGTs) in 2011. NDPHs, as publicly owned and operated facilities, are able to provide the non-federal share of Medicaid expenditures. They currently fund non-federal share only through the IGTs for the AB 113 supplemental program.

The following table shows the Administration's assumptions about the impact this proposal would have on both the GF and the NDPHs:

<i>(Dollars In Millions)</i>	2012-13 Impact on GF	2012-13 Impact on NDPHs
Eliminate Current Methodology	(\$76.42)	(\$152.84)
Eliminate Current NDPH Supplemental Pool	(\$1.90)	(\$3.80)
Eliminate AB 113 IGT Supplemental Payment	\$3.32	(\$31.68)
Convert to CPE Methodology	-	\$100.00
New SNCP Uncompensated Care (FFP only)	-	\$30.00
New DSRIP (FFP only)	-	\$30.00
NDPH TOTAL	(\$75.00)	(\$28.32)

NDPHs are currently reimbursed with a combination of State General Fund (50 percent) and Federal Funds (50 percent). The table illustrates the fact that this proposal would eliminate the State General Fund (50 percent of their funding), which is proposed to be replaced with various sources of federal funds that require federal approvals yet to be secured. Moreover, the current combination of GF and Federal Funds reimburses NDPHs for Medi-Cal services. The federal funds proposed to be used to replace GF are not Medi-Cal funding sources; they are intended to cover the costs of uncompensated care. Finally, the primary source of replacement funding is in the form of certified public expenditures, which depends on federal approval of NDPH expenditures.

STAFF COMMENT / QUESTIONS

According to representatives of the NDPHs and state hospital associations, this proposal may be financially devastating to many of these hospitals and several NDPHs may close if this proposal is approved and implemented. The NDPHs are open to considering a change to this payment methodology, however making a change of this magnitude would require planning time of more than a few weeks. However, the administration indicates that their intent is that all federal approvals must be received in order for implementation of this proposal to proceed, and that they are working on changes to their proposed trailer bill to reflect this intent.

Furthermore, this proposal asks NDPHs to accept a fifty percent rate reduction with no guarantee of replacement funding, given the need for federal CMS approval of the funds proposed to replace State General Fund. Again, the administration intends for this to be

implemented only as a total package, not in individual pieces. Therefore, the General Fund rate reduction would not occur unless and until federal approval has been secured on proposed new federal funds.

Subcommittee staff has asked DHCS to present this proposal and respond to the following:

1. Please describe the anticipated time-line for implementation of this proposal, including securing necessary federal approvals.
2. Please describe how the proposed methodology is similar and/or different from the methodology used with Designated Public Hospitals.
3. Please describe the changes to trailer bill that are currently being worked on by DHCS.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as additional time is needed to await revised trailer bill and clarify certain aspects of the proposal.

ISSUE 3: DESIGNATED PUBLIC HOSPITALS – UNEXPENDED FEDERAL WAIVER FUNDS

In order to achieve \$100 million in GF savings in 2012-13, DHCS proposes to split federal waiver funds between the State and Designated Public Hospitals (DPHs).

BACKGROUND

The Bridge to Reform (BTR) Waiver includes federal funding available to counties for the Health Care Coverage Initiative (HCCI) component of the Low Income Health Program (LIHP) to provide coverage to uninsured individuals between 133 percent and 200 percent of the federal poverty limit. Based on existing statutory direction in Welfare & Institutions code 15916, the State has sought an amendment to the BTR Waiver to rollover unspent HCCI funding into the Safety Net Care Pool Uncompensated Care (SNCP) component. This proposal would result in \$100 million in GF savings in 2012-13.

This proposal allows the Designated Public Hospitals (DPHs) to voluntarily utilize their certified public expenditures (CPE) to claim the additional SNCP funding with specified conditions. As a condition of utilizing their CPE to claim the additional federal funding, this proposal requires that the DPHs allow the State to retain 50 percent of the federal funding attributable to the HCCI rollover. In addition, this proposal requires DPHs to allow the State to utilize their excess CPE, to the extent necessary for the State to achieve its designated GF savings of \$400 million.

STAFF COMMENT / QUESTIONS

According to hospital representatives, this proposal would undo an agreement between public and private hospitals and the state. The agreement held that \$200 million in left-over, unspent waiver funds would go to DPHs. Under this proposal, DPHs would receive \$100 million and the State would retain \$100 million.

Subcommittee staff has asked DHCS to present this proposal and explain the source of the funding being proposed to be split between the State and DPHs.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as additional time is needed to clarify certain aspects of the proposal.

ISSUE 4: PRIVATE HOSPITALS – HOSPITAL FEE REVENUE

This proposal would redirect \$150 million in hospital fee revenue in 2012-13 (currently intended to fund increased rates to managed care plans for them to increase payments to hospitals) to instead offset GF expenditures for providing health coverage to children. The increase would have funded supplemental payments to private hospitals by the managed care plans. The proposal would redirect an additional \$95 million in fee revenue in 2013-14 for GF benefit. Under current law, this funding would be provided to managed care plans (\$75 million would have supported supplemental payments to private hospital and \$20 million for supplemental payments to designated public hospitals). This proposal would also eliminate direct grants to designated public hospitals in 2013-14 and would instead use the funds for children's health coverage under Medi-Cal (\$21.5 million).

BACKGROUND

DHCS implemented California's first hospital provider fee and supplemental payment program for the period of April 1, 2009, through December 31, 2010. That program resulted in fee collections of \$3 billion, and hospital payments of \$5.7 billion. Fee revenue of \$560 million was retained by the state to pay for health care coverage for children. The program was initially extended for the additional six-month period of January 1 through June 30, 2011. The six-month program resulted in fee collection of \$1 billion, hospital payments of \$1.9 billion, and \$210 million in GF offsets to pay for health care coverage for children.

The most recent hospital fee legislation SB 335 (Hernandez and Steinberg) Chapter 286, Statutes of 2011 extended the fee program through December 31, 2013, and is projected to generate approximately \$7.1 billion in fees from hospitals during the program period. Approximately \$6.1 billion will be used to draw down an equal amount in additional federal funds in order to increase Medi-Cal payments to private hospitals and managed care plans. About \$920 million will be retained to offset GF costs to pay for health care coverage for children. SB 335 set up various hospital payments, including supplemental fee-for-service payments made directly to private hospitals, increased payments to managed health care plans for the purposes of providing supplemental payments to private and designated public hospitals, direct grants to designated and non-designated public hospitals, and funding for children's health care coverage.

STAFF COMMENT / QUESTIONS

The California Hospital Association (CHA) explains that the current 30-month fee program already contributes over \$1 billion to the State for GF relief. This proposal would take an additional \$150 million in 2012-13 and another \$75 million in 2013-14. The CHA states that although private hospitals will receive an additional \$5 billion as a result of the fee program, they also lose approximately \$4.6 billion annually on Medi-Cal patients. Therefore, they state that private hospitals' will lose \$11.5 billion during the 30-month time period of the fee, resulting in a net loss of \$6.5 billion.

Subcommittee staff has asked DHCS to present this proposal.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as additional time is needed to clarify certain aspects of the proposal.

ISSUE 5: SKILLED NURSING FACILITIES – RATES

In order to achieve \$56.6 million in GF savings in 2012-13, DHCS is proposing to delay payments under the Quality/Accountability Payment Program to Freestanding Skilled Nursing Facilities-level-B (FS/NF-B) and subacute care units (FSSA/NF-B), also known as AB1629 facilities, until April 2014. The proposal also authorizes the 2012-13 rate for a facility to be up to 1 percent below the rate on file May 31, 2011, and retains the 1 percent set aside of the weighted average Medi-Cal reimbursement rate for GF savings in the 2012-13 rate year.

For the 2012-13 rate year only, the savings from capping the professional liability insurance (PLI) at the 75th percentile is proposed to not be transferred to the Skilled Nursing Facility Quality and Accountability Special Fund, and instead will remain in the GF. The PLI and 1 percent set-aside are estimated to achieve \$23 million in savings.

Finally, this proposal rescinds language that authorizes, but does not require, a rate increase in 2012-13 up to the difference between 2.4 percent and the rate increase provided in 2011-12. This piece of the proposal is estimated to achieve \$33 million in General Fund Savings.

BACKGROUND

Established through AB 1629 in 2004 (as described below), skilled nursing facilities (SNFs) pay a Quality Assurance Fee (QAF) to the state, which enables the state to increase federal financial participation in the Medi-Cal program and increase rates to SNFs. The Legislature's goal in increasing rates to SNFs was to increase the quality of care to SNF patients through increased resources. The SNF QAF has undergone a complex legislative history, as follows:

- **AB 1629** (Frommer), Chapter 875, Statutes of 2004 changed the methodology for calculating reimbursement rates for freestanding SNF level-B and subacute units of those freestanding SNFs and allowed the Department of Health Care Services (DHCS) to assess a QAF to provide a revenue stream to fund the higher payments under the new reimbursement methodology. AB 1629 contains provisions, which negate the entire statute should DHCS cease to assess the QAF or cease to use the AB 1629 rate reimbursement methodology. AB 1629 delayed the AB 1075 requirement to implement a rate methodology from August 1, 2004, until August 1, 2005, and it allowed DHCS to implement the legislation via provider bulletin, avoiding a lengthy regulatory process.
- **AB 360** (Frommer), Chapter 508, Statutes of 2005 was a technical cleanup measure to AB 1629. AB 360 exempted pediatric subacute units and institutions for mental disease (IMDs) from the QAF and from the facility-specific rate methodology.

- **AB 203** (Committee on Budget), Chapter 188, Statutes of 2007 extended AB 1629's sunset provision for an additional year to July 31, 2009. This was necessary to allow DHCS to continue collecting the QAF and maintaining the facility-specific rate methodology. Further, AB 203 extended for one year the mandated report to the Legislature relative to SNF staffing levels, staffing retention, worker wages and benefits, state citations, and the extent to which SNF residents were able to return to the community.
- **AB 5 X4** (Evans), Chapter 5, Statutes of 2009-10 Fourth Extraordinary Session changed the allowable increase for the weighted average Medi-Cal reimbursement rates for the 2009-10 rate year from 5 percent to 0 percent over the weighted average Medi-Cal reimbursement rate in effect for 2008-09 fiscal year. AB 5 X4 mandated that Medicare revenues received for routine and ancillary services and Medicare revenue received for services provided to residents under a Medicare managed care plan be included in the calculation of the QAF for the 2009-10 rate year by amending the definition of net revenue to gross revenue, with the inclusion of Medicare revenues.
- **SB 853** (Arambula), Chapter 717, Statutes of 2010 extended the sunset provision by one year and mandated the following methodology changes: 1) lifted the rate freeze for the 2010-11 rate year; 2) issued a rate increase of up to 3.93 percent over the weighted average for the 2010-11 rate year; 3) authorized DHCS to trend revenue data forward using inflationary factors to increase the revenue base on which the QAF is calculated; 4) assessed the QAF on multilevel facilities; and, 5) established a quality and accountability supplemental payment system that allows DHCS to issue supplemental payments based upon quality measures.
- **AB 97** (Committee on Budget), Chapter 3, Statutes of 2011 implemented a 10 percent payment reduction to SNFs and other long-term care facilities effective June 1, 2011.
- **AB 19 X1** (Blumenfield), Chapter 4, Statutes of 2011-12 First Extraordinary Session extended the sunset provision by one year and mandated the following methodology changes: 1) provided a rate increase of no more than 2.4 percent in 2012-13 rate year (resulting from the difference between the 2.4 percent increase and the actual rate increase from the 2011-12 rate year); 2) terminated the 10 percent reductions on August 1, 2012, for AB 1629 SNFs; 3) held harmless facilities from rates that are less than their rate that was on file as of May 31, 2011; 4) provided a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction applied from June 1, 2011, to July 31, 2012, for Medi-Cal fee-for-service SNFs; 5) delayed until rate year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System (QASP) of 1 percent of the AB 1629 facilities reimbursement rate; and, 6) delayed implementation of the QASP for one year.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DHCS to present and explain this proposal.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as additional time is needed to clarify certain aspects of the proposal.

ISSUE 6: COMMUNITY BASED ADULT SERVICES – RESOURCES REQUEST

DHCS is requesting 5 new limited term positions and \$358,000 in 2012-13 and \$601,000 in 2013-14 to implement the new Community Based Adult Services (CBAS) program, which is replacing the Adult Day Health Care (ADHC) benefit in Medi-Cal, an optional benefit that was eliminated in the 2011 budget package. The Department of Aging is also requesting resources for the implementation of CBAS; specifically, their request is for 16 positions and \$3.264 million.

BACKGROUND

AB 1611 (Chapter 1066, statutes of 1977) established ADHC as a Medi-Cal community-based benefit that provided an array of therapeutic, social and health activities and services to frail older persons or adults with chronic medical, cognitive, or mental health conditions and/or disabilities. The program goal was to provide an alternative to institutionalization for individuals who were capable of living at home with the aid of appropriate health care and rehabilitative and social services. The majority of ADHC participants were Medi-Cal beneficiaries.

The ADHC program was administered under an interagency agreement by the DHCS, the single state agency for Medicaid (Medi-Cal), the California Department of Public Health (CDPH) and CDA. DHCS was responsible for the obtaining approval of the Medi-Cal state plan, setting rates, provider enrollment, provider payment, audits of payments and investigations of payment fraud and abuse. CDPH was responsible for licensing the ADHC centers and complaint investigations. CDA was responsible for certifying ADHC centers for participation in Medi-Cal, including initial certification of new centers, certification renewal of licensed centers; providing ongoing training and technical assistance to the centers; and recommending adverse actions against a center's certification for those centers that were substantially out-of-compliance with program requirements.

Given the significant state budget shortfall, AB 97 (the 2011 health budget trailer bill) eliminated the ADHC program as a Medi-Cal optional benefit. On July 1, 2011, the Center for Medicare and Medicaid Services (CMS) approved the DHCS state plan amendment to eliminate the ADHC program effective September 1, 2011.

In June 2011, seven ADHC participants filed a motion for preliminary injunction in federal court to stop the elimination of ADHC "unless and until adequate replacement services were in place," asserting that the elimination of the benefit would place them at risk of unnecessary institutionalization.

DHCS moved the ADHC program elimination date from September 1, 2011 to December 1, 2011, with a court hearing scheduled for November 17, 2011. The parties in the case reached a settlement prior to the court hearing and on January 24, 2012, the U.S. District Court (Northern District of California, San Francisco Division) formally approved the settlement agreement. This agreement allowed the elimination of the ADHC program as an optional Medicaid benefit on February 29, 2012 and required establishment of the CBAS program on March 1, 2012 (subsequently moved to April 1, 2012) to provide substantially similar services in outpatient facilities (CBAS centers) to seniors and adults with disabilities who met the eligibility criteria defined in the agreement. This proposal does not address all terms of the settlement

agreement or the waiver amendment, only those substantively relevant to this staff workload proposal and analysis.

Under CBAS, DHCS's, CDA's, and CDPH's roles remain similar to what they were for the ADHC program: DHCS, as the designated single state Medicaid agency, is responsible for obtaining approval of the Medi-Cal waiver, setting rates, contractor management and payment, enrollment of CBAS centers as Medi-Cal providers, and audits and investigations for fraud and abuse; CDA is responsible for certifying (and recertifying) the centers for participation in the Medi-Cal program and monitoring center compliance with CBAS standards, including staffing and service delivery requirements, quality assurance activities, training and technical assistance; and CDPH is responsible for facility licensure.

Role of CDA staff

The former CDA ADHC staff (now CBAS staff) will monitor the CBAS centers to ensure compliance and corrective actions. Essential certification activities include:

- Processing certification applications (new, renewals, and changes);
- Conducting on-site surveys at least every 24 months per statute;
- Issuing statements of deficiency and obtaining plans of correction;
- Providing on-going technical assistance and training as resources allow;
- Ongoing monitoring of centers for compliance; and,
- Taking adverse actions against providers that are substantially out of compliance.

These ongoing activities will continue to be critical as CBAS moves into a managed care environment to ensure that MCOs have a network of quality providers for their enrollees.

Role of DHCS staff

The role of DHCS staff will be to oversee the transition of ADHC to CBAS under the BTR waiver and to provide contract oversight and monitoring to MCOs. Essential activities will include:

- Instituting program improvement and performance expectations with CBAS providers;
- Ensuring appropriate utilization of CBAS center services;
- Overseeing and monitoring MCO contracts as they relate to CBAS services;
- Working with MCOs to provide enhanced case management to CBAS participants; and,
- Supporting performance measurement, enrollment and state hearing coordination to ensure MCO members receive medically necessary covered services.

Long-Term Care Division (LTCD)

Per the ADHC Settlement Agreement, the LTCD will oversee the transition of ADHC as a Medi-Cal Optional Benefit to Community-Based Adult Services (CBAS) under a Bridge To Reform (1115) waiver amendment, effective April 2012 and in Medi-Cal managed care counties, a benefit available in these counties only through enrollment in Medi-Cal managed care plans. LTCD will also oversee transition of ADHC to CBAS in non-managed care counties and Enhanced Case Management services offered to former ADHC recipients who do not meet the eligibility criteria for CBAS services. LTCD will work closely with the CDA to establish standards and performance measures of the CBAS Centers. CDA will continue to monitor and certify CBAS Centers. The LTCD's role is short term.

Medi-Cal Managed Care Division

Medi-Cal Managed Care Division (MMCD) serves as the contract oversight, monitoring, member assistance, contract processing, and federal liaison for managed care. Additionally, MMCD supports performance measurement, enrollment and state hearing coordination to ensure that members receive all medically necessary covered services. This process includes a thorough review of the material submitted; research of all applicable, contracts, laws, rules, and regulations; and working with internal and external parties to obtain information.

STAFF COMMENT / QUESTIONS

This proposal represents a net reduction in staff, as ADHC transitions to CBAS. Within the ADHC program, 28 limited-term positions are expiring; DHCS is requesting these 5 limited-term positions for CBAS.

Subcommittee staff has asked DHCS to present this proposal.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends approval of this proposal.

ISSUE 7: COUNTY MEDICAL SERVICES PROGRAM – GENERAL FUND LOAN TRAILER BILL

This trailer bill language would permit the Director of Finance to approve no more than \$100 million GF in cash flow loans in fiscal years 2012-13 and 2013-14 for County Medical Services Program (CMSP) Governing Board expenditures associated with a Low-Income Health Program operated by the CMSP Governing Board. Any cash flow loans made would be considered short term and would not constitute GF expenditures. The loans and their repayment would not affect the GF reserve.

BACKGROUND

The CMSP provides health care coverage to low-income adults who are ineligible for Medi-Cal in 34 counties, and, effective July 1, 2012, 35 counties. The CMSP Governing Board was established in 1995 and has overall program and fiscal responsibility for the program.

AB 342, (Pérez), Chapter 723, Statutes of 2010, established the Coverage Expansion and Enrollment Demonstration program, now known as the Low Income Health Program (LIHP), as part of the Section 1115 Bridge to Reform Waiver (Waiver). Counties, or a consortium of counties such as the CMSP Governing Board, may establish LIHPs in order to provide health care benefits to individuals ineligible for the Medi-Cal program with family incomes up to 200 percent of the federal poverty level. Program costs are shared equally between counties, or consortium of counties, and the federal government.

The CMSP Governing Board elected to administer a LIHP; however, due to the fiscal challenges its member counties currently face, it requires a loan to bridge the time between when it will be required to pay out its first claims and when federal funds will begin to flow back to the program. This proposal would allow the CMSP Governing Board, upon approval from the Director of Finance, access to a cash flow loan of no more than \$100 million over two fiscal years, 2012-13, and 2013-14, in order to ensure the Board's ability to maintain a financially solvent LIHP.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DHCS to present this proposal and explain the need for this proposed trailer bill.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as additional time is needed to clarify certain aspects of the proposal.

ISSUE 8: LOW-INCOME HEALTH PROGRAM – CAPITATION PAYMENT TRAILER BILL

Public hospitals are requesting trailer bill language to clarify that capitation rates for Low-Income Health Programs may be implemented for the current demonstration year, regardless of the date upon which they are approved by the federal government.

BACKGROUND

Public hospital systems are prepared to evolve their Low-Income Health Programs (LIHPs) from fee-for-service to risk-based programs using capitated rates – but a timing issue may prevent them from doing so. A change to current statute would ameliorate this issue.

State statute allows LIHPs to be reimbursed under a capitated model. It also requires an LIHP to agree to a capitated rate with DHCS during a given Demonstration Year (DY). That rate may then be implemented retroactively back to the first day of the DY, if it is agreed upon during the same DY.

DHCS, in consultation with a number of public hospital LIHPs, has proposed LIHP capitation rates for federal approval. There is some concern that federal approval of the proposed rates and subsequent agreement between the LIHP and DHCS will not be finalized before June 30, 2012, the end of the current DY. This would mean that these LIHPs would lose the ability to go capitated during the current DY resulting in a loss of significant federal reimbursement. This is especially concerning because the Program's have worked diligently to provide all of the necessary information to: both DHCS and CMS regarding the capitated rate model, and meet the many stringent requirements associated with capitated reimbursement during the current DY. Despite these efforts, workload demands at the state level have resulted in uncertainties about achieving an agreed upon rate by June 30, 2012.

A clarification to current statute would rectify this issue and ensure that public hospital LIHPs do not lose the ability to draw down federal reimbursement. This statutory amendment would allow the federally approved capitation rates to apply to DY 7 (July 1, 2011 through June 30, 2012), the current DY, regardless of their approval date. Therefore, public hospitals propose the following trailer bill language:

Proposed Amendment Language

The department, in consultation with a number of the Low-Income Health Programs (LIHPs), has proposed LIHP capitation rates for federal approval. However, federal approval of the proposed rates may not be received and implemented through contract amendments before June 30, 2012. This statutory amendment would allow the federally approved capitation rates to apply to the LIHP year (July 1, 2011 through June 30, 2012), even if federal approval and the necessary contract amendments are not finalized until after June 30, 2012. Therefore, it is the Legislature's intent in amending Section 15911(e) to allow the LIHP capitation rates to apply for FY 2011-2012, even if final agreements on the capitation rates are delayed while awaiting federal approval and are not finalized until after June 30, 2012.

Section 15911(e)

Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate., except that for the LIHP year ending June 30, 2012, the rate may apply as early as July 1, 2011 without regard to the date of the agreement between the participating entity and the department.

STAFF COMMENT / QUESTIONS

Subcommittee staff has asked DHCS to present and explain this proposal from public hospitals and to provide the department's perspective and disposition on the proposed language.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends approval of the proposed trailer bill.

ISSUE 9: JUVENILE INMATES (AB 396) CLEAN-UP TRAILER BILL

The Administration is requesting approval of technical clean-up trailer bill language of Welfare & Institutions (W&I) Code Section 14053.8 -- changes to the provisions of AB 396 (Mitchell), Chapter 394, Statutes of 2011. The Administration's goal is to reduce the potential impact to the State General Fund from AB 396. The language also includes technical, non-substantive changes to W&I Code Section 14053.9.

BACKGROUND

Prior to AB 396, county juvenile detainees were not eligible for Medi-Cal because they were juvenile inmates who, pursuant to Welfare and Institutions Code Section 14011.10, must be suspended and may not receive Medi-Cal benefits during the pendency of their suspension. As such, the counties were responsible for providing and paying for the medical services received by the county juvenile detainees whether the services were provided on or off the detention facilities. AB 396 requires that Medi-Cal eligibility not be denied to a county juvenile inmate who is an inpatient in a medical institution because of their status as an inmate of a public institution. AB 396 authorizes DHCS to develop a process for the counties to receive any available Federal Financial Participation for acute inpatient hospital services and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates admitted as inpatients into a medical institution off the grounds of the detention facilities. This process must be coordinated, to the extent possible, with the processes implemented in accordance with Welfare and Institutions (W & I) Code section 14053.7 and section 5072 of the Penal Code.

DHCS received communication from the federal CMS expressing concerns about this bill creating increased State General Fund costs. Therefore, DHCS strongly recommends the following amendments to AB 396:

Section 14053.8(a):

"...This subdivision shall not be construed to alter or abrogate any obligation of the state pursuant to an administrative action or a court order that is final and no longer subject to appeal to fund and reimburse counties for any medical services provided to a juvenile inmate."

The Administration states that the above language may lead to a potential for increased GF costs if the state is required to pay the nonfederal share of the medical services and related administrative expenses provided to county juvenile inmates pursuant to this bill. DHCS requests changes to reinforce the understanding that the county pays the costs upfront and receives reimbursement of FFP.

Section 14053.8(h)

According to DHCS, AB 396, as currently written, is not budget neutral and does not protect the State if the counties decide to shift to the State the burden of cost for providing medical services provided by the counties to their Medi-Cal eligible juvenile inmates. If a county elects to take a juvenile detainee off the grounds of the institution to a private hospital for acute inpatient hospital services and inpatient psychiatric services and elects to not pay for the services

provided, the State may be required to pay and cover the cost. Further, the State would not be allowed to retain the federal reimbursement.

Therefore, DHCS seeks to amend AB 396 to limit the counties from shifting the cost of providing medical services from the counties to the State especially while the counties retain the legal right to receive the federal reimbursement for the cost of services provided.

Section 14053.9(k & l)

Proposed amendments makes technical, non-substantive changes.

STAFF COMMENT / QUESTIONS

Prior to the passage of AB 396, DHCS worked closely with the author's office to include additional language that would protect the State General Fund from unintended costs of implementing the bill. However, that language was not incorporated before its passage; therefore, the author and the Administration agreed to pursue clean-up legislation during the next legislative session to ensure the enacted legislation would remain cost neutral to the State General Fund.

Subcommittee staff has asked DHCS to present this proposed trailer bill language and explain its necessity.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends approval of placeholder trailer bill to address the administration's concerns.

ISSUE 10: COORDINATED CARE INITIATIVE – MAY REVISE CHANGES

The Governor's January budget included a Coordinated Care Initiative (CCI) for Medi-Cal enrollees (the subject of the Subcommittee's hearing on March 7, 2012). With this initiative, the Administration intends to improve service delivery for the 1.1 million people eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 additional Medi-Cal enrollees who rely on long-term services and supports (LTSS). The May Revision proposes various changes to the CCI.

BACKGROUND

The May Revision proposes the following changes to the CCI:

- **Implementation date.** In response to stakeholder feedback that more time is needed to prepare for enrollment, the May Revision proposes to move the implementation date from January 1, 2013 to **March 1, 2013**. Enrollment will be phased in throughout the rest of 2013.
- **Demonstration Counties.** The number of counties proposed for demonstration implementation in 2013 has been reduced from ten to eight. The Administration has suspended work on launching the demonstration in Contra Costa and Sacramento counties for 2013, but intends to include those counties in the second year expansion.
- **Mandatory Medi-Cal Managed Care Enrollment.** The May Revision limits dual eligible mandatory enrollment in Medi-Cal managed care in 2013 to only the eight counties where the duals demonstration is implemented. Previously, the Coordinated Care Initiative proposed mandatory Medi-Cal managed care for wrap-around Medi-Cal services in all managed care counties in 2013. (This change was made in February, but the fiscal estimates have been updated in the May Revision to reflect this change).
- **Long-Term Supports and Services.** The May Revision indicates the Administration's intention to eventually transition In-Home Supportive Services collective bargaining from the local government level to the state.

The Administration indicates that the revised Medicare Shared Savings reflects a delay in the implementation date and a lower participation of Medicare enrollees (the January budget assumed 90 percent participation and the May Revision assumes 60 percent participation).

STAFF COMMENT / QUESTIONS

The Subcommittee has requested DHCS to explain the changes that have been made to this proposal since January and respond to the following questions:

1. Please provide an update on DHCS' discussions with CMS regarding this demonstration proposal, including any feedback from CMS on the federal/state sharing ratio of Medicare savings.
2. Please highlight some of the key discussion points and issues that have been raised during the stakeholder meetings.

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office

Staff Recommendation: Staff recommends holding this issue open as discussions about the overall proposal related to dual-eligibles, long-term care services integration, and managed care are on-going.
