

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

ASSEMBLYMEMBER GILBERT CEDILLO, CHAIR

MONDAY, MAY 6, 2002
STATE CAPITOL, ROOM 127
4:00 P.M.

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ITEM 0530 SECRETARY FOR CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY**ISSUE 1: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT – HIPAA - OVERSIGHT****BACKGROUND:**

The HIPAA was enacted in 1996. Its authors were Senators Kassebaum and Kennedy. HIPAA is designed to expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets. Also, it is to: combat waste in health care delivery; promote the use of medical savings accounts; improve access to long-term care services and coverage; and simplify the administration of health insurance. Within this context HIPAA includes a provision called Administrative Simplification, which is intended to improve the efficiency and effectiveness of the health care system by encouraging the development of standards for electronic transmission of certain health information. HIPAA also establishes privacy and security standards related to health information.

Through the adoption of national standards, the health care industry can realize cost-savings by reducing administrative duplication. The standards are developed according to the HIPAA legislation and are established by a rule being published in the National Register. There are nine rules regarding HIPAA (see accompanying chart); two are final, six are in draft and the enforcement rule is under development.

The Transaction and Code Sets was the first rule published in August 2000. Health care organizations were to have until October 16, 2002 to comply with its requirements. However, Congress passed and the President signed a one-year deadline extension to October 2003. The Transaction and Code Sets rule will apply to those covered entities that perform the following business functions: send or receive health care claims; pay health care services; send or receive eligibility inquiries; conduct provider referrals and service authorizations; perform health plan enrollment; and perform co-ordination of benefits activities. All public health and behavioral health programs will be effected.

Health care and medical information will have new code set standards and formats. There also are new rules for the receiving, distributing and retaining the information. HIPAA will eliminate the use of "local codes", codes that are not within the standard code sets. One major area of impact will be local codes for billing services, which are eliminated by HIPAA. These code sets include medical procedure, health care service, mental health services and administrative reporting codes. Many such codes are utilized to support programs with county, city and provider processes. New ways to track and report and report services will need to be developed for non-standard codes. If alternative reporting solutions are not developed, an entity's ability to administratively support some programs may be impaired. The Medi-Cal program will be required to change over 10,000 local codes to the national code sets. Complying with the national standards creates significant issues regarding medical and payment policy implications, rate of payment and special programs scope-of-service definitions.

The California Office of HIPAA Implementation (CalOHI) was created in 2001, Chapter 635, Statutes of 2001 (SB 456, Speier). The bill created the statutory framework for CalOHI within the Health and Human Services Agency. The Office was created to assume leadership of the state's HIPAA activities. CalOHI will work with county and city organizations to ensure co-

ordination, although it does not have oversight responsibilities for these entities. CalOHI has developed a standard set of definitions to support the tracking and reporting of state entity progress towards HIPAA compliance. The five step definitions are: Project Initiation; Initial Assessment; Project Plan; Detailed Assessment; and Implementation.

COMMENTS:

Please provide the Subcommittee with an overview the establishment of the California Office of HIPAA Implementation.

Please provide an overview of the status of implementation of HIPAA in the various affected state agencies.

What problems has the state encountered in its implementation efforts?

Please provide an overview of the state's transition to national codes.

HIPAA Rules	Issue of Proposed Rule	Anticipated Issue of Final Rule Date	Final Rule Issue Date	Testing Date	Implementation Date
Transactions & Code Sets	August 2000	---	October 2000	April 2003	October 2003
Security	August 1998	MARCH/April 2002	---	---	Anticipated for Summer 2004
Privacy	November 1999	December 2000	December 2000	---	April 2003
National Provider Identifiers	May 1998	On Hold	---	---	---
Enforcement	Late 2002	---	---	---	---
National Employer Identifier	06/16/1998	Feb/March 2002	---	---	---
National Health Plan Identifier	April/May 2002	---	---	---	---
First Report of Injury	Late 2002	---	---	---	---
Claims Attachments	March 2002	---	---	---	---

ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**ISSUE 1: OUTCOMES REPORTING****BACKGROUND:**

In 1991, the California Hospital Outcomes Project was created to study and report on the quality of care in individual hospitals. OSHPD is required to publish risk-adjusted outcome reports on medical, surgical, and obstetrical procedures and conditions selected with input from a Technical Advisory Committee.

Historically, OSHPD has contracted with the University of California to develop the risk-adjusted outcomes models and to produce valid reports from the data. Due to competing demands, UC did not produce the ongoing reports in a timely manner. In 1999-2000, OSHPD established four limited-term positions to provide analysts who could produce regular reports using the analytical framework established by UC for risk-adjusted outcomes studies. The 2001-2002 budget made these positions permanent.

The Office has produced a series of four outcomes reports on Acute Myocardial Infarction (heart attacks) and has reports on four additional conditions under development. A report on mortality following Coronary Artery Bypass Graft (CABG) surgery, using data submitted voluntarily by 79 hospitals, was issued in August 2001. Each year, approximately 27,000 Californians with advanced heart disease undergo a CABG in California. There are 118 hospitals that offer bypass surgery to adult patients. The CABG report provides comparative data on bypass surgery outcomes for California hospitals. This type of information is critical for hospital quality improvement efforts and for enabling patients and their families to make informed decisions about where to receive treatment. California is one of the few states that has taken on the challenge of developing risk-adjusted outcomes reports.

Chapter 898, Statutes of 2001, SB 680 (Figueroa), added several major provisions to OSHPD's outcomes reporting requirements. OSHPD is required to report CABG outcome reports beginning in 2004. In 2002 and 2003 the reports remain voluntary. In addition, OSHPD is required to report outcomes by surgeons as well as hospitals in 2004 and every other year thereafter. Also, OSHPD is given the authority to produce physician-level outcomes reports for other conditions/procedures. The Office is required to establish specialized Clinical Panels to review and approve newly developed, surgeon-level, risk-adjusted outcomes models. The Office is also given the authority to collect data necessary to produce CABG Reports.

The BCP seeks one-time and ongoing funding for OSHPD's Healthcare Quality and Analysis Division to complete additional hospital outcomes reports, add physician-level data to the reports; provide one-time funding for OSHPD's Healthcare Information Division to modify hospital, emergency department and ambulatory surgery center reporting systems to collect the primary language spoken by patients. The Office requires an augmentation of \$863,000 from the Hospital Data Planning Fund for the expansion of outcome reports and data collection.

COMMENTS:

OSHPD, briefly review your BCP funding request to implement SB 680.

ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 2: SEISMIC SAFETY EXTENSION**BACKGROUND:**

The Office of Statewide Health Planning and Development has responsibility to review and approve plans for hospital construction, including ensuring compliance with standards for hospital seismic safety. The Office has recently approved extensions of seismic safety compliance deadlines for four hospitals. SEIU is very concerned with the extensions because public notice was not given nor was an opportunity to comment afforded. SEIU wants hospitals to publicly justify why they are unable to comply with the 2008 compliance deadline. The union states that that it recognizes that rebuilding or retrofitting an entire hospital by 2008 may not be feasible in many instances.

The union requests the Subcommittee adopt two pieces of trailer bill language: a requirement that hospitals be required to justify why they are not reasonably able to comply with the law and need an extension; and a public notice with a public comment period within which the relevant documents will be made available for 30 days.

Rather than adopting the trailer bill language the Senate requested the Service Employee International Union (SEIU) and California Healthcare Association (CHA) get together and work out the issue. The Subcommittee asked

COMMENTS:

SEIU/CHA describe your agreement for the Subcommittee, please.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 1: MEDI-CAL DRUG PROGRAM****BACKGROUND:**

The proposed budget would save \$200.8 million, \$100.4 million General Fund through the enactment of several changes.

	(\$1,000)	
	Total Savings	General Fund
AIDS & Cancer Drugs Supplemental Rebates	-\$14,094	-\$7,047
Aged Rebate Disputes	-\$13,500	-\$6,750
Generic Drug Contracting	-\$53,455	-\$26,727
TCR* Atypical Antipsychotics	-\$29,535	-\$14,768
Enteral Nutrition Contracts	-\$18,138	-\$9,069
Enteral Nutrition Rate Reduction	-\$21,262	-\$10,631
Medical Supply Contracting	-\$17,920	-\$8,960
TCR* for Nonsteroidal Anti-inflammatory Drugs	-\$16,855	-\$8,427
Duration of Therapy Audits	-\$10,000	-\$5,000
Frequency of Billing Audits	-\$6,000	-\$3,000
Total	-\$200,759	-\$100,379
<small>*Therapeutic Category Review</small>		

1. STAFFING PROPOSAL

To achieve the new budget savings and maintain current supplemental rebate program, the Department of Health Services must increase its pharmacy staff, hire 16 and contract for four through the state's Fiscal Intermediary. There is a shortage of pharmacists in the state and the state's salary structure does not allow it to compete in the market for the pharmacists it needs to administer the program. The Department is seeking authority to contract with the Fiscal Intermediary for the pharmaceutical consultant staff necessary to administer the current program as well as the proposed changes to the program. The LAO has proposed that the Department modify its proposal and seek higher-level pharmacists positions.

COMMENTS:

Department please outline your need for additional staff to implement the expanded rebate efforts for the Subcommittee.

LAO, please describe for the Subcommittee your alternative staffing proposal.

Department, please respond to the LAO's proposal.

2. AIDS AND CANCER DRUGS – SUPPLEMENTAL REBATES

The Department expects to receive \$14.1 million, \$7 million General Fund savings from requiring a 10 percent rebate from AIDS and Cancer drug manufacturers on drugs that are automatically added to the Formulary. The automatic addition to the Formulary permits the state to gain the federally mandated rebate; it does not allow the state to get a supplemental rebate. The trailer bill language proposed by the state would require the 10 percent rebate. If a manufacturer doesn't agree to pay (through a signed contract with the Department) the rebate, all of the manufacturer's drugs, with the exception of the AIDS and cancer drugs, would be suspended from the List and therefore available only through the Treatment Authorization Request (TAR) process. Patients taking a suspended drug would be able to continue the drug without a TAR due to continuing care provisions in the proposed statute.

Pharmaceutical companies have raised opposition to the exclusion of all other products in their product line if they do not negotiate a rebate agreement with the state. One argument against the exclusion is if company "A" brings out a product that is cheaper than company "B's" and the company does not have negotiated agreement with the state, the savings that accrue from company "A's" drug would be denied the state for the lack of an agreement. The manufacturers maintain the "hammer", exclusion from participation for all non-AIDS and non-cancer drugs, is unnecessary because of the size of the market in California.

COMMENTS:

Department, please describe for the Subcommittee your rebate proposal.

Department, please respond to the concerns of the pharmaceutical manufacturers about having a fixed percentage in the statute.

Department, please address the issue of the so-called "hammer" over the manufacturers and the state's need for one to assure the requisite rebates are achieved.

3. AGED REBATE DISPUTES

The Department expects to collect \$13.5 million, \$6.8 million General Fund, in additional revenue from the resolution of additional aged rebate payment disputes. The state relies on the its Fiscal Intermediary to submit quarterly invoices to pharmaceutical manufacturers for the amount of fee-for-service drugs reimbursed by Medi-Cal during the quarter. The manufacturers utilize their rebate agreements to calculate the amount they owe Medi-Cal. If a manufacturer disagrees with the amount billed by Medi-Cal the manufacturer can dispute the amount. If the dispute is resolved in the favor of the Department the drug manufacturer must make an interest payment in addition to the disputed amount. The Department only needs the extra staffing, no trailer bill language, to achieve the savings.

COMMENTS:

Department please briefly review for the Subcommittee how the disputes are resolved.

4. GENERIC DRUG CONTRACTING

The Department expects to receive \$53.6 million, \$26.7 million General Fund, from contracting with manufacturers of generic drugs. The state does not now contract with generic drug manufacturers. According to the Department of Health Services multi-source drugs account for approximately twenty percent of the drug expenditures made by the state. Existing statute already gives the state the authority to contract with generic manufacturers. The State will, however, need to obtain an exemption from the CMS to exceed the federal upper limit of reimbursement levels.

COMMENTS:

Department, please outline for the Subcommittee the timing of obtaining the federal exemption for the contracting.

Department, how many manufacturers do you expect to be contracting with when the program is fully developed?

5. THERAPEUTIC CATEGORY REVIEWS FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS AND ATYPICAL ANTI-PSYCHOTICS

The budget proposes savings of \$16.8 million, \$8.4 million General Fund, from a therapeutic review of Non-steroidal Anti-inflammatory drugs and \$29.5 million, \$14.8 million General Fund, from Atypical Anti-psychotic drugs in the budget year. The savings will be achieved either by renegotiating contracts or by reviewing the cost effectiveness of all drugs of the through a Therapeutic Category Review.

The Atypical Anti-psychotics is the category of drugs for which Medi-Cal pays the most in terms of total expenditures, \$400 million. The fiscal estimate expects a 7.5 percent reduction in the costs of the negotiation process. The Non-Steroidal Anti-inflammatory savings are projected to ten percent.

COMMENTS:

Department please describe for the Subcommittee a Therapeutic Category Review and how it will provide budgetary savings for the state.

6. ENTERAL NUTRITION CONTACTS AND RATE REDUCTIONS

The Department expects to receive \$18.1 million, \$9.1 million General Fund, from enteral contracting. It projects \$21.3 million, \$10.6 million General Fund, reduction in costs from the shift from a fifty percent mark-up to a \$4.05 dispensing fee for enteral. Medi-Cal currently covers enteral formulae products through the TAR process. A TAR is approved if the enteral formulae product is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. In the one year period from October 1, 2000 through September 30, 2001, the expenditure for these products was approximately \$59.5 million TF. The reimbursement rate for these products is based on estimated acquisition cost plus a 50-percent mark-up.

DHS currently does not contract with manufacturers for rebates on enteral formulae products. New W&I Code section 14105.8 would establish a list of contract enteral formulae. This new section would also define those products that are currently considered benefits of the program (a description of the benefit does not currently exist in statute). New W&I Code Section 14132(bb) adds enteral formulae to the schedule of benefits under Medi-Cal. New W&I Code Section 14105.85 would change the reimbursement rate from a 50 percent markup to a dispensing fee. The dispensing fee would be equal to that used for prescription drug reimbursement (\$4.05 per claim).

The California Association of Medical Product Suppliers has raised two issues with the proposal:

- The effect of moving from a 50-percent markup to a pharmacy dispensing fee is significant and possibly detrimental to its member pharmacies ability to deliver the prescribed nutritional supplements; and
- The possibility that some Enteral formulae manufacturers have not submitted all of their products for classification, pediatric and protein supplements for persons with metabolic conditions, and, therefore may be excluded because they will not be on the approved list of Medi-Cal products. **NOTE:** The Department has stated that this is a technical problem and it will be addressed by the Department.

COMMENTS:

Department, please describe for the Subcommittee the reasoning and effect of moving from a reimbursement rate of 50 percent mark-up to the pharmacy dispensing fee.

Department, will all Enteral products currently approved for Medi-Cal beneficiaries by TARs be placed on the approved product list

7. MEDICAL SUPPLY CONTRACTING

The Department expects to reduce expenditures by \$17.9 million, \$8.96 million General Fund, by contracting for Blood Glucose test-strips. The state spends about \$56 million annually for the strips. The contracting would reduce the state's expenditures for test strips by 32 percent.

Medical supply claims constitute a significant percentage of the combined drug/medical supply expenditures. Expenditures are more than \$200 million annually; thirteen percent of the total from the drug/medical supplies item. Individual items need to be easily identifiable by manufacturer and product. The UPN (Universal Product Number) plays an essential role in the identification. The Department needs to make substantial changes to its claim processing system, therefore is starting contracting with medical supplies that can be identified with the UPN. Thus the Department is beginning with Blood Glucose test strips.

The Diabetes Coalition of California and the diabetes test strip manufacturers are opposed to the contracting by the Medi-Cal Program for test strips and monitors. The Diabetes Coalition and the manufacturers believe the Administration's proposal to contract for the strips could result in fewer choices for beneficiaries, for both strips and monitors. Availability of different types of systems are needed for people within the Medi-Cal population:

- Pregnant women with diabetes may have to "stick" themselves 8 to 10 times each day for blood samples and use a system that allows blood samples to be drawn from arms instead of fingertips.
- Certain monitors require a smaller blood sample and are utilized with babies, some of whom must be tested every 1 to 2 hours.
- Many people with visual impairments use monitors with verbal cues.
- Many children and people who are non-English speaking use monitors with icons.

The manufacturers believe the same level of savings can be achieved without limiting choice, by reducing utilization among Medi-Cal beneficiaries, which they believe is significantly higher than among the population as a whole. Also, they believe the state could reduce the state's reimbursement rate to the providers, which they believe is also higher than the national average. They suggest statutory language be adopted to limit the number of blood glucose strips that may be prescribed during a specific time period, similar to the limits set by Medicare.

COMMENTS:

Department, please describe for the Subcommittee, your discussions with the Diabetes Coalition of California and the diabetes test strip manufacturers and the status of their proposal to regulate the number of strips.

8. DURATION of THERAPY and FREQUENCY of BILLING AUDITS

The Department expects expenditures to decline by \$10 million, \$5 million General Fund, by limiting the duration of therapy audits. The Department also expects to save \$6 million, \$3 million General Fund, through frequency of billing audits.

Inappropriateness of drug utilization is controlled by two mechanisms. The first is Duration of Therapy where the use of a drug is limited to a set period and then the use of the drug is controlled through TARs (Treatment Authorization Requests). The audit process, prior authorization review, evaluates a drug for its appropriateness for chronic treatment. The other method, Frequency of Billing, controls utilization through limiting the number of claims and strength of a drug within a set time frame. There is an ongoing need to review and assess the appropriateness of the prevailing limitations on the utilization of drugs.

COMMENTS:

Department, please describe for the Subcommittee the impact on the TAR process of the audits.

OTHER TRAILER BILL PROVISIONS**9. ELIMINATION OF DRUG PROGRAM SUNSET PROVISIONS**

Various provisions in the W&I Code allow the Department to contract with drug manufacturers to obtain the most favorable drug prices for Medi-Cal and provide for an expedited process for Medi-Cal drug formulary changes. These provisions sunset January 1, 2003. Allowing these provisions to sunset would result in the loss of supplemental drug rebates and would require a lengthy regulatory process for changes to the drug formulary. The proposed changes to W&I code would eliminate the current sunset provisions and eliminate those sections that would become active upon the sunset occurring. The Legislature, through budget trailer bills, has extended the sunset provisions approximately every two years since the beginning of the supplemental rebate program in 1991. The most recent extension of the Medi-Cal drug rebate program was enacted in 2000, Chapter 93, Statutes of 2000 (AB 2877) for two additional years, to the current sunset of January 1, 2003.

Upon sunset, current law requires the Department return to the system in place prior to 1990 in which there was no drug contracting for additional rebates and each addition to the drug formulary required a change in regulations. Neither the Department or drug industry manufacturers would like to reinstate this regulatory process. Drug additions through this regulatory process take longer (18 months average compared to 6 to 9 months for the current process) and result in fewer new drug additions (4 to 5 new drug additions pre year in 1988 and 1989 compared to 20 to 30 new additions per year from 1996 on). Elimination (instead of extension) of the drug rebate sunset date avoids the necessity of repeatedly seeking reauthorization every year or two while maintaining the fiscal integrity of the program.

The pharmaceutical manufacturers believe the program sunset should be extended as it has been done the past.

COMMENTS:

Department, please describe for the Subcommittee the consequences of extending rather than eliminating the drug rebate program sunset.

10. CLEAN-UP OF CURRENT STATUTE

W&I Code Section 14105.37 has language that allows the Department to suspend or delete a drug from the List at the expiration of the contract term or when the contract between the Department and the manufacturer of that drug is terminated. Some drugs on the List were added without a contract and therefore no clear authority exists in current statute that allows the Department to remove such products. Addition of subdivision (h) to this section would allow the Department to suspend or delete products from the list that for which there has never been a contract.

W&I Code Section 14105.39, subdivision (c), contains obsolete language that provides for the immediate inclusion on the Medi-Cal drug formulary of any new drug designated by the FDA as having an "important therapeutic gain." The FDA stopped designating new drugs as having "an important therapeutic gain" in 1992, when the requirements changed to a priority review process. The presence of this language has caused confusion among drug manufacturers about the Department's process for adding new drugs to the Medi-Cal drug formulary. Retaining this obsolete language in State law will continue to cause confusion and controversy among a few drug manufacturers regarding automatic inclusion of new drug products on the Medi-Cal drug formulary. The controversy cannot be resolved by maintaining the status quo.

The repeal of the language gives control of the formulary to the Medi-Cal program. New drugs will not be added automatically to the formulary, the companies will have to negotiate a rebate to have them added. Secondly, it will allow Medi-Cal to keep unsafe drugs off the formulary.

On the issue of safety of some drugs, a recent NY Times article stated that approximately 10 percent of the new drugs introduced are not safe. If the language is not repealed Medi-Cal will not have the authority to exclude new drugs from the formulary if they are unsafe.

There is no direct fiscal impact association with either the addition of 14105.37(h) or the deletion of 14105.39(c).

COMMENTS:

Department, please provide the Subcommittee with a brief summary of the proposed clean up of the statute.

Department please discuss the safety aspect of the repeal of the Language in W&I Code Section 14105.39©.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 2: MEDI-CAL FRAUD

BACKGROUND:

The Department of Health Services has a total of 225 people involved in its Fraud and Abuse Prevention efforts. Personnel are on the staff in the following divisions: Medi-Cal Policy Division (9 positions); Payment Systems Division (59 positions); Medi-Cal Managed Care Division (20 positions); Medi-Cal Fraud Prevention Bureau (26 positions); Primary Care & Family Health (3 positions); Laboratory Field Services (10 positions); Office of Legal Services (27 positions); Office of Public Affairs (1 position); Information Technology Services Division (3 positions); Administration (9 positions); and Audits & Investigations (58 positions).

Fraud prevention is measured in two ways: savings; and cost avoidance. Savings are the result of an anti-fraud effort when providers already enrolled in the program are found to be engaging in fraud or abuse and their activities are stopped. Cost avoidance results when new providers are prevented from enrolling in the program when fraud is suspected. The Department also collects data on collections and receivables as part of its anti-fraud efforts. Collections and receivables are the collections made and receivables recorded by the DHS Payment Systems Division, Third Party Liability Branch due the Department from Department of Justice prosecutions and provider audits by Audits and Investigations and the State Controller’s Office. The main focus of the Department is on fraud prevention.

Savings and “Cost Avoidance” Resulting from Antifraud Activities
(Millions)*

	ACTUAL 2000-2001	PROJECTED 2001-2002	PROJECTED 2002-2003
SAVINGS	\$95	\$108	\$163
DOLLARS SAVED PER DOLLAR SPENT	3	4	6
COST AVOIDANCE	226	126	173
DOLLARS AVOIDED PER DOLLAR SPENT	9	4	6
TOTALS	\$321	\$234	\$336
DOLLARS SAVED AND AVOIDED PER DOLLAR SPENT	\$12	\$8	\$12

* Except for dollars saved and dollars avoided per \$1 spent

LAO Table

COMMENTS:

Department, please provide the Subcommittee with an overview of the Department's anti-fraud program. What are the current areas of focus of the antifraud efforts?

LAO, please describe your assessment of the success of the state's anti-fraud efforts.

LAO, please describe your proposal for an annual Supplemental Report on the Department's anti-fraud activities and the results of the activities.

The Department of Health Services shall report annually to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature on its antifraud activities that occurred in the prior fiscal year. The report shall include a description of each type of activity, the nature and quantity of actions taken as a result of each antifraud activity, the savings and cost avoidance associated with actions taken, and the overall cost-effectiveness of the resources allocated for antifraud activities. The report shall be due on or before December 1 of each year.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 3: MEDI-CAL ADMINISTRATION****BACKGROUND:**

During the current year the Legislature appropriated full funding for the county administration of the Medi-Cal program. The appropriation included an increase that was included in the May Revision of the 2001-2002 budget. The item was not vetoed nor reduced by the Governor when he signed the budget. In the late fall counties were advised the Administration was not going to allocate \$108 million of the appropriation, it reverted to the General Fund.

The counties conduct the enrollment and eligibility processing for the Medi-Cal Program. Funding is provided to the counties for: cost-of-doing business; policy changes; increases in the costs of goods and services; and staff training and development. Counties plan their budgets on the assumption the appropriated level of funding will be provided. The counties were/are forced to manage the Medi-Cal enrollment operations within the reduced budget. As a result of no notification to the counties or the Legislature, the County Welfare Directors are urging the Legislature to adopt trailer bill language to address the lack of notification. The proposed language would require notification by the Department of Health Services, or other appropriate agency, when it determines it will not allocate the full appropriation for Medi-Cal Administration in any fiscal year. The proposed language would not affect the Administration's ability to manage the state budget.

Counties feel they were denied an opportunity to bring their case to the Legislature for review and consideration. The CWDA contends this language is needed in order for counties to plan their budgets accordingly. Finding out late in the year that there is no intention to allocate baseline funds impedes the counties' ability to manage operations within the resources provided.

COMMENTS:

Department, please describe for the Subcommittee the process for providing how notice of non-allocation is provided to counties and the timing of issuing such notices.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 4: LONG-TERM CARE STAFFING AND REIMBURSEMENT****BACKGROUND:**

The Department of Health Services is requesting 55.5 positions to implement Chapter 684, Statutes of 2001, AB 1075 (Shelley). The Department is required to:

- Establish staff-to-patient ratios for direct caregivers by August 1, 2003; and
- A new facility specific Medi-Cal reimbursement system for freestanding and hospital based nursing facilities by August 1, 2004.

The Governor's Budget is proposing to add 55.5 positions at a cost of \$5.343 million, \$2.714 million General Fund and \$2.630 million Federal Funds.

Licensing and Certification Program – The program would receive 13.5 positions. The new responsibilities would include: development of the nursing ratio regulations over a two year period; verify one third of the nursing facilities each for the accuracy of the facility's' minimum data set (patient acuity data); verify compliance with the established minimum staffing ratio standards for 40 percent of the facilities; and develop the methodology for assessing the integrity of the Minimum Data Set.

Medical Care Services – The program would receive five positions. The responsibilities would include: development of cost and rate issues associated with the development of new nurse staffing standards; and facilitate the transition from a flat rate methodology to a facility specific reimbursement system.

Office of Legal Services – The program would receive two new two-year limited term positions. The responsibilities would include: legal support for the Medical Care Services as it undertakes the development and implementation of the facility specific reimbursement methodology in a highly litigious environment; and develop regulations that establish staff-to-patient ratios for direct caregivers in nursing facilities.

Audits and Investigations – The program would receive 35 positions. The positions would perform the audits of an increased number of facilities and to do an expanded audit of those selected for audit.

The Legislative Analyst Office recommended the deleting 11.5 positions from the request. Specifically, the LAO recommends deleting; 1.5 positions in the Licensing and Certification program; 3 positions in the Medical Care Services program; 2 in the Office of Legal Services program; and 5 in the Audits and Investigations program. The Department of Health Services agreed to modify its request by deleting 1.5 positions in the Licensing and Certification program and 5 in the Audit and Investigations program.

COMMENTS:

Department please provide the Subcommittee with an overview of the staffing request for implementation of nurse staffing ratios and facility specific reimbursement rates.

LAO, please provide the Subcommittee an overview of your analysis of the Department's proposal.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PROPOSITION 99**ISSUE 1: CHILDRENS TREATMENT PROGRAM****BACKGROUND:**

The Children's Treatment Program (CTP) is experiencing a funding shortfall in the current year and also is expected to have continuing fiscal problems in the budget year. In March, consideration was given to sending out notices to providers informing them that CTP would suspend payment of all claims beginning on April 1st. The providers and child health advocates who knew of the problem were concerned. A Section 86 request was not submitted.

At the last minute, a decision was made to continue paying CTP claims even though the program would probably run out of cash in June. As a result, June claims that could not be paid and the balance of incurred, but not yet paid claims for 02-03, were to be held until the budget year for payment. The carryover of debt plus a similar funding shortfall in the budget year would leave CTP facing an overall shortfall of approximately \$1.45 million. If that were to occur the program would have to suspend operations in December of 2002 unless additional revenues are obtained.

CTP needs an augmentation of \$750,000 in the current year and \$700,000 in the Budget Year. The augmentation would be to the Rural Health Services appropriation line item and be composed primarily of Physicians Account and Unallocated Account monies from the Prop 99 Tobacco Surtax Fund. The estimated need of \$700,000 in the budget year accounts for the offsetting impacts of declining Prop 99 revenues and the expected savings which will result from the CHDP/Healthy Families/MediCal streamlined eligibility initiative.

COMMENTS:

DHS and DOF can funds in the Rural Health Services Program be redirected to the Children's Treatment Program in the current year so the treatment program will continue uninterrupted?

DHS, what sort of an effect will the new CHDP/Medi-Cal/Healthy Families Gateway have on the caseload in the Children's Treatment Program? Why?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH**ISSUE 1: CHDP – INFORMATIONAL ONLY****UPDATE**

On April 3 Governor Davis announced the Department of Health Services would be utilizing the existing Child Health and Disability Prevention program to develop an Internet based enrollment system that will make CHDP an effective gateway to enroll more children into comprehensive health care through the Medi-Cal or the Healthy Families Programs. On April 30, before the May Revise, the DHS announced the commendable programmatic details on what the CHDP Gateway is, implementation plans and proposed timelines. The system will be implemented in the spring of 2003. The budget details will be released as part of the May Revise.

This announcement came after DHS held stakeholders workgroups in February and March to solicit input on a comprehensive plan to maximize the number of CHDP children who enroll in Medi-Cal or Healthy Families Program. Over 100 representatives of the stakeholders groups provided comments and recommendations that were valuable in assessing the role that CHDP plays in assuring that children in California have access to health care services. The input was instrumental in the DHS proposed restructuring of CHDP.

The CHDP GATEWAY

- I. **CHDP provider completes income verification and Internet or Point of Service Device application and transmits application.**
- II. **CHDP application serves as the enrollment process for CHDP and a pre-enrollment application for Healthy Families or Medi-Cal.**
 - A. Pre-enrollment application is sent to the Fiscal Intermediary
 - B. FI sends pre-enrollment application to MEDS for file clearance
 - C. If MEDS identifies the child as having had pre-enrollment within the CHDP periodicity schedule:
 1. No Pre-enrollment again until allowed under the periodicity schedule and CHDP service cannot be authorized
 - D. If child is currently on MEDS for the current month as limited scope:
 - E. Not eligible for pre-enrollment
 - F. Medi-Cal covers emergency services
 - G. State only CHDP covers screen, lab tests and immunizations
 - A. If child is not currently on MEDS or the Healthy Families Program and gross income is below 200% of federal poverty level:
 1. CHDP service provided, and:
 - a) Child is put on pre-enrollment Medi-Cal/Healthy Families and receives services through the Medi-Cal fee-for-service system.
 - b) Pre-enrollment sets termination date at end of 2nd month
 - c) Supplemental application sent to family
 - d) Federal claiming between Title XIX and Title XXI is done based upon the families gross income level and whether it meets Medi-Cal or Healthy Families income standards

If child is already enrolled in full scope Medi-Cal or Healthy Families, the provider is provided with the applicant's billing information.

If supplemental application is returned to Single Point of Entry (SPE):

1. SPE extends pre-enrollment period SPE screens and forwards application to County Welfare Department or Healthy Families Program
2. County Welfare Department or Healthy Families Program follow existing procedures for processing applications

H. If supplemental application is not returned:

1. DHS will check MEDS on 15th day of second pre-enrollment month to determine if pre-enrollment extended
2. DHS will send reminder letter to family
3. Pre-enrollment terminates on end of 2nd month

III. Parent does not want to apply for Healthy Families or Medi-Cal

- A. Pre-enrollment application sent to MEDS for file clearance
- B. If child is currently on HFP or no-cost full scope Medi-Cal:
 1. Child is not put on pre-enrollment
- C. If child is not currently on HFP or no-cost Medi-Cal:
 1. Pre-enrollment activated for month of application plus one month
 2. Pre-application may be submitted annually or upon CHDP periodicity, whichever is sooner
- D. If child is on MEDS for the current month as limited scope:
 1. State only CHDP service covered
 2. Child not eligible for pre-enrollment
- E. Family is not sent supplemental application.

Department of Health Services

04/30/02

Complementary Expansion

The California WIC Association and the Children’s Partnership are proposing that WIC be a gateway to Medi-Cal and Healthy Families just as is proposed for CHDP. The groups are advocating the simultaneous development of the Internet-based system to minimize development costs. The proponents state that only nominal information system changes would need to be made to handle such things as different income bases used for eligibility.

Request of WIC Association and Children's Partnership

- Build WIC and CHDP express enrollment computer systems simultaneously, not sequentially
- Utilize WIC staff in information system planning
- Make WIC/CHDP health access a priority for WIC Branch leadership and staff, by establishing a DHS Work Group and requiring the completion of a feasibility report in three months; and
- Seek federal, state or private funds to provide compensation local WIC staff to perform the outreach and enrollment steps necessary to complete the express enrollment of infants and children in Medi-Cal and Healthy Families.

COMMENTS:

Department, please summarize for the Subcommittee, the proposed CHDP Gateway to the Medi-Cal and Healthy Families Programs.

Why did the Department utilize the Breast and Cervical Cancer model for the enrollment rather than Health-e-App?

Department, can WIC funds be used for the development of the Gateway and to perform the enrollment and outreach functions for the children who are in the WIC program?