

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

Assemblymember Mervyn Dymally, Chair

MONDAY, APRIL 12, 2004
STATE CAPITOL, ROOM 444
4:00 PM

ITEMS TO BE HEARD

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES –PUBLIC HEALTH**ISSUE 1: GENETICALLY HANDICAPPED PERSONS PROGRAM****BACKGROUND:**

Genetically Handicapped Persons Program (GHPP) provides health coverage for Californians 21 years of age and older who have specific genetic diseases including cystic fibrosis, hemophilia, sickle cell disease, and certain neurological and metabolic diseases. GHPP also serves children under the age of 21 with GHPP-eligible medical conditions who are not financially eligible for California Children Services. The program also provides all medically necessary health care, including dental, to persons enrolled in GHPP. GHPP pays for the health care after all other insurance sources, private as well as public, are exhausted. The funding for the payment of health care services provided in the program is General Fund.

Although there are no maximum income eligibility requirements, families with adjusted gross income (AGI) exceeding 200 percent of the federal income guidelines pay an enrollment fee toward treatment costs. This cost is based on a sliding fee scale for family size and income. The Department collected \$198,000 in the 2002-2003 fiscal year and projects that it will receive \$200,000 in the 2004-2005 fiscal year.

The Administration's proposal would: cap the enrollment in the program; reduce provider rates by an additional 10 percent; and impose a co-payment for the program.

Cap on Enrollment

The budget proposes to limit enrollment in the program to what it had attained as of January 1, 2004. Enrollment in the state only GHPP was projected to be 842 as of January 1, 2004 and that on average three persons per month would be on the waiting list. The Administration's waiting list was on a first-come first-serve basis and did not include a modifier such as a medical necessity prioritization. The Department projected a savings of \$245,000 in the fiscal year 2003-2004 and \$194,000 in the budget year.

The consequences to those who would be on the waiting list could be grievous and/or death. The alternative would be to seek care through the county indigent program if the person could qualify.

Provider Rate Reduction

The Administration proposed a 10 percent provider rate reduction for the Budget Year. It is in addition to the five percent reduction that was enacted for the 2003-2004 budget. The five percent reduction is in effect for the GHPP program because it is state only and not affected by the injunction that was gained for the Medi-Cal Program. The five percent rate reduction will reduce General Fund expenditures by \$2.172 million in the Budget Year. The 10 percent rate reduction is projected to save the program an additional \$4.344 million in the Budget Year.

Co-Payment

The budget proposes to impose a co-payment for services provided by the program. The proposed co-payment is \$10 and the Department projects it will save \$576,000 in the Budget Year. The beneficiary will make the co-payment to the provider and the state will reduce the provider's reimbursement by the amount. If the provider doesn't collect the co-payment from the

beneficiary the co-payment serves as another provider rate reduction. No other details on the co-payment were provided.

Pharmaceutical Rebates and Program Cost Control

The 2002-2003 budget gave the Department of Health Services the authority to receive rebates from pharmaceutical manufacturers for the GHPP program. The November estimate for the 2002-2003 budget estimated that the state would receive \$6.426 million in rebates in the 2002-2003 fiscal year. The Department of Health Services states the state was eligible for rebates from pharmaceutical manufacturers of \$4.231 million for the 2002-2003 budget year, \$2 million less than projected in the November estimate. Payments of \$287,800 have been paid and the remaining balance is \$3.943 million (See table below). A firm schedule for the payment of the rebates has not, as of yet, been established by the Department.

Manufacturer	Total Due	Amount Paid	Balanced Due GHPP
Alpha Therapeutic	\$155,818	\$154,693	\$1,125
American Red Cross	\$168,949	\$128,954	\$39,994
Aventis	\$220,320	0	\$220,319
Baxter	\$2,541,362	0	\$2,541,361
Bayer	\$263,699	0	\$263,698
Genetics Institute	\$382,447	0	\$382,447
Nabi	\$4,175	\$4,174	0
Novo Nordisk	\$494,507	0	\$494,507
TOTAL (Rounded)	\$4,231,277	\$287,821	\$3,943,456

The 2003-2004 budget expanded the Department's authority to contract with pharmaceutical manufacturers. For the 2003-2004 fiscal year the Department projected \$7.426 million in rebates. The Department states that rebates due from the 1st quarter of the fiscal year was \$1.072 million and that rebates paid in the 1st quarter were \$520,600. The November estimate for the 2003-2004 projects \$0 in savings from rebates. The 2004-2005 budget year indicates the Department projects only receiving \$1.5 million from contracting with pharmaceutical manufacturers, \$6.0 million less than was projected for the 2003-2004 budget year.

In addition, the Department was provided additional staffing to achieve savings in the program. The Department was not allowed to hire the staff because of the hiring freeze and was, therefore, unable to achieve the projected results. The cumulative losses in contracting and cost controls greatly exceed the savings from the cap on enrollment.

COMMENTS:

Department of Health Services, please describe how the enrollment cap on the GHPP program would operate and what costs the Department would incur as a result.

LAO, what is your assessment of enrollment caps and the costs they may impose on the budget?

Department Of Health Services, please comment on the following Trailer Bill Language adopted by the Senate.

Proposed Trailer Bill Language—Establish Special Fund for GHPP and CCS Rebates.
Add new section to Health and Safety Code (suggest 120956).

The Children's Medical Services Rebate Fund is hereby created as a special fund in the State Treasury. All rebates for the delivery of health care, medical supplies, pharmaceuticals, including blood replacement products, and equipment for clients enrolled in the state funded and California Children's Services and interest earned shall be deposited in the Children's Medical Services Fund exclusively to cover costs related to services, and their administration, provided through the Genetically Handicapped Person Program and California Children's Services and shall be continuously available for expenditure by the Department of Health Services unless appropriated by the Legislature. Funds deposited in this account shall be treated as revenue and shall be accounted for on a cash basis.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –PUBLIC HEALTH**ISSUE 2: CALIFORNIA CHILDREN SERVICES****BACKGROUND:**

The Administration's budget proposes to cap enrollment in the California Children's Services Program (CCS) as of January 1, 2004. The capped enrollment was projected to 37,594 and the waiting list at the end of the 2004-2005 fiscal year was projected to be 1,512. The projected savings for the 2003-2004 budget year were \$121,000 General Fund, \$121,000 County Funds and for the 2004-2005 budget the savings were projected to be \$1.895 million General Fund and \$1.895 County Funds.

The LAO recommends the rejection of the proposed cap on the CCS program as it would create an inequitable situation in which CCS children with intensive medical needs would lack coverage while children needing only routine care would have coverage.

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

The 2003-2004 budget estimated the state would be able to receive millions in savings if staff were hired to conduct contracting for the CCS and GHPP programs. The budget year hiring freeze affected the CCS program much the same way as it did the GHPP. As a consequence the \$2.6 million program budget savings and manufacturers rebates anticipated in the 2003-2004 budget were not achieved. The 2004-2005 budget does not project any savings from contracting in the CCS Program.

COMMENTS:

Department of Health Services, please describe how the cap on the program would have worked.

Department of Health Services, why doesn't the proposed budget contain any contract savings for budget year 2004-2005?

Department of Finance. When will the freeze exemptions be granted to the Department so the program savings associated with the positions can be achieved?

Utilize the special fund adopted for GHPP for CCS Conforms with the Senate. Conforms with the Senate

Appropriate \$2.5 million General Fund from the implementation of contracting and cost efficiencies that were anticipated in the 2003-2004 budget when it was enacted. Conforms with the Senate.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –PUBLIC HEALTH

ISSUE 3: FACTOR REIMBURSEMENT METHODOLOGY

BACKGROUND:

The reimbursement methodology for factor was amended as part of the 2003-2004 budget adopted by the Assembly. Patients with hemophilia require treatment with special "blood factor" concentrates to prevent and manage internal bleeding episodes. The factor concentrates are medications that are made through purification of plasma proteins or through a process of genetic engineering. The blood factor products are clinically complex and are not interchangeable. The formula in place was "average acquisition cost plus 1 percent ". The methodology was amended into the Assembly Budget after negotiations between the vendors and the Department of Health Services. The new reimbursement methodology was "average selling price plus 20 percent", it is scheduled to be implemented on June 1, 2004. Exempting blood factor reimbursements from the five percent provider rate reductions would increase expenditures by \$4.949 million. Provider reimbursement totals \$155.33 million for Medi-Cal, CCS and GHPP.

The Assembly did not adopt the health care provider rate reduction proposed by the Administration. The budget savings were to be confined to the new reimbursement methodology. When the budget bill came to the Assembly from the Senate it contained a five percent rate reduction and the factor distributors had both a new rate methodology and a provider rate reduction.

COMMENTS:

Department of Health Services, please describe the new reimbursement methodology for factor suppliers?

Department of Health Services, please describe how the 5 percent rate reduction interacts with the new reimbursement methodology.

Department of Health Services, please provide the Subcommittee your assessment of the effect of further reducing provider reimbursement rates by 10 percent.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –PUBLIC HEALTH**ISSUE 4: COMMUNITY CHALLENGE GRANTS****BACKGROUND:**

The Community Challenge Grant Program (CCG) was one of the four components of the Partners Responsible Parenting Initiative established in 1996. The budget proposal for 2004-2005 would eliminate funding for the program.

The Partnership for Responsible Parenting was established to break the cycle of teen and unwanted pregnancy and to address issues of statutory rape and absent fathers.

- Every year, nearly 59,000 babies are born to teens in California. The babies are more likely to have low birth weights and health complications. 134 Community Challenge Grant projects and more than 1,500 community groups work to reduce teen pregnancy.
- One-in-three babies are born to unwed mothers. Among teen-agers that figure rises to two-out-of-three children. In many of the cases the father is absent from the life of the child. 25 projects statewide help young men play a positive role in reducing teen pregnancy.
- Statistics show that 26 percent of minors become pregnant as a result of statutory rape. Seventy percent of defendants are older than 20 and 61 percent of the victims are 15 years or younger. Statutory rape vertical prosecution programs have been established in 55 counties.

CCG brings together local groups and the state to respond to the challenge of teenage pregnancy. The major goals of the program were to:

- Reduce the number of teen-age and unwed pregnancies;
- Reduce the number of children growing up in homes without fathers as a result of these pregnancies; and
- Promote responsible parenting and the involvement of the father.

The CCG program targets specific population groups. The local programs are not limited to only those populations specified by the program. The target populations are: pre-sexually active adolescents; sexually active adolescents; pregnant and parenting teens; parents and families of adults at risk for unwed motherhood or absentee fatherhood.

The mission of the Community Challenge Grant Program is to:

- Raise public awareness about and involvement in solutions to the problem;
- Identify and support local community solutions; and
- Less frequently now, send a strong message to adult men that having sex with girls under 18 is a crime that will be prosecuted.

COMMENTS:

Department of Health Service's, please provide a brief funding history of the Community Challenge Grant Program.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –PUBLIC HEALTH**ISSUE 5: PROPOSITION 99****BACKGROUND:**

The Administration's budget proposes to cap the Enrollment in the Healthy Families program. The state needs \$32.6 million for the state share to fully fund the program

The funding for the state's share would come from: programs in Proposition 99. They include: \$6.756 million from Expanded Access to Primary Care; \$22.324 million from California Healthcare for Indigents Program – Uncompensated Hospital Emergency Services; \$2.479 million from Rural Health Services – Uncompensated Hospital Emergency Services; and \$1 million from improved collections resulting from anti-bootlegging efforts.

Proposition 99 increased taxes on tobacco products by \$.25 per pack. It was enacted in 1988. The programs that are funded by Proposition 99 are: tobacco education and tobacco use prevention, tobacco-related disease research, environmental protection and recreational resource enhancement programs and health care services for low-income, uninsured Californians.

The collections from the tax have declined over time. As the price of tobacco products has increased, the consumption has declined. In addition to the \$.25 per pack increase from Proposition 99, the prices have increased because of the Proposition 10 increase of \$.50 per pack, the \$.02 per pack increase for Breast Cancer and the \$.45 per pack increase from the manufacturers to fund the Master Tax Settlement agreement. Many programs funded by Proposition 99 have been forced to retrench over the years. Several programs, however, are protected from the declines in revenue from Proposition 99, leaving other programs to absorb the decline in revenues.

Funding for clinics and emergency room physicians in 2004-2005 will be robust. A coalition of health care provider organizations, including clinics and emergency room doctors are putting an initiative on the November 2004 ballot. The initiative would impose a tax on 911 telephone service, it is projected to raise \$550 million in annual revenues. The funding would be dedicated and outside the budget process. Additionally, the initiative also would permanently dedicate \$32 million from Proposition 99 to its purposes.

The proposed budget for 2004-2005 will reimburse clinics approximately a net of \$100 million in Medi-Cal reimbursements in the budget year. Much of the reimbursement is for expansion of services in prior years. In addition, clinics will receive an inflation increase in their reimbursements from the Medi-Cal clinic prospective payment system.

In addition, many, but not all, counties could tap into unspent Emergency Medical Services (EMS) funds to reimburse for uncompensated care in emergency rooms. The funds come from penalties collected on fines and bail forfeitures for certain criminal offenses and motor vehicle violations. The most recent fund statement available (2001-2002) indicates that counties had more than \$48 million in funds carried over from prior years that could be used for uncompensated care in emergency rooms.

Legislation was adopted in 2003 would enable greater access to the unspent EMS funds. Prior to the passage of Chapter 707, Statutes of 2003 (SB 476), Florez) physicians were only reimbursed up to 50 percent of their losses from providing uncompensated medical care. Now, physicians and surgeons could be reimbursed more, later in the fiscal year. Under Chapter 707, counties are required to disburse any EMS Funds remaining at the end of the fiscal year (in excess of their reserve) to physicians and surgeons that submitted claims.

COMMENTS:

LAO, please provide the Subcommittee a brief overview of "The 911 Emergency Trauma Care Act".

LAO, please provide a history of the EMS Fund and the fund condition statement.

Legislative Analyst, please outline for the Subcommittee the Medi-Cal funding for clinics in the Budget Year.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – FINANCE LETTER**ISSUE 1: GENETIC DISEASE BRANCH STAFFING****BACKGROUND:**

The Administration has proposed increasing expenditures from the Genetic Disease Testing Fund for staffing to address a backlog and on-going workload in fee collections and customer service. Expenditures would increase by \$394,000 from the Genetic Disease Testing Fund to hire seven staff, three permanent and four part-time, over the last few years the program has lost 35 positions. The Department projects the increase revenues from the fee collections will cover the operating costs and help assure the repayment of a General Fund loans issued to the Genetic disease Branch. It is expected that the positions will increase collections of program test revenue by approximately \$600,000 to \$1.0 million per year.

The Genetic Disease Branch (GDB) administers two statewide screening programs: the Newborn Screening Program (NBS) and the Alpha Fetoprotein Screening Program (AFP). The NBS screens all newborns for a series of heritable preventable metabolic disorders and the AFP which screens pregnant women for neural tube defects and chromosomal abnormalities. All screening is fee supported, NBS fees are collected from hospitals, birthing centers and Medi-Cal. AFP fees are collected from pregnant women and/or their third party coverage. The Genetic Disease Branch administers approximately 920,000 NBS and AFP test annually, each which requires a fee collection. Approximately \$65 million in fees is collected annually.

One time changes in the NBS fee collection authority, staff reductions in the last couple of years and an increased complexity of fee collections have led to the Genetic Disease Branch's inability to be timely in billing and collecting fees and respond to public inquiries. The current backlog of uncollected bills is 250,000 and 6,000 unresolved calls. Unless the Department receives additional resources, the backlog will grow every month as the testing continues.

The monthly volume of work to be performed (payments, insurance billings insurance claims processing, returned bills, etc) is 28,000 items and 14,000 billing-related telephone calls are received. Of the volume, all current staff process, on average 12,800 items and resolves 8,000 calls per month. On average, each staff processes 2,560 items and 1,600 telephone calls per month. With 7 staff in addition to the current staff, GDB will be able to process 30,720 items and 19,200 phone calls each month. This will allow GDB to handle the current workload and eliminate the backlog of telephone calls in two months, at which time 3 staff can be reassigned to handling new items. That will result in GDB being able to process 38,400 items each month 10,400 more than the number of incoming items. $250,000/10,400 = 24$ months. The 7 positions will bring GDB up to date in 2 years.

COMMENTS:

Department of Health Services, please outline for the Subcommittee how the backlog will be addressed and what percentage of the backlog will be addressed on a monthly basis.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – FINANCE LETTER**ISSUE 2: INFANT BOTULISM****BACKGROUND:**

The Administration is proposing to increase expenditures from the Botulism Immune Globulin Fund by \$3.785 million. Also, the proposal would increase position authority by 4.0 positions to establish the Infant Botulism Program and initiate the next vaccine production cycle under the recently acquired federal licensure for BabyBIG, the Department of Health Services vaccine for infant botulism. Trailer Bill Language establishes the program and authorizes full production of the vaccine. Finally, the proposal would provide a loan of \$500,000 to the Department from the Health Statistics Special Fund for initiation of full-scale production. The loan is to be repaid by June 30, 2007 by revenues collected from vaccine sales nationwide.

Botulism is the paralyzing disease caused by botulinum toxin, the most paralyzing substance known. Infant botulism occurs when the botulism bacteria temporarily colonize and produce toxin in the baby's intestine and is the most common form of human botulism in the United States. BabyBIG is the DHS –Sponsored Orphan Drug that treats infant botulism by neutralizing botulinum toxin, preventing paralysis. BabyBIG is the only antidote available for infant botulism in the world because the horse-derived botulinum antitoxin used to treat adults with botulism is unsafe for infants because of its high incidence of serious side-effects, such as allergic shock and kidney damage. On October 23, 2003 the U.S. Food and Drug Association issued a license to the Department of Health Services for the Orphan Drug Botulism Immune Globulin Intravenous (Human) under the registered name of BabyBIG. The Department is now authorized to charge the full fee for BabyBIG.

Without treatment, affected infants spend weeks to months in the hospital, much of that time in intensive care. Approximately 100 cases of infant botulism occur in the United States each year. Since 1998, about one-third of all US cases of infant botulism occur in California. At present, about 75-80 US infant botulism cases are treated with BabyBIG each year. With the achievement of licensure, utilization of the medicine is expected to increase as awareness of it spreads.

The current supply of Lot 2 of BabyBIG is low and will be used up in calendar 2004. Lot 3 of BabyBIG is scheduled to start manufacturing in 2004. The manufacturing process of the treatment takes approximately one year. It is projected that production costs in the 2003-2004 fiscal year of Lot 3 will be \$800,000 and revenues will be \$1 million (44 cases X \$22,900 fee per case). For 2004-2005 the program costs will be \$3.8 million and fee revenue will be \$3.2 million (71 cases X \$45,300 fee per case).

COMMENTS:

Department of Health Services, please outline for the Subcommittee when the program will be earning enough to pay off its loans.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – FINANCE LETTER**ISSUE 3: ADULT INFLUENZA VACCINE PURCHASE****BACKGROUND:**

The Finance Letter would authorize an augmentation in funding, \$2.527 million, for the purchase of influenza vaccine by the Department Health Services. The demand for vaccine has increased over the last few years and the price of the vaccine increased commensurately. It is expected that the next flu season will be severe and that prices for the vaccine will increase significantly. The increased appropriation is to provide the Department the ability to maintain a purchase level of 700,000 vaccine doses for elderly and vulnerable populations in California. The Department estimates the cost per dose will \$9.11 and the budget need at \$6.377 million. The appropriation included in the budget bill is \$3.850 million, requiring an augmentation of \$2.527 million.

COMMENTS:

Department of Health Services, please outline for the Subcommittee why the vaccine needs to be purchased in the Spring.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – FINANCE LETTER**ISSUE 4: CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP)
GATEWAY****BACKGROUND:**

The Finance Letter proposes to make 2.5 limited term positions permanent at a cost of \$104,000 General Funds, \$209,000 total funds. The need for the position is identified as being associated with ongoing workload associated with monitoring activities for the newly established CHDP Gateway to Medi-Cal. Medi-Cal has increased enrollment by over 1 million over the last few years. The positions will provide oversight for all of those children who enter Medi-Cal or Healthy Families through the presumptive eligibility of the Gateway.

Over 50,000 children pre-enroll in the Gateway each month and over 80 percent request a joint application for Medi-Cal and Healthy Families. The complexity of the computer processing of the Department of Health Services and its interface with the eligibility determinations of the counties and Healthy Families cause some problems each month with duplicate records or mis-identification or linkage with other Medi-Cal eligibles with similar name, age, address etc. As the number of children served continues to increase, the number of errors needing resolution will increase. The Department is requesting 2.5 positions to address the legal and policy issues raised by the implementation of the CHDP Gateway.

COMMENTS:

Department of Health Services, please outline for the Subcommittee what the responsibilities of these positions would be.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – FINANCE LETTER

ISSUE 5: METHADONE REGULATORY PROGRAM

BACKGROUND:

The Administration proposes to repeal the statute and regulations that require the state to operate a State-Only Methadone laboratory regulatory program. The resources to operate the program were eliminated pursuant to the Section 4.10 budget cuts authorized in the Budget Act of 2003. Other laboratories throughout the state will continue to operate and provide the services under federal regulations.

COMMENTS:

Department of Health Services, please outline for the Subcommittee why the state a program and what needs it served.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 1: MEDI-CAL STATE ONLY CAPPED PROGRAMS****BACKGROUND:**

The Administration's 2004-2005 budget proposes to cap the enrollment in Medi-Cal for Documented Immigrants Program. The proposal also would cap the enrollment in Medi-Cal for undocumented immigrants, including those receiving treatment in the Breast and Cervical Cancer Treatment Program (BCCT). The budget would save \$17.182 million in the 2004-2005 budget year, \$5.6 million for full-scope Medi-Cal for documented immigrants, \$1.8 million for BCCT and \$9.8 million for prenatal and long-term care.

Enrollment in Medi-Cal for documented immigrants would be capped at the projected enrollment on January 1, 2004, 113,139. With a waiting list of 11,459 at the end of the Budget Year. Enrollment in the Medi-Cal for undocumented immigrants would be capped at its January 1, 2004 projected enrollment of 796,358. The waiting list at the end of budget year 2004-2005 was projected to be 66,425.

The caps on the programs would create an extremely complex environment. Both the state and the counties would need to make substantial changes to current practices. No funding has been included in the proposal but it requires counties to make significant changes in their data processing systems. Multiple waiting lists would have to be developed all in conjunction with a variety of changes in the Medi-Cal data processing system to accommodate the complex environment. Changes would be required for providing notice to Medi-Cal beneficiaries.

The waiting list would be on a first-come-first-serve basis, and there would be no recognition of medical necessity.

COMMENTS:

LAO, please summarize your analysis of the cap proposals.
Department of Health Services, please describe how the caps would operate and what resources are needed to implement the proposed caps.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 2: MEDI-CAL - RESTRUCTURING****BACKGROUND:**

The Administration is proposing a major restructuring in the Medi-Cal Program. The articulated principles of the Administration's proposal are:

- Simplify Medi-Cal eligibility standards;
- Maintain Medi-Cal benefits for children and adults most in need of benefits;
- Continue coverage for higher-income adults,
- Offer a choice of benefit packages;
- Require co-payments; and
- Expand managed care.

The Administration states that it may:

- Achieve simplification by adopting the CalWORKS income, asset and deprivation standards;
- Offer different benefit packages and different premium structures;
- Require co-payments and give providers legal authority to require co-payments as a condition of providing non-emergency care;
- Conform the Medi-Cal optional benefit package to that of private health plans; and
- Expand managed care to additional counties and encourage enrollment of the Aged, Blind and Disabled into managed care.

The reform is not projected to achieve any savings in the budget year, as it will require a long lead-time to implement the program changes. For budget year 2005-2006, the Administration projects up to \$400 million General Fund, \$800 million total funds, in savings. In a related budget document on the Department of Finance's web site the budget proposal notes that other states have obtained up to 10 percent of program costs in savings through adopting similar programmatic modifications. The Medi-Cal program is projected to cost \$31.2 billion total funds in budget year 2004-2005 and the savings objective, therefore, could be in the neighborhood of \$1.1 billion General Fund, \$2.2 billion total funds.

The Administration has engaged all interested parties in a work group process to develop issues that need to be addressed possible alternatives to addressing the issue. There have been five work groups and they have met multiple times and they are continuing to meet. The process is expected to be complete within the next two weeks and the Department will begin summarizing the issues and alternatives preparation for developing its proposal to reduce the Medi-Cal budget by a minimum of \$800 million in total funds in budget year 2005-2006.

The General Fund savings from the Administration's proposal will be enormous and the impact on the Medi-Cal beneficiaries lives will be striking. People will forego health care, primarily because they could not afford it. Not being able to afford private health care is the reason people seek out the Medi-Cal Program. People want and need health care and the Administration's proposal while maintaining eligibility will reduce the benefit package as well as

charging co-insurance and co-payments. Many Medi-Cal beneficiaries will drop Medi-Cal because they cannot afford the cost of the public program.

The draft trailer bill provided by the Administration does not contain any details. The Administration has stated that it is developing the proposal through a number of workgroup meetings that include participants from a wide variety of interest groups.

The Legislative Analysts Office notes the proposal warrants careful consideration by Legislature given the projections of continued caseload and expenditure growth in the program.

COMMENTS:

Department of Health Services, please describe the Administrations Medi-Cal proposal. What is the status of the work groups? When will the work groups conclude their business? Is there any evolving consensus on issues? When might the Legislature receive the Administration proposal?

LAO, please describe for the Subcommittee the merits of the Administration's proposal.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 3: MEDI-CAL REFORM - MANAGED CARE EXPANSION****BACKGROUND:**

An expansion of the Medi-Cal Managed Care is one aspect of the Governor's proposed restructuring of the Medi-Cal Program. The expansion could increase the number of counties in the managed care program from 22 to 36. There are approximately 3.5 million people enrolled in Medi-Cal Managed Care at this time. The expansion is projected to add 414,000 beneficiaries to the Medi - Cal Managed Care rolls. In addition, the Department will be exploring options for the voluntary enrollment of the aged, blind and disabled beneficiaries to the rolls in the non-County Organized Health System (COHS) counties.

The Department will be seeking authority to restructure the Medi-Cal Program through an 1115 waiver from the Federal Government's Center for Medicare and Medicaid Services. The state has many waivers for the various aspects of the Medi-Cal program and may seek a waiver that encompasses all of the existing waivers or it may seek one less comprehensive in nature. An 1115 waiver allows the flexibility in design of the system by waiving certain aspects of federal law and regulation. The state would be obligated to demonstrate that the costs of the program are less under the waiver than what they would be in a non-waiver program.

The state has three different managed care models:

- **COHS:** The County Organized Health Systems are health-insuring organizations organized and operated by the county. COHS are not required to be State licensed HMO. All Medi-Cal beneficiaries residing within the county are required to enroll regardless of their eligibility category. Beneficiaries do not have the option of obtaining Medi-Cal services through the traditional fee-for-service Medi-Cal system. Five COHS plans operate in the following counties: Santa Barbara; San Mateo; Solano; Napa; Orange; Santa Cruz; Monterey and Yolo Counties.
- **Two-Plan:** The Department of Health Services contracts with one locally developed health care service plan known as the Local Initiative and one non-government operated Health Maintenance Organization, referred to as the Commercial Plan. In general, enrollment is mandatory for beneficiaries in public assistance linked and percent of poverty aid code categories, and voluntary for the aged, blind and disabled aid categories. The following counties participate in the model: Alameda; Contra Costa; Fresno; Kern; Los Angeles; Riverside; San Bernardino; San Francisco; San Joaquin; Santa Clara; Stanislaus and Tulare Counties.
- **Geographic Managed Care:** Under the Geographic Managed Care model Medi-Cal beneficiaries are given the option of choosing from among multiple commercial HMO to receive their health care services. The model first employed in Sacramento County and then it was extended to San Diego county. Enrollment is mandatory for beneficiaries in public assistance linked and percent of poverty aid code categories and voluntary for the aged, blind and disabled code categories.

The expansion could be as follows:

- **County Organized Counties:** Marin, Mendocino, Sonoma, San Luis Obispo, Ventura and San Benito.
- **Two Plan:** Madera and Merced.
- **Geographic Managed Care:** Butte, El Dorado, Imperial, Placer, Sutter and Yuba.

The Department projects savings would begin in the 2005-2006 budget year. The estimated savings for 2005-2006 before staff and contractor costs are \$24.2 million in total funds, \$12.1 million General Fund. After subtracting the costs the savings will total \$16.3 million total fund, \$8.15 million total Funds. The savings for budget year 2006-2007 and thereafter before subtracting staff and contractor costs are projected to be \$37.2 million total funds and \$18.6 million General Fund. After subtracting for the additional costs the savings are projected to be \$32.9 million total funds, \$16.45 million General Fund.

The Legislative Analyst notes that two of the COHS are in serious financial difficulties. The difficulties the LAO notes are that capitation rates are lagging inflation; "profits" are used for services and persons outside of Medi-Cal; rates paid to health care providers are greater than fee-for-service; and the lack of monitoring of the finances.

COMMENTS:

LAO, please provide the Subcommittee a brief assessment of the Administration's proposal to expand Medi-Cal Managed Care.

Department of Health Services, please explain to the Subcommittee how the shift of Medi-Cal beneficiaries to managed care **will not adversely** affect the Voluntary Intergovernmental Transfer hospital reimbursement.

Department of Health Services, the LAO notes that some County Organized Health Systems are having financial difficulties, does the Department concur in the analysis? What could be done to improve the financial strength of them?

Department of Health Services, describe for the Subcommittee why it makes sense to expand the County Organized Health Systems when the Health Plan of San Mateo is closing its doors?

LAO, what is your recommendation for the additional staffing the Department of Health Services is requesting.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 6: MEDI-CAL REFORM - MANAGED CARE EXPANSION – AGED, BLIND AND DISABLED****BACKGROUND:**

In addition to the Administration's Medi-Cal Managed Care expansion discussed above the LAO is recommending increasing the number of the Aged, Blind and Disabled Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. The LAO identifies a population of 310,000 Medi-Cal beneficiaries who could gradually be shifted. Over the next few years the LAO projects this population would approach 330,000. The LAO estimates the state could achieve a net savings of \$100 million General Fund, \$200 million total funds, annually by 2006-2007 through such an expansion. The LAO analysis concludes that a carefully targeted expansion of enrollment in managed care could yield a number of benefits, including improved coordination of care; increased access to care; a greater emphasis on prevention, quality assurance, and improved outcomes; and potentially significant state savings.

The LAO's analysis recommends gradually shifting the targeted Aged, Blind and Disabled into managed care in counties that already have a Medi-Cal health plan. The LAO recommends against shifting Medi-Cal beneficiaries who are dual eligibles, have a share of cost, receive long-term care or are enrolled in CCS. The target population is primarily disabled adults with some disabled children and aged adults included.

As the LAO notes in the analysis there are significant implications for hospital reimbursement when shifting people from fee-for-service health care to managed care. In fee-for-service Medi-Cal the state operates under a waiver from the federal government. The waiver permits the state to selectively contract with hospitals rather than contracting with all hospitals. The state must spend less under the program, Selective Provider Contracting Program (SPCP), than it would if it contracted with all hospitals. Historically, the state has saved hundreds of millions of dollars each year through the SPCP.

As a result of the savings from the SPCP, the state utilizes a feature in the Medicaid law that allows non-state governmental entities (county hospitals, UC hospitals, Health Care District hospitals) to transfer funds to the state, have them matched with federal funds and then distributed to providers as additional reimbursements. This Voluntary Intergovernmental Transfer Program will provide \$800 million in additional federal funds in the Budget Year that will be used to reimburse safety net hospitals for health care delivered to the Medi-Cal population. Over the last decade the state has relied on the Voluntary Intergovernmental transfer program and the so-called Disproportionate Share Program to provide the bulk of rate increases to hospitals in the California safety net.

Savings under managed care are not included in the SPCP program. Shifting beneficiaries to managed care from fee-for-service will cause the level of SPCP savings to decline. Thus, savings from managed care will increase as savings from fee-for-service decrease and concomitantly reimbursements for safety net hospitals will decrease. What the state saves on the one hand it loses on the other.

COMMENTS:

LAO, please describe your suggestion to the Subcommittee.

Department of Health Services, please describe for the Subcommittee how this proposed shift of Medi-Cal beneficiaries to managed care **will adversely** effect the Voluntary Intergovernmental Transfer hospital reimbursement program.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 7: MEDI-CAL REFORM - MANAGED CARE EXPANSION – PUBLIC HMO INTERGOVERNMENTAL TRANSFER****BACKGROUND:**

The proposed budget contains a 6 percent Quality Improvement Assessment Fee on all Medi-Cal managed care plans. The state will realize a net gain of 25 percent of the fee. The 6 percent fee will generate \$300 million from the plans. The state will keep \$75 million and will match the remaining \$225 million of the assessment fee with \$225 million from the federal government, for a total of \$450 million to be distributed to the Medi-Cal plans. The state will then increase the reimbursement to the plans and distribute the funds. The remaining \$75 million will remain as a revenue to the state. The 2003-2004 budget contained a Quality Assessment Fee but it was not able to be assessed for technical reasons.

A second tool is available to the state to increase the funding to Medi-Cal managed care plans. Hospitals rely upon a voluntary intergovernmental transfer from the public hospitals to the state for a match for federal funds, the funds are then distributed to hospitals through contract negotiations conducted by the California Medical Assistance Commission with the hospitals. The voluntary intergovernmental transfer will provide \$800 million of federal funds for hospital reimbursement for Medi-Cal services. The intergovernmental transfer (IGT) is limited by the amount of savings the state receives from its hospital contracting program and the federal upper payment limit on the amount hospitals may be reimbursed for Medi-Cal services. The same opportunity is available for use by the public HMOs.

An impediment in the discussions with the federal government has been whether the local public entities are government entities. The federal government said they are public entities because they do not have the ability to levy taxes. The other issue is the source of the funds used for the transfer. Draft placeholder trailer bill language will clarify that COHS are governmental entities with Joint Powers taxing authority. Governmental HMOs contract with the state for Medi-Cal and Healthy Families services and receive a

capitation rate. After reimbursing providers for the services they provide the governmental entities place the excess in reserve, it is no longer federal or state funds,

A second impediment to instituting an Intergovernmental Transfer Program for the County Organized Health Systems and the Local Initiatives is the source of the funds that are used for the match. Generally, the funds received by the public HMOs comes from capitation rate the plans receive from the state. Other than the Medi-Cal program the plans have little or no revenues from other sources. Therefore, the reserves that accrue are a result of federal and state funding and the federal government does not match federal funds with federal funds. However, the question of ownership is confusing because after the plans pay for the services the excess is plans and it is not an asset of the federal or state government.

Finally, the federal government does not want the additional funding to go to the reserves of the plans, should they receive the additional federal funds. The purpose of the transfer is for the reimbursement for services and not the build-up of the reserves of the plans. To pay for the services provided to the Medi-Cal beneficiaries in the Plan, the COHS have had to dip into their reserves because the payment is not adequate for the cost of the services. Some plans are in danger of crossing the operational line with respect to Tangible Net Equity and the increased funding from the IGT would permit the plans to operate without dipping into their reserves. If the plans were to cross the operational line they would be out of the business and the state would have to take over in the county. Health care would return to a fee-for-service basis at a significantly higher cost.

COMMENTS:

Department of Health Services, please provide the Subcommittee with your assessment of the feasibility an intergovernmental transfer program for public HMOs.

Department of Health Services how might the proposal be strengthened?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 8: PROVIDER RATE REDUCTION****BACKGROUND:**

The budget proposes to reduce provider rates by 10 percent effective January 1, 2004. This is in addition to the five percent provider rate reduction that was enacted as part of the 2003-2004 budget.

The budget for 2003-2004 projected budget savings of \$102.8 million General Fund and \$210.3 million total funds in the 2003-2004 fiscal year. The projected savings for 2004-2005 are \$236.8 million General Fund and \$485.1 million total funds. The rate reduction was to go into place on January 1, 2004. However, the rate reduction was enjoined by the court. The Medi-Cal fee-for-service provider rates were not reduced but the Medi-Cal Managed Care Rates and the state-only provider rates were reduced. The state is receiving approximately \$65 million in General Fund savings in the current year. The managed care plans have indicated to the Department of Health Services that it intends to dispute the rate calculation methodology.

The additional 10 percent reduction was first proposed in the Governor's Mid-Year Reduction Plan. The savings in 2003-2004 budget were projected to be \$160.1 million in General Funds and \$325.5 million total funds. The estimate for the 2004-2005 budget year is \$459.9 million General Fund and \$942.9 million total funds.

If enacted by the Legislature and not enjoined by the Court, the combined rate reductions would provide \$263 million in General Fund savings in 2003-2004. In the 2004-2005 budget year the General Fund savings would be \$960 million.

COMMENTS:

Department of Health Services, to the extent possible please provide the Subcommittee with an update on the status of the provider rate case.

Department of Health Services, please outline the managed care plans' challenge of the rate methodology.

LAO, please provide the Subcommittee your assessment of the possible consequences of reducing provider rates by 15 percent.

Department of Health Services, please provide the Subcommittee with an assessment of what the effect would be on access if the provider rates were to be reduced by a total of 15 percent.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES –MEDI-CAL**ISSUE 9: MEDICAL EDUCATION****BACKGROUND:**

The University of California has requested the Medi-Cal Medical Education Supplemental Payment Fund (Med Ed Fund), which is scheduled to expire on June 30, 2004, be permanently established in law

The University's academic health centers comprise the nation's largest public academic health system and are a state and national resource. They provide considerable public benefit and are a necessary investment in the health and welfare of California's citizens. The University's medical centers and outpatient clinics:

1. Are a crucial component of the health care safety net, and annually provide:
 - 233,000 inpatient days of care to the poor and uninsured;
 - 23% of its inpatient care to indigent and uninsured patients;
 - 58,000 days of care to the state's poor and very sick children; and
 - approximately \$152 million in uncompensated and under-compensated care
2. Provide high quality and intensive care to a significant number of Californians, including:
 - 782,000 inpatient days of care to over 135,000 patients;
 - 3.6 million outpatient visits per year; and
 - more intensive pediatric care days than any health care provider;
3. Lead the nation in medical research that benefits patients with rare and chronic illnesses

The Med Ed Fund is a state-federal Medicaid matching program that provides supplemental payments to eligible hospitals through negotiations with the California Medical Assistance Commission (CMAC). Under this program, the University of California funds the state portion of funds that are matched by federal dollars and then distributed to hospitals with accredited medical education programs that provide inpatient care to Medi-Cal patients. In the 1997-1998 health budget trailer bill the program was expanded to include a total of 26 hospitals, the University of California teaching hospitals, the children's hospitals and major non-university teaching hospitals. As a result of changes in federal regulations UC is limited in the amount of money which can be used in the program. As a result, children's hospitals no longer receive direct funding under the Med-Ed program.

There is no cost to the State General Fund for this program, which annually provides approximately \$129 million (averaged over 7 years) in University and federal dollars to support the costs of graduate medical education at hospitals throughout the state that provide inpatient care to Medi-Cal patients. The Med Ed Fund is supported entirely through intergovernmental transfers from the University of California that are matched by federal Medicaid dollars. Last year, the University provided the \$65 million for the state's share of the matching funds needed to support the program. On average, the University has provided \$63.9 million per year in matching funds to support the Med Ed Fund.

Eighteen public and private teaching institutions are currently eligible to participate in the program: the five University of California teaching hospitals, Loma Linda University, Stanford,

Los Angeles County (3 hospitals), Highland General, Kern Medical Center, San Bernardino County Medical Center, San Francisco General, Valley Medical Center of Fresno, Riverside General Hospital, Santa Clara Valley Medical Center, and White Memorial Medical Center.

COMMENTS:

Department of Health Services, does the Administration support making the Graduate Medical Education Program in Medi-Cal permanent?

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD**ISSUE 1: HEALTHY FAMILIES BLOCK GRANT & ENROLLMENT CAP****BACKGROUND:****Block Grant**

The Administration's budget proposal also would block grant documented immigrant services in the Healthy Families Program. The programs included in the block grant are: CalWORKS; California Food Assistance Program; and Cash Assistance Program. The budget estimates that savings of \$848,721 would be saved from anticipated unspecified efficiencies. The details of the proposal are to be included in the May Revision.

Healthy Families Cap

The Administration's budget proposal for the 2004-2005 budget year would cap the enrollment in the Healthy Families Program. The enrollment would be capped at the projected January 1, 2004 level of 732,300. The waiting list at the end of the 2004-2005 budget year would be 113,800 children. Instituting the enrollment cap would save the General Fund \$31.5 million in the budget year. The state would not save any funds in the current fiscal year because of the costs, \$1.5 million General Fund, for the administrative system changes.

The waiting list would be a first-come-first-serve basis as are the other waiting lists on programs proposed to be capped by the Administration in its budget for 2004-2005.

Healthy Families is the states health insurance program for children 18 years old and younger who live in California. Families can qualify if: the family income is less than 250 percent of the Federal Poverty Level, adjusted for family size; the children do not qualify for no-cost Medi-Cal; the children have not been covered by insurance from an employer, for at least three months; and the children are either a U.S. citizen, a U.S. non-citizen national or a qualified immigrant.

COMMENTS:

Managed Risk Medical Insurance Board (MRMIB), please describe the block grant proposal. How are the efficiencies to be obtained?

MRMIB, please outline for the Subcommittee how the cap on the program would work.

MRMIB, please outline for the Subcommittee what the consequences of a cap on the program would be.

LAO, please provide your assessment of the caseload cap on the Healthy Families Program.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 2: HEALTHY FAMILIES TIERED BENEFIT PACKAGE

BACKGROUND:

The Administration is proposing to implement a two-tiered benefit package in the 2005-2006 budget year for families with income in excess of 200 percent and less than 250 percent of the Federal Poverty Level. The families will have the option of choosing an all inclusive benefit package that includes health, dental and vision benefits but requires them to pay a higher premium. The families can choose a reduced benefit package and pay the current premium.

To accomplish this the administrative vendor would have to make changes in order to track the various premium levels families would pay depending on the benefit package chosen. The costs for implementing the change is \$263,000 General Fund and \$750,000 total funds.

COMMENTS:

MRMIB, please describe the proposal and how it would work.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE3: IMPLEMENTATION OF SB 2**BACKGROUND:**

SB 2 (see language below) authorizes the State to provide a General Fund Loan to the MRMIB for the start up costs for implementing the health insurance expansion authorized by the bill. The 2004-2005 budget does not provide a loan to MRMIB. At this time neither the Department of Finance nor MRMIB have a public detailed estimate of what it would cost to implement the bill.

SB 2 Language

Notwithstanding Section 2130.4, the board is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses related to the establishment and administration of this part prior to the collection of the employer fee. The proceeds of the loan are subject to appropriation in the annual Budget Act. The board shall repay principal and interest, using the rate of interest paid under the Pooled Money Investment Account, to the General Fund no later than five years after the first year of implementation of the employer fee.

COMMENTS:

Department of Finance, to the extent possible please provide the Subcommittee with a detailed estimate of the costs of implementing SB 2.