AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER PATTY BERG, CHAIR

MONDAY, APRIL 28, 2008
STATE CAPITOL, ROOM 127
4:00 P.M.

4260 DEPARTMENT OF HEALTH CARE SERVICES—MEDI-CAL

ISSUE 1: ELIMINATION OF MEDI-CAL OPTIONAL BENEFITS—OVERVIEW

The Governor's Budget proposes enactment of legislation to discontinue nine categories of Medi-Cal "optional" benefits for adults (age 21 or older). These benefits are optional in the sense that federal Medicaid law does not require the state to provide them to adults who are not in nursing facilities, although the federal government provides matching funds for states that choose to provide them.

The Governor included these benefit eliminations in his Special Session Budget-Balancing Reduction (BBR) proposals. The BBR proposals assumed enactment of legislation in March 2008 and termination of the benefits three months later—on June 1. 2008. The budget estimated General Fund savings of $10 million in the current year and $134 million in 2008-09 from these actions. These proposals, however, were not acted on in the Special Session. If budget legislation to end these benefits were adopted by July 1, the benefits would terminate October 1, 2008, and the $134 million savings estimate for 2008-09 would be reduced. According to DHCS, the reduced savings would be $102.5 million.

Table 1 (next page) lists information provided by the Department of Health Care Services (DHCS) showing total (state and federal) fee-for-service spending for each of the optional benefits provided by Medi-Cal in 2005-06 and also showing the estimated 2008-09 savings from the specific optional benefit eliminations proposed in the budget. These figures exclude spending for children 18 years old or younger (the budget will be adjusted in the May Revision to exclude costs for persons under 21 years of age).

Little or No Potential Savings for Many Optional Benefits. The first column of figures in Table 1 lists total spending in 2005-06 for each optional benefit. The second column shows the percentage of that spending that DHCS estimates would shift to mandatory benefit categories if the optional benefit were eliminated. For example, DHCS estimates that all of the spending for the Nurse Midwife benefit (second row) would shift to mandatory labor and delivery services, and therefore no savings would result. The same is true (or nearly so) for many of the other optional benefits.

Impact on the Elderly and Disabled. The next three columns in Table 1 show the total annual savings net of the shift to mandatory services and how the reductions would affect Aged, Blind and Disabled (ABD) Medi-Cal beneficiaries versus other adults (primarily parents and pregnant women) on Medi-Cal. For all but two of the optional benefits with potential savings, almost all of the impact would be to the ABD population. The exceptions are Adult Dental services--the most significant of the optional benefits proposed for elimination--and Chiropractic services. The final (right-hand) column shows the 2008-09 General Fund savings estimate for those optional benefits proposed for elimination (based on enactment of legislation in March 2008).

Table 1
Department of Health Care Services--Medi-Cal
Proposed Fee-for-Service Savings From Elimination of Selected Optional Services
(Dollars in Thousands)

	2005-06 (Total Funds)					
			Annual Savings Net of Shift to Mandatory Services			
Optional Service Category	Total Spending	Estimated Shift to Mandatory Services If Optional Service Eliminated	Adults--Aged, Blind & Disabled (ABD)	Non-ABD Adults	Total Cost for Adults	Budgeted General Fund Savings 2008-09
01-Adult Day Hlth Care Ctr	$ 387,931	50%	$ 193,386	$ 580	$ 193,965	-
05-Nurse Midwife	4,845	100%	-	-	-	-
06-Certified Hospice Service	133,041	100%	-	-	-	-
07-Certd Pediatric Nurse Pract	533	100%	-	-	-	-
08-Certd Family Nurse Pract	1,315	100%	-	-	-	-
09-Respiratory Care Pract	22	100%	-	-	-	-
11-Fabricating Optical Lab	13,749	0%	9,822	3,926	13,749	**$ 6,160**
12-Optometric Group	4,189	90%	346	73	419	**190**
28-Optometrist	18,867	90%	1,535	352	1,887	**846**
13-Nurse Anesthetist	873	100%	-	-	-	-
29-Dispensing Optician	2,888	0%	2,685	202	2,888	-
30-Chiropractor	1,127	25%	421	424	845	**379**
31-Psychologist	1,123	50%	526	35	561	**251**
32-Podiatrist	6,293	40%	3,544	232	3,776	**1,692**
33-Acupuncturist	6,339	0%	5,735	604	6,339	**2,840**
34-Physical Therapist	1,084	90%	73	35	108	-
35-Occupational Therapist	88	60%	33	2	35	-
36-Speech Therapist	3,229	50%	1,607	7	1,614	**450**
37-Audiologist	10,683	50%	5,247	95	5,342	**1,550**
38-Prosthetist	6,402	75%	1,407	193	1,600	-
39-Orthotist	670	75%	158	9	167	-
41-Blood Bank	9	100%	-	-	-	-
45-Hearing Aid Dispenser	8,343	0%	8,228	116	8,343	-
47-ICF-DD	355,123	100%	-	-	-	-
49-Birthing Ctr	281	100%	-	-	-	-
55-Local Education Agency	5,113	0%	4,567	546	5,113	-
71-Home & Commty Based Waiver Svs	55,544	100%	-	-	-	-
72-SurgiCenter	7,058	100%	-	-	-	-
73-AIDS Waiver Services	15,506	100%	-	-	-	-
75-Organized Outpatient Clinic	176,208	100%	-	-	-	-
79-Independent Rehab Facility	626	60%	214	37	250	-
81-MSSP Waiver Services	42,352	100%	-	-	-	-
83-Pediatric Subacute Rehab/Weaning	8	100%	-	-	-	-
91-Outpatient Heroin Detox	224	0%	153	71	224	-
26a-Pharmacist Services	3,966,345	100%	-	-	-	-
26b-Pharmacist Supplies	29,309	30%	17,216	77	17,293	-
26c-Pharmacist Supplies-Creams & Washes	10,744	0%	10,690	54	10,744	**4,685**
Durable Medical Equipment	5,786	25%	4,037	302	4,339	-
Dental	287,374	0%	140,053	147,321	229,899	**114,950**
Totals	**$ 5,571,241**		**$ 411,685**	**$ 155,292**	**$ 509,502**	**$ 133,991**

Bold indicates services proposed for elimination by the Governor's Budget.

The optional benefits proposed for elimination are briefly discussed below (except for adult dental, which is discussed in Issue 2 below). The savings figures are the Governor's Budget estimates for 2008-09 assuming benefits terminate July 1.

- ***Optical Labs ($6.2 million).*** Eliminates eyeglasses and contact lenses. Currently all 50 states provide this service, according to the budget. Eyeglasses for Medi-Cal beneficiaries currently are produced by the Prison Industry Authority (PIA), which made 830,000 pairs of eyeglasses for Medi-Cal in 2006—at an average cost of around $20/pair. More than 70 percent of the spending on optical labs is for the ABD population. The budget assumes that no shift to mandatory services or increased impact to other services (such as In Home Supportive Services--IHSS) will result from eliminating the provision of eyeglasses and contact lenses. According to the department, all 50 states currently offer optical lab services as a Medicaid benefit.

- ***Optometrists/Opticians ($1 million).*** Eliminates these services, including low-vision services for the visually impaired and the legally blind. The budget assumes, however, that *only 10 percent* of the cost of these services will be realized as savings because eye exams and related services will shift to, community clinics and emergency rooms. Because there are few ophthalmologists in rural areas access to eye services in those localities could become very constrained. According to the department, 40 states currently offer optometry as a Medicaid benefit.

- ***Chiropractor ($0.4 million).*** Savings estimate is net of 25-percent offset for shifts to physician services.

- ***Psychologist ($0.3 million).*** Current benefit limited to 2 visits per month unless provided by county mental health services (access to those services would remain for those with severe mental illness). Savings are offset by 50 percent for shift to psychiatric and other services. Access to anti-depressants and other medications through by physician prescription would remain available to Medi-Cal beneficiaries with less severe mental illness.

- ***Podiatrist ($1.7 million).*** Savings are offset by 40 percent for shift to physician and other services. Almost all (94 percent) of this benefit is provided to the ABD population. DHCS points out that "most podiatry services are provided to treat conditions that complicate chronic medical diseases or disorders that significantly impair the ability to walk." It is not clear whether any additional costs to IHSS or for nursing home care have been taken into account.

- ***Acupuncturist ($2.8 million).*** The budget assumes that there will be no cost-shift to other services from elimination of acupuncture. The ABD population receives 90 percent of acupuncture services.

- ***Audiologist and Speech Therapist ($2 million).*** Savings have been reduced by 50 percent due to increased costs for nursing homes, according to the budget. (Since services would be maintained for nursing home residents, this offset presumably is for additional nursing home admissions of persons who could have stayed out of a nursing home with appropriate hearing and speech therapy. Reduced spending on hearing aids also is assumed since there would be fewer screenings for hearing problems. According to the department, 40 states currently offer audiology and speech therapy as a Medicaid benefit.

- ***Pharmacy Supplies—Incontinence Creams and Washes ($4.7 million).*** Eliminates these prescribed incontinence supplies as a benefit. No cost shift or impact on other services is assumed. The budget notes that beneficiaries may purchase commercially available products with their own funds.

STAFF COMMENTS

- After release of the Governor's Budget, the Department identified additional dental managed care savings due to the elimination of adult dental services (which is not shown in Table 1 above). The Department's current estimate of $102.5 million savings for elimination of the optional benefits starting October 1, 2008 includes $4 million of dental managed care savings.

- The Department now indicates that savings are overstated because (except for adult dental benefits) the spending figures that it used to compute the savings (and that are shown in Table 1) did not exclude the cost of services to residents of long-term care facilities.

- The budget also notes that, in some cases, the elimination of these optional benefits would result in future savings due to rate reductions in Medi-Cal managed care.

ISSUE 2: ELIMINATION OF ADULT DENTAL OPTIONAL BENEFIT

The budget proposes to discontinue Medi-Cal dental services for adults 21 years of age or older, including pregnant women and individuals with developmental disabilities. Only those adults in nursing facilities would continue to receive Medi-Cal dental services as required under federal law. The budget assumes a General Fund savings of $120.3 million in 2008-09 from the elimination of this benefit. As noted in the Issue 1 above, this figure assumed enactment of legislation in March 2008 and termination of the benefit starting in June. If legislation were enacted with the budget on July 1, dental benefits would end October 1, 2008 and the savings would be reduced to $90.2 million, according to DHCS.

Budget Fails to Recognize Impact on Other Services. In Table 1 (see Issue 1 above), the Department reduced the cost for adult dental services by 20 percent prior to calculating savings in order to account for the existing utilization of dental services by Medi-Cal beneficiaries in long-term care facilities. However, the budget does not include any savings offset due to increased use of physician or emergency room services by Medi-Cal beneficiaries who otherwise would have gone to a dentist for treatment of pain or other symptoms or for whom lack of dental treatment results in infection, disease, or disability. According to the California HealthCare Foundation, the Surgeon General has reported that oral health problems can cause infection and signal trouble in other parts of the body. The foundation also indicates that untreated dental disease can lead to severe pain and infection leading to a variety of health problems, difficulty with activities of daily living, and (although rarely) death. A study of the impact of the elimination of emergency adult dental services in Maryland in 1993 found a 12-percent increase in hospital emergency department visits.

Budget Fails to Recognize Costs for the Developmentally Disabled. Another cost that the budget failed to recognize is for the continuation of dental services to Medi-Cal enrollees with developmental disabilities. State law entitles these individuals to a broad range of services, including dental care, which the Department of Developmental Services (DDS) would need to provide without a federal match. According to DDS, an increase of $4.68 million (General Fund) would be needed to provide these services, which would be another offset to the budgeted savings.

Rate-Cut Double-Counted. In estimating the savings from eliminating adult dental services, the Governor's Budget did not account for the interaction with the 10-percent Medi-Cal provider rate reduction that also was included in the budget. The rate reduction was adopted in AB 5 X3, and will reduce spending by a total of $60.3 million ($30.8 million General Fund) in 2008-09, according to the department's estimate. The Legislative Analyst's Office estimates that the rate cut reduces the 2008-09 General Fund savings assumed in the Governor's Budget from elimination of adult dental services by $10.6 million.

Fiscal Intermediary Savings. The Governor's Budget also includes a related General Fund reduction of $700,000 to Dental Fiscal Intermediary Surveillance and Utilization Review Subsystem. The primary basis for this reduction is the workload reduction from the elimination of the adult dental benefit. This function receives a 3-to-1 federal match, so that the total reduction is $2.8 million.

Background—Denti-Cal

Medi-Cal's dental program—"Denti-Cal"—provides primary and specialty dental care for adults and children. Adult dental care is provided at the state's option and is not federally required, except for adults in nursing homes, but is federally reimbursed. Six other states besides California provide these services to adults. Federal law requires states to provide dental services to children.

According to the most recent actual expenditures from 2005-06, Denti-Cal expenditures were $553.7 million (total funds). Of this amount, $266.3 million in expenditures, or 48 percent, were for services to children. The remaining $287.4 million in expenditures were the remaining $287.4 million in expenditures were for adults. Of the amount expended for adults, $140.1 million, or 48 percent, was for adults who are in the aged, blind, and disabled Medi-Cal eligibility category. Therefore, 74 percent of the Denti-Cal Program expenditures are for children and aged, blind and disabled adults.

Denti-Cal employs significant cost-containment measures and utilization controls. Recent changes enacted to control expenditures and minimize fraud and abuse include: (1) adult limit of one annual preventive visit, (2) pre-treatment x-rays to justify restorations; (3) restricted use for certain laboratory processed crowns; (4) increased provider enrollment requirements; (5) reduced payment for root planning and subgingival curettage ; and (6) an $1,800 annual cap for adult services (with certain exclusions). In addition as noted above, a 10-percent rate reduction to all dental procedures provided under Denti-Cal (both child and adult) will be effective July 1, 2008.

California Dental Association (CDA) Alternative

As an alternative to eliminating adult dental services and to the rate reduction for dental services, CDA has put forward a proposal to eliminate the following selected procedures for adults:

- 452 - root planning and scaling (with an exception for persons in nursing homes because this procedure is necessary for people with very poor oral health who are not brushing, which is frequently the case in nursing homes).

- 512 - bicuspid root canal therapy

- 513 - molar root canal therapy

- 671 - stainless steel crown (permanent teeth)
- 672 - post
- 998 - unlisted therapeutic services (specifically eliminate coverage for implants)

Extracting Savings. Elimination of the procedures listed above would retain a program for adults that covers prevention and basic restoration but not major restorative work for posterior (back) teeth. For back teeth that could not be restored with a filling, the only option would be extraction.

STAFF COMMENTS

1. Actual savings from the administration's proposal to eliminate adult dental services are likely to be significantly less than the amount now estimated by DHCS. In addition to the cost offset at DDS, the interaction with the rate cut, and the adjustment for 19 and 20 year-olds, the savings figure should be reduced to account for shifts to other services, which the Department's description of the impact of this cut recognizes will occur.

2. Spending on the adult procedures that would be eliminated in the CDA alternative totaled $52.5 million in 2006-07 (about $26.3 million General Fund). The actual savings would be less due to retention of services for enrollees in long-term care. Consequently, the CDA alternative would not generate as much savings as either the rate cut or the elimination of adult dental services.

3. The department has raised an issue regarding whether federal law allows the state to exclude selected services as proposed in the CDA alternative (versus eliminating the entire benefit). The Department should explain the legal basis for its concern, particularly since existing law currently excludes certain services from Denti-Cal.

4. Another alternative savings approach would be to reduce the $1,800 annual cap for adult dental care. The Subcommittee may wish to ask DHCS and CDA to address the potential savings and the potential impacts on dental care of a reduction in the annual cap. It should also be noted that the $1,800 cap sunsets January 1, 2009. The Administration has not proposed an extension because it is proposing to eliminate the benefit. If the benefit is retained, the cap would need to be extended at the current or lower level in order to avoid an escalation in costs.

ISSUE 3: PUBLIC HOSPITALS—SHIFT OF SAFETY NET CARE POOL FUNDING

The Governor's Budget proposes to shift to the state a portion of the Safety Net Care Pool (SNCP) federal funds provided to designated public hospitals under the state's Hospital Financing Medicaid Waiver demonstration program from the federal government. The shifted SNCP funds would be used to replace additional state General Fund costs in certain state-operated programs--the Medically Indigent Adult Long-Term Care Program, the Breast and Cervical Cancer Treatment Program (BCCTP), the California Children's Services (CCS) Program, and the Genetically Handicapped Persons Program (GHPP). The Governor's proposal would reduce the amount of state funds needed in those programs essentially to the minimum needed to match SNCP funds. The proposal would require statutory change.

SNCP Funds are capped at $560 million annually and are provided to ensure continued support for health care services to the uninsured. Under the terms of the waiver, $180 million each year is designated for the Coverage Initiative--expanded coverage options for the uninsured, generally making use of safety net hospitals, clinics and other resources. Most of the remaining funds are allocated to the designated public hospitals to assist them in meeting their uncompensated care costs to treat the uninsured. However, $44.5 million of SNCP funds currently is used by the state to offset General Fund costs in the state-operated programs cited above.

$34.4 Million Increase in State Allocation Proposed for 2008-09. Table 2 below outlines the existing SNCP funding provided to these state-operated programs, along with the Governor's proposed increase in the state allocation for 2008-09. As noted, the existing SNCP allocation results in almost $44.5 million of General Fund savings. The Governor's additional shift would save an additional $34.4 million in 2008-09. The total SNCP allocation to the state would be $78.85 million in 2008-09. On a fully annualized basis (effective in 2009-2010, the last full state fiscal year under the current waiver), the additional savings would grow to $54.2 million (for total SNCP funding of $98.7 million).

Table 2

Summary of Governor's Proposed Use of Safety Net Care Pool Funds

Program	Existing Redirection (Baseline)	Additional Shift for 2008-09 (Increase)	Total Amount of Shift for 2008-09	Total Amount Annualized
Medically Indigent--LTC	$18,450,000	$6,726,000	$25,176,000	$23,480,000
Breast & Cervical Cancer	--	$1,024,000	$1,024,000	$1,913,000
CA Children's Services Program	$18,000,000	$17,839,000	$35,839,000	$55,257,000
Genetically Handicapped Persons	$8,000,000	$8,811,000	$16,811,000	$18,000,000
TOTALS	**$44,450,000**	**$34,400,000**	**$78,850,000**	**$98,650,000**

The federal government provides the SNCP waiver funds on a matching basis. The designated public hospitals match the federal funds with "certified public expenditures" (CPEs)—amounts that they spend from their own funds (including Realignment funds) to provide care. The state uses General Fund dollars spent on the designated programs as the match for those programs. The Governor's proposal would reduce SNCP funding to Public Hospitals. This could affect access to services by both Medi-Cal enrollees and the uninsured.

Legislative Analyst's Proposal—Shift an Additional Amount

As part of their Alternative Budget Proposal, the LAO included an increase in the amount of SNCP funds shifted from the public hospitals to the state to generate additional General Fund savings. Specifically, the LAO now proposes an additional shift of $20.1 million to offset existing state funding that provides grants for support of safety-net clinics in the Expanded Access to Primary Care Program (EAPC), Rural Health Services Program, Clinic Grants-In-Aid Program, and the Seasonal and Migratory Workers Clinic Program. This shift would also involve the movement of Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds).

STAFF COMMENTS

Physician State Plan Amendment (SPA) Benefits Public Hospitals. The state recently received federal approval of the Physician SPA. Public hospitals and affiliated government-operated physician practice groups now will be able to receive federal Medicaid reimbursement based on the actual cost of providing physician and other professional services to treat Medi-Cal patients, rather than being limited to the Medi-Cal payment rate. In effect, this means that the federal government will pay for half of the difference between the Medi-Cal rate for these services and a cost-based rate. The additional federal funds will free-up other funds—such as county funds, university funds, Realignment funds, and DSH funds that currently cover this gap.

The Physician SPA has been anticipated as part of the hospital financing picture for some time, and federal approval took longer than expected. However, DHCS now estimates the net benefit from the Physician SPA to be around $100 million annually, compared with earlier estimates of around $50 million. Consequently, public hospitals will be about $50 million/year better off than had been anticipated. Although this larger benefit by no means implies that public hospitals are "overfunded," it does reduce somewhat the pressure on the hospitals' other funding sources, such as the SNCP,

Federal Approval Would Be Needed. The language of the waiver specifies the state programs that may directly use SNCP funds. Currently, only the programs now receiving funds are listed in the waiver. Providing SNCP funding to the EAPC and other clinic programs would require an amendment to the waiver, which would be contingent on federal approval.

ISSUE 4: 10-PERCENT CUT TO DSH-REPLACEMENT HOSPITAL FUNDS

The Governor proposes to reduce by 10 percent the amount paid to private hospitals and district hospitals under the state's Hospital Financing Waiver by making adjustments to General Fund "replacement" disproportionate share hospital (DSH) payments. The budget proposes a total reduction of $47.3 million ($24 million General Fund and the remainder in federal matching funds) for 2008-09.

This proposal would, in effect, reduce by 10 percent the amount that qualified Private Hospitals (those that function as part of the Safety Net) and District Hospitals receive in replacement DSH payments to offset a portion of their costs of uncompensated care.

When the current Hospital Financing Waiver was developed, regular federal DSH funds and other supplemental funding that had been provided to the private and district hospitals under the previous hospital selective contracting waiver were restructured and moved to the designated public hospitals, which use their own CPEs, rather than state General Fund, to match federal funds. In place of the former supplemental funds, the state now provides private and district hospitals with about $233 million of additional General Fund Medi-Cal payments (replacement DSH) plus an equal federal match, which is intended to maintain, in the aggregate, the amount of supplemental funding that these hospitals received in 2004-05 (i.e., prior to the current Waiver). District hospitals may choose to use their own CPEs to continue to receive the federal share of the replacement DSH funding, but this option is not open to private hospitals.

STAFF COMMENTS

The department and hospital representatives should explain how the replacement DSH funding mechanism works and how this reduction would affect hospital finances and access to care.

ISSUE 5: MIS/DSS REDUCTION

As part of the Budget-Balancing Reductions, the administration proposes to reduce contract funding for support of the Medi-Cal Management Information System/Decision Support System (MIS/DSS) by 25 percent, for a General fund savings of $525,000 in 2008-09. The total contract reduction would be $2.1 million because this function receives a 3-to-1 federal match.

Background

The MIS/DSS consolidates data from many disparate Medi-Cal operational systems and organizes it into an integrated knowledge-based system used by DHCS, the Department of Public Health, and the LAO. According to the department, an independent evaluation found a positive return on investment of $156 million in 2003-04 for the original system, which dates back to 1997. In 2005, DHCS began procurement of the next generation MIS/DSS and a contract was signed in February 2007. The new system will build on the existing system and the contractor also will provide additional support to maximize the system's usefulness and to accomplish knowledge transfer to state staff. The proposed budget reduction will require a renegotiation of the existing contract.

Impact of the Reduction

Impacts cited by the department include: inability to perform critical analyses, such as predictive modeling of policy changes, longer lead times to complete projects and analyses in critical and high-profile programs, such as anti-fraud efforts, managed care expansion and rate-setting, waiver program reporting, and the Care and Disease Management program pilots.

STAFF COMMENTS

1. The contractor (Bull Services) has provided a list of MIS/DSS activities and projects that it believes would not be accomplished if this reduction is adopted. The estimated savings (state and federal) in 2008-09 from these activities is $227 million, according to the contractor.

2. The Department should respond to the figures cited above. Would lost savings greatly exceed reduced spending from the contract cut, as claimed by the contractor? If there would be a significant loss of savings, does the budget take this into account?

ISSUE 6: FISCAL INTERMEDIARY SYSTEMS GROUP REDUCTION

Electronic Data Systems (EDS) is the main fiscal intermediary (FI) for Medi-Cal. The FI plays a crucial role in the operation of Medi-Cal because the FI is the entity that, under DHCS supervision, processes billings and payments, implements procedures to detect and prevent fraud, maintains provider enrollment, processes treatment authorizations, and operates the drug rebate system, among many other tasks.

The Governor's Budget includes a Budget-Balancing General Fund reduction of $2.1 million to the FI Systems Group in 2008-09. The total funding reduction would be $12.6 million, including federal funds. The reduction would result in a loss of 70 systems analysts.

STAFF COMMENTS

- Information provided on behalf of EDS indicates that the FI funding reduction will reduce the addition of new categories of drugs to the Rebate Accounting System, resulting in a loss of 6 categories yielding an average of $2 million each per quarter in drug rebates. The General Fund would receive $9 million (75 percent) of this amount per quarter--a potential loss of up to $36 million GF (probably somewhat less because the new categories likely are added over time). The FI cut also would reduce Health Insurance Portability and Accountability Act (HIPAA) conversion activities.

- In preliminary discussions, the Department indicated that the rebates could be collected later if incorporation of new drug categories into the accounting system is delayed. However, it is not clear whether rebate documentation and collection would be more difficult in that case. Furthermore, if these cuts are intended to be ongoing, then the impact wouldn't just be a delay, but a permanent reduction, so it is not clear when the drug categories would be added and the rebates collected.

- The Department should respond to the points raised above and also discuss the consequences of delaying HIPAA conversion.