AGENDA
SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER PATTY BERG, CHAIR

MONDAY, MARCH 26, 2007
STATE CAPITOL, ROOM 127
4:00 P.M.

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4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH
HIV/AIDS PROGRAMS

Department of Public Health Office of AIDS

The Office of AIDS (OA), which will be located in the Department of Public Health, is the lead agency responsible for coordinating state programs, services, and activities relating to HIV/AIDS. The office is committed to assess, prevent, and interrupt the

transmission of HIV, and to provide for the needs of HIV-infected Californians. There are three branches and two sections in the OA: HIV/AIDS Epidemiology Branch, HIV Care Branch, HIV Education and Prevention Services Branch, AIDS Drug Assistance Program Section, and the Administration Section.

For 2007-08, the Governor's Budget proposes a total of $414.6 million ($176.9 General Fund) for programs operated by the OA. This represents a reduction of $3.7 million ($3.6 million General Fund) compared with estimated spending in the current year. The largest program operated by the OA is the AIDS Drug Assistance Program (ADAP), which ensures that uninsured and under-insured HIV-positive persons who do not qualify for Medi-Cal have access to drug therapies that can increase the duration and quality of their lives. Budgeted ADAP spending in 2007-08 totals $299.4 million ($107.7 million General Fund), which is the same as estimated current-year spending for the program.

Department of Health Care Services—Medi-Cal

Medi-Cal also provides health care for low-income persons with HIV/AIDS who qualify for Medi-Cal. The Department of Health Services (DHS) estimates that these health care costs will be over $700 million ($350 million General Fund) in 2007-08.

ISSUE 1: PROPOSED CUT TO EDUCATION AND PREVENTION

The Governor's Budget proposes to reduce funding by $5.6 million (General Fund) for Education and Prevention Programs administered by the OA. Total funding would decrease from $37.8 million ($30.5 million General Fund) in the current year to $32.2 million ($24.9 million General Fund) in 2007-08. The spending amount in the current year also reflects a reduction of $1.2 million from 2005-06 due to a reduced level of federal funds.

BACKGROUND

The HIV Education and Prevention Services Branch collaborates with local health jurisdictions (LHJs), community-based organizations (CBOs), service providers, advocacy organizations, universities, and other state and federal agencies to develop and implement focused HIV education and prevention programs. The Branch's three sections, (HIV Counseling, Testing, and Training; HIV Community Prevention; and HIV Prevention Policy and Program Development) carry out its primary goals: preventing HIV transmission, changing individual attitudes about HIV and risk behaviors, promoting the development of risk-reduction skills, and changing community norms that may sanction unsafe sexual and drug-taking behaviors.

The goals of the HIV Education and Prevention Services Branch are to positively impact community norms; increase the community's knowledge of HIV; and change individual behaviors through HIV education, risk reduction, and HIV detection. California's local

health jurisdictions develop comprehensive education and prevention plans that include interventions based in behavioral science theory and tailored to meet the specific needs of individuals in their jurisdictions. Virtually every education, risk reduction, and prevention intervention must be customized to be effective, culturally appropriate, and sensitive to the individuals being served.

Funding History. The program's base received a $4 million budget reduction in 2001-02 during the state's fiscal crisis. For 2005-06, DHS implemented a revised allocation formula primarily based on each jurisdiction's proportion of current HIV/AIDS cases (the prior formula also targeted hard-to-reach low-income populations in minority communities). As a result, there was a significant reallocation of funds within the already-reduced base that would have left some counties with a substantial shortfall. In response, the Legislature restored base funding by $5.6 million in 2005-06 to maintain funding to the impacted jurisdictions at their 2001-02 levels under the new allocation formula. The Governor's 2006-07 Budget proposed to eliminate this funding, but the Legislature again acted to restore it.

Use of the Funds. The OA provided the restored funds to local jurisdictions for use in four focus areas: current program augmentation; new programs (without OA committing to ongoing funding); capacity building; and capital expenditures (equipment and supplies to support education and prevention interventions). Forty-seven individual or regional health jurisdictions received additional funds in 2006-2007, and were allowed to invest in some, or all, of the focus areas.

- 70 percent invested in current programs
- 47 percent invested in capacity building
- 17 percent invested in capital expenditures, equipment or supplies
- 32 percent invested in new programs

If the $5.6 million budget reduction is not restored, these jurisdictions will have to reduce or halt expanded programming in the four focus areas above. Some examples of programs funded in the current year with these funds include the following:

- Alameda County implemented a Partner Counseling and Referral Service program building on the formative research project completed for the African – American Initiative.

- The City of Berkeley increased the number of high-risk methamphetamine users

receiving risk-reduction sessions from 150 to 350.

- Fresno, Kings, Madera, Merced, and Tulare Counties created a regional collaboration to develop and present consistent HIV/AIDS risk-reduction and testing messages. Various media were developed and counties will select materials best suited to their communities. Additionally, Tulare and Kings County collaborated to present an HIV risk-reduction conference for migrant workers and their families.

- The Santa Cruz Public Health Department provided a mini-grant to Salud Para La Gente for HIV prevention services in the south county area targeting primarily Latinos. This allowed for Spanish-speaking targeted prevention activities and individual level interventions.

STAFF COMMENTS

- The department should comment as to whether it believes that there is a reduced need for HIV/AIDS prevention and education efforts.

- The current General Fund support of $35.5 million for this program should be compared with the more than $500 million annual cost of HIV/AIDS care and treatment (plus substantial costs to health insurers). Prevention has a large potential payoff.

ISSUE 2: THERAPEUTIC MONITORING PROGRAM

The budget proposes to continue funding at $4 million (General Fund) for the Therapeutic Monitoring Program (TMP) in 2007-08. The OA administers the program, which provides access to specific laboratory tests (viral load and resistance testing) through a voucher-based program for low income, HIV-infected Californians who are uninsured or underinsured. HIV therapeutic monitoring provides clinicians with the objective tools to measure the efficacy of a particular course of highly active antiretroviral therapy (HAART), thereby increasing successful outcomes, and ensuring the quality of life and longevity of HIV-infected persons.

Additional Funding Needed to Meet the Need for Testing. In response to a staff inquiry, the OA indicates that an increase of $4.5 million (General Fund) would allow the program to be responsive to requests from the local health jurisdictions for additional vouchers. The additional money would purchase viral load and resistance tests at the following rates: viral load = $100/test; genotypic resistance tests = $360/test; phenotypic resistance tests = $675/test and virtual phenotype (a new offering based on

the recent RFA process) = $145/test.

In 2005-06, the Office of AIDS received 53,288 requests for viral load vouchers and only had the funding to release 38,820 (approximately 73 percent of need). The unmet need for 2006-07 is estimated at 13,000 viral load tests, 1,134 genotypic vouchers, and 154 phenotypic vouchers.

For 2007-08, a statewide survey of anticipated need for TMP was conducted in October 2006, and the response indicated total viral load test requests for 59,600 vouchers, 4,233 requests for genotypic resistance test vouchers, and 1,490 requests for phenotypic resistance test vouchers. Based on these survey responses alone, there would be a need for $8.5 million ($4.5 million more than budgeted).

STAFF COMMENTS

1.
Therapeutic monitoring is needed to ensure that drug therapies are effective. They enable physicians to prescribe the best drug combinations and regimens for HIV-infected patients. The tests also are crucial to determine if resistance to a drug has occurred and the medications require adjustment.

2.
Cutting off vouchers for therapeutic monitoring risks wasting state funds on drug therapies that may not be as effective as possible or may not be effective at all. Most importantly, it exposes patients to unnecessary risk of deterioration and premature death.

ISSUE 3: MEDI-CAL HIV/AIDS PHARMACY PILOT PROJECT

AB 1367 (Laird and Steinberg)—Chapter 850 of 2004 established this program to evaluate the effectiveness of pharmacist care in improving health outcomes for people with HIV/AIDS. The program is limited to 10 specialty pharmacies who serve at least 90 percent HIV/AIDS patients. These pharmacies receive an additional dispensing fee of $9.50 in order to cover the cost of providing medication therapy management services to these patients. These services may include patient assessments, formal treatment plans, frequent monitoring and adherence counseling, specialized packaging, home delivery, and coordination with broader managed care.

Evaluation Required. AB 1367 requires the department to gather information from the pilot project in order to evaluate the effectiveness of pharmacist care in improving health outcomes for HIV/AIDS patients.

Under AB 1367, the pilot sunsets on January 1, 2008. The Governor's budget includes

$570,000 (General Fund) for half-year funding in 2007-08. However, no evaluation results have been produced to date. The department has contracted for an evaluation with the University of California, San Diego, and hopes to have an initial set of preliminary results by late May.

STAFF COMMENTS

1. It would be premature to end funding for the project before the evaluation results are available.

2. An initial study in San Francisco provides evidence that the pharmacy pilot project is improving several indicators of HIV infection status in participants.

3. If the UC San Diego evaluation demonstrates that improved health outcomes for patients that would constitute a basis for making the program ongoing.

4. For the small extra cost of the dispensing fee, Medi-Cal may be saving significant costs for hospitalization and treatment of AIDS-related conditions. The evaluation results are needed to determine if this is the case.

ISSUE 4: NEW STRATEGIES FOR HIV/AIDS PROGRAMS

The California HIV Alliance indicates that an estimated 25 percent of Californians who are HIV-positive do not know it, and that 20 percent of Californians who know that they are HIV-positive are not receiving treatment. Furthermore, the Alliance indicates that new HIV infections in California remain constant at between 6,700 and 9,000 persons each year. The Alliance is proposing the following additional new strategies.

$2.5 million for Innovative Testing. Innovative HIV testing would include mobile vans, and neighborhood-based HIV testing. The Office of AIDS (OA) indicates that this proposal would be consistent with its Neighborhood Intervention Geared toward High-risk Testing (NIGHT) program in which testing and outreach is taken into the areas where high-risk individuals work, live, and socialize. For a number of years, OA has approved funding for mobile vans for several local health jurisdictions (LHJs); however, many have ultimately declined funding of the vans because of other costs associated such as maintenance/repairs, fuel, and insurance.

$2 million for HIV Testing in County Hospital Emergency Rooms. Emergency room (ER) testing is recommended by the Centers for Disease Control (CDC). The OA indicates that $2 million would purchase approximately 150,000 rapid test kits, plus controls. However, while the OA is generally in favor of more testing in county hospital ERs, it believes that funding for such testing should be covered by third-party payers, Medi-Cal or other types of funding sources. CDC believes that HIV testing in ER settings is an effective way to identify new HIV-positive clients that would not access the existing public health testing system. ER staff that have instituted such programs report staff buy-in and training as significant, but surmountable, challenges to implementing testing in these settings. Highland Hospital (Alameda County), SF General Hospital (San Francisco County), and USC Hospital (Los Angeles County) currently conduct ER testing, according to the OA.

$500,000 for a Demonstration Project to Fund Free Supplies of Condoms. The condoms could be ordered over the OA's website for distribution to health, social service agencies, and businesses frequented by high-risk individuals. The OA believes this proposal would be useful. In the past, the office has had to take funds from condom distribution to fund rapid test kit purchases and the proposed additional funds would help address this shortfall. In 2004, the decision to divert funding from condom distribution to purchase rapid test kits was a public health decision based on the number of people who had actually tested preliminary HIV-positive, yet had not returned to receive their test result. A New York program, begun in 2006, has been successful according to all of the media coverage it has received and the Office of AIDS has not noted any negative coverage. This is a new program which began in 2006. The website ordering system could have a benefit in getting condoms where they really need to go, rather than only distributing them to the LHJ, which is the current process.

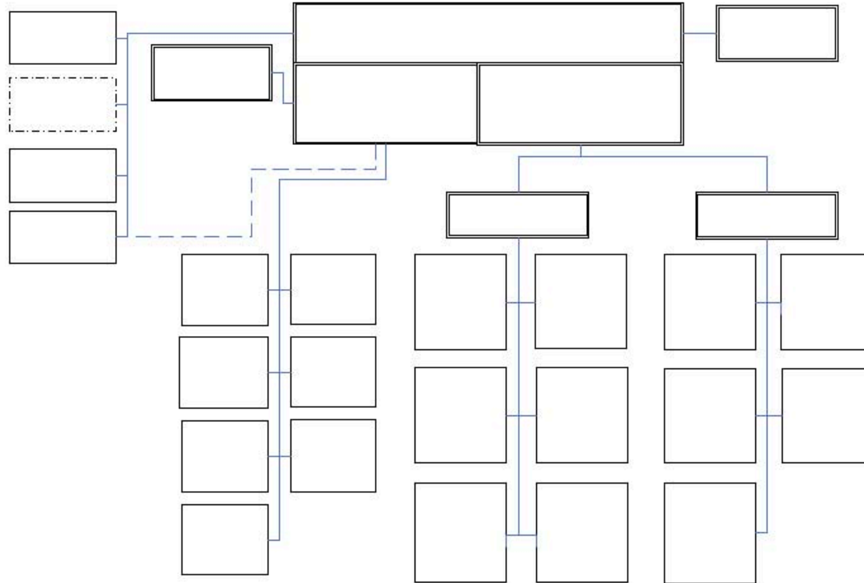
4260 DEPARTMENT OF HEALTH CARE SERVICES

Effective July 1, 2007, the budget plan implements Chapter 241, Statutes of 2006 (SB 162, Ortiz), which creates a new state Department of Public Health and renames the existing Department of Health Services as the Department of Health Care Services (DHCS). The DHCS finances and administers several health care service delivery programs, including the Medi-Cal Program, Children’s Medical Services, the Office of Long-Term Care, the Primary Care Clinic Program, and the Rural Health Program. The budget proposes total expenditures of $38.1 billion ($14.9 billion General Fund) for DHCS in 2007-08. Of the total amount, $37.7 billion ($14.7 billion General Fund) is for local assistance (primarily payments to health care providers and to counties) and $418.8 million ($151.7 million General Fund) is for state support. The largest portion of DCHS spending by far is for the Medi-Cal Program ($37.7 billion, or 99 percent). Other significant expenditures are for Children's Medical Services ($314 million) and for Primary and Rural Health Programs ($57.8 million). The budget proposes total staffing of 2,957 personnel-years (PYs) for DHCS in 2007-08.

The chart below shows the planned organization of the new DHCS.

Department of Health Care Services

Effective July 1, 2007



Medi-Cal

The California Medical Assistance Program (Medi-Cal) provides health care services to qualified low-income persons (primarily children and families with children and the aged, blind, or disabled). The program provides health care to both CalWORKs and SSI/SSP recipients, but most Medi-Cal enrollees are not welfare recipients. Medi-Cal incorporates California's version of the federal Medicaid Program plus several state-only components. Expenditures for medical benefits generally are shared about equally by the General Fund and by federal funds. The DHCS will continue to be the single state agency accountable for all federal Medicaid funding. Consequently, the DHCS Medi-Cal budget also includes federal Medicaid funds for (1) disproportionate share hospital payments and other supplemental payments, which provide additional funds to certain hospitals that serve Medi-Cal or other low-income patients; and (2) matching funds for state and local funds in other related programs.

The budget proposes Medi-Cal expenditures totaling $37.7 billion from all funds for state operations and local assistance in 2007-08. Figure 1 displays a summary of Medi-Cal General Fund expenditures in the DHCS budget for the past, current, and budget years. Proposed General Fund spending for local assistance ($14.6 billion) increases by about $980 million, or 7.2 percent, compared with the estimate for the current year. The bulk of this increase is for benefit costs. Significant factors contributing

to this increase are (1) higher costs for services provided to Medi-Cal beneficiaries and (2) required rate increases for managed care plans, nursing facilities, and certain long-term care facilities. Some of these rate costs are offset by fees assessed on those providers and deposited in the General Fund, which are not reflected here.

Source: Legislative Analyst's *Analysis of the 2007-08 Budget Bill.*

The budget also includes $22 billion of federal funds, an increase of 4.4 percent from the current year. This amount includes about $5.3 billion of federal matching funds budgeted for programs operated by other departments or counties. In addition, the spending total for the Medi-Cal budget includes an estimated $607 million in local government funds for certain payments to hospitals.

The 2007-08 budget proposal does not include any resources for the Governor's health care coverage expansion plan.

Figure 1

Medi-Cal General Fund Budget Summary[a]
Department of Health Services

(Dollars in Millions)

	Expenditures			Change From 2006-07	
	Actual 2005-06	Estimated 2006-07	Proposed 2007-08	Amount	Percent
Local Assistance					
Benefits	$12,072	$12,828	$13,765	$937	7.3%
County administration (eligibility)	674	720	763	43	6.0
Fiscal intermediaries (claims processing)	84	101	101	—	—
Totals, Local Assistance	$12,830	$13,649	$14,629	$980	7.2%
Support (state operations)	$131	$146	$119	-$27	-1.8%
Caseload (thousands)	6,572	6,594	6,702	108	1.6%

[a] Excludes General Fund Medi-Cal budgeted in other departments.
Detail may not total due to rounding.

ISSUE 1: HELPING VETERANS USE VA HEALTH CARE

The Legislative Analyst's Office (LAO) estimates that there are approximately 144,000 military veterans in California who could be receiving comprehensive medical benefits from the Veterans Administration (VA) health care system but who are enrolled instead in the Medi-Cal Program. The LAO believes that the state could eventually save as much as $250 million General Fund annually from a voluntary shift of veterans from Medi-Cal into VA health care. This is because the state generally pays for about half of Medi-Cal costs, while the VA's support is entirely federal. As a starting point LAO recommends that the state implement a federal data matching system which would allow California to identify veterans who could transfer to the VA health care system.

BACKGROUND: VA HEALTH CARE IN CALIFORNIA

The VA operates an extensive and comprehensive health care system in California. There are major VA medical centers in Loma Linda, Long Beach, Los Angeles, and San Diego, which comprise the Desert Pacific Healthcare Network, and in San Francisco, Palo Alto, Sacramento and Fresno, which comprise the Sierra Pacific Network. In fiscal year 2004, VA facilities in the Sierra Pacific Network had more than 2.4 million outpatient visits and 23,000 inpatient admissions. Facilities in the Desert Pacific Healthcare Network had more than 2.3 million outpatient visits and 24,700 inpatient admissions.

VA California provides a full range of medical services, including acute medical, surgical, psychiatric and nursing home care. Specialty units at most medical centers offer veterans cardiac catheterization, lithotripsy, clinical pharmacology, MRI, PET scanning, radiation therapy, women's health programs, and treatment for spinal cord and traumatic brain injuries, post-traumatic stress disorders and blind rehabilitation. The medical centers are augmented by 48 community outpatient clinics located throughout the state. These clinics offer a full array of primary care services for veterans in the communities where they live and work.

Each medical facility is affiliated with at least one major medical school (University of California, San Francisco, Davis, Irvine, San Diego and Los Angeles; Stanford University; University of Southern California and Loma Linda University) and provides training for more than 4,000 students annually in nursing, dentistry, dietetics, audiology and speech pathology, medical technology, radiation technology, pharmacology, podiatry, psychology, physical and occupational therapy and social work.

A wide range of geriatric health-care services are offered, including home-based primary care, geriatric clinics, adult day care, and home-based hospice programs. Nursing home programs are located at San Francisco, San Diego, Palo Alto (two), Los Angeles (two), Livermore, Fresno, Loma Linda, Long Beach, and Martinez. Services offered in these programs include hospice, sub-acute, dementia, gero-psychiatric, respite neurocognitive, and rehabilitation care.

Status of VA Facilities. Walter Reed Hospital, where the most serious deficiencies in care have occurred for wounded soldiers, is a Department of Defense facility, not a VA hospital. A recent survey of VA hospitals found some deterioration due to unmet maintenance needs. VA facilities will face challenges in caring for a significant number of wounded and injured veterans of the Iraq War. It appears likely, however, that Congress will provide funding to help address these issues.

VA Health Benefit Eligibility

The VA has eight priority groups for veterans' health care. The higher priority groups receive preference if VA resources are limited. Veterans who are eligible for Medi-Cal automatically qualify for the fifth priority group and may qualify for a higher priority group on an individual basis, such as a service-connected disability. Family members of

veterans also may be eligible for VA-sponsored coverage.

Some Benefits Better than Medi-Cal. Once enrolled in the VA healthcare system, veterans have greater access to some medical benefits, such as mental health counseling and treatment for alcohol and substance abuse, than they would have under Medi-Cal. For example, the VA does not place a cap on the cost of dental services or limit the number of days a patient can be hospitalized for inpatient stays on a yearly basis. Unlike Medi-Cal, the VA system does not require that a beneficiary pay down his or her assets until they become "medically needy" before covering the costs of long-term care.

PARIS MATCHING SYSTEM

The LAO has identified a federal computer data matching process known as the Public Assistance Reporting Information System (PARIS) that enables states to share information with one another about individuals enrolled in state and federal health and social services programs. The system identifies public assistance recipients in participating states who are eligible for federal benefits, including VA benefits. The process also identifies individuals who are simultaneously enrolled in and receiving benefits from Medicaid, SSI/SSP, Temporary Assistance for Needy Families (known as TANF or CalWORKs in California) and/or Food Stamps in more than one state.

According to LAO, the state's participation in PARIS could benefit both the state and veterans by reducing Medi-Cal costs and increasing veterans' access to medical services. The state's participation in PARIS also could improve program integrity and result in a cost reduction in certain state health and social services programs.

Current Veteran Identification Process. As part of the regular Medi-Cal eligibility process, county welfare workers ask applicants whether they have served in the armed forces and have veteran's status. If so, the county eligibility worker has the applicant fill out a form, which is then forwarded to a County Veterans Service Office (CVSO) where a case worker will contact the VA to determine the benefits to which the applicant is entitled. The CVSO performs any necessary follow-up Medi-Cal currently reimburses the CVSOs approximately $800,000 annually for these activities.

Not all veterans enroll in Medi-Cal through county welfare offices. The U.S. Social Security Administration (USSSA) determines eligibility for SSI/SSP grants, which also provide automatic Medi-Cal eligibility. Social Security offices do not file any forms with the CVSOs or provide them with any notification that would alert the CVSO that it needs to perform outreach to a veteran.

Potential for up to $250 Million Annual State Savings Eventually. Under federal law, the Medicaid Program is intended to be the payor of last resort, meaning that all other available sources for a beneficiary's provision of care, such as private insurance or other federal programs (such as the VA), must be exhausted before Medi-Cal can provide services. Although county welfare workers are supposed to screen for veterans when processing Medi-Cal applications, a 2005 survey performed by the US Census

Bureau indicates that approximately 144,000 veterans in California received Medi-Cal benefits. LAO estimates the cost of such benefits totals approximately $500 million ($250 million General Fund). Because approximately 90,000 of the 144,000 veterans served in World War II, the Korean War, and the Vietnam War, they are likely to be in the aged and disabled category of beneficiaries, which is a high-utilization, and therefore high cost, group.

Short-Term Savings Goal of $25 million. It is unlikely that the state could save the full $250 million because some veterans may choose to continue receiving Medi-Cal services. In some areas, VA services may be more difficult to access. Some veterans in Medi-Cal may have established relationships with physicians and other providers that they wish to maintain. For some veterans, a mix of Medi-Cal and VA health services may be the best approach and could provide a better benefit package than either system could alone. Furthermore, it will take some time to implement an effective matching system, perform outreach to eligible veterans and to transition them into appropriate VA care. For these reasons, the LAO suggest a short-term state savings target of $25 million—shifting 10 percent of Medi-Cal veterans' costs to the VA.

Additional Savings from Other Matches. In addition, LAO points out that the PARIS system can be used to generate additional General Fund savings of $3 million by eliminating capitation payments for Medi-Cal beneficiaries who have moved to another state and $4 million by eliminating CalWORKs and SSI/SSP payments to recipients who are no longer in the state.

Most Other States Already Participate in PARIS. Currently, 42 states participate, including New York, Florida, Nevada, Arizona, and Oregon. Of the Western and Southwestern states, only California and Texas do not currently participate.

LAO RECOMMENDATIONS

LAO recommends that the state participate in the PARIS computer matching process by taking the following steps:

1. Establish DHCS as Lead Agency with County Review of the Matches. Participating states have emphasized the need for each state to establish a central point of contact to ensure quick communication between states regarding matches. LAO recommends that DHCS act as the lead department because it has the largest potential for savings. Matched cases need prompt review to ensure success. LAO also recommends designating county welfare offices to complete the follow up when a PARIS match indicates that a person is receiving duplicate benefits.

2. Provide Resources to Implement PARIS. Funding will be needed to make system changes in various health and social services computer programs so they can interact with PARIS. LAO recommends that DHCS and DSS report at budget hearings on the estimated savings that are likely to result from PARIS, the resources required at the state and local level to implement PARIS, and federal funding available to offset these

costs.

3. Report at Budget Hearings on Feasibility of Implementing DHCS Data System Changes. LAO recommends that DHCS report at budget hearings on the feasibility of changing the DHCS' MEDS system to allow county eligibility workers and DHCS to flag veterans during intake and allow DHCS to easily scan the Medi-Cal rolls for veterans on a regular basis in order to facilitate outreach to them.

4. Utilize the CVSOs in Outreach Efforts for Veterans. County welfare departments are supposed to refer veterans to CVSOs. However, it appears this is not always happening. LAO recommends that DHCS report at hearings on ways to improve coordination of referrals between county welfare departments and CVSOs.

5. Renegotiate MOU With Social Security Field Offices. The current memorandum of understanding (MOU) with USSSA regarding the SSI/SSP Program does not require that Social Security eligibility workers refer veterans to CVSOs. LAO recommends that the DHCS work with DSS to modify the MOU between DSS and USSSA requiring these eligibility workers to refer all eligible veterans to CVSOs as is the practice with county eligibility workers.

STAFF COMMENTS

1. LAO indicates that DHCS currently is studying PARIS implementation. DHCS should respond to each of the specific LAO recommendations.

2. LAO and DHCS should address the feasibility of a General Fund savings target of at least $25 million in 2007-08. How much savings could be realized through relatively simple steps to identify veterans? For example, screening SSI/SSP intakes and the MEDS eligibility database and providing outreach through the CVSOs and counties to those veterans to make them aware of VA benefits and health care resources and to assist them to access those resources.

3. What steps should be taken to coordinate care and provide for continuity of care for veterans in Medi-Cal?

a. For example, would it be helpful to establish pilot programs with County Organized Health Systems to transition veterans to the VA and/or to manage ongoing coordinated care from both systems when that would provide the best care for a veteran?

b.
 Would any state or federal law changes be necessary to enable transition and coordination between Medi-Cal and the VA?

ISSUE 2: MEDI-CAL MANAGED CARE RATES

As has become customary, the Governor's budget for 2007-08 does not include any funding for new rate increases for Medi-Cal managed care plans. The budget does include $66 million in the current year and $133 million in 2007-08 (total funds) to restore the 5-percent fee-for-service provider rate reduction, which was enacted with the 2003-04 budget and ended on January 1, 2007. The reduction had been restored for fee-for-service providers, but an equivalent 2-percent reduction continued to be applied to Medi-Cal managed care plans until January. Otherwise, the budget provides for anticipated caseload growth and the continuation of certain ad-hoc adjustments made in the current year to keep certain plans financially viable. The department indicates that it expects to propose managed care rate adjustments in the May Revision.

Rate Status

The Medi-Cal Managed Care program has three models for serving Medi-Cal beneficiaries in 22 counties and contracts with Kaiser in two additional counties (Marin and Sonoma).

GMC and COHS Plans. The California Medical Assistance Commission (CMAC) has statutory authority for negotiating the contracts for the Geographic Managed Care (GMC) plans and four of the five County Organized Health Systems (COHS), and under state law, those negotiations are confidential. The GMC contracts are in Sacramento and San Diego counties and the COHS model used in Yolo, Napa, and Solano counties (Partnership HealthPlan); the health plan of San Mateo; CalOptima in Orange County; and the Central Coast Alliance for Health in Monterey, and Santa Cruz counties. All of these COHS have a rate year beginning July 1, except CalOptima, which has a rate year beginning October 1.

Two-Plan Model. This model operates in San Francisco, Alameda, Contra Costa, Santa Clara, Stanislaus, Fresno, San Joaquin, Kern, Tulare, Riverside, San Bernardino, and Los Angeles. The Two-Plan model has a rate year of October through September. The CDHS is paying all contracts at the current 2006-07 rates. These rates comprise the annual redetermination, effective October 1, 2006 and the restoration of the provider rate decrease effective January 1, 2007. All contract amendments and change orders are fully executed. The CDHS granted Contra Costa Health Plan, which is the local initiative in Contra Costa County, an additional increase as a result of a financial review conducted by the department in 2005-06. That increase is included in the existing contract and rates.

Prepaid Health Plan. Kaiser operates as a prepaid health plan in Marin and Sonoma

counties and has a rate year of October to September. The CDHS has calculated rates for the annual redetermination, effective October 1, 2006 and the restoration of the provider rate decrease effective January 1, 2007. The CDHS is processing a contract amendment for these rates and is paying at January 2006 rates until the amendment is fully executed.

Santa Barbara Regional Health Authority. SBRHA is one of five COHS plans, but is the only one that negotiates directly with DHS on its contract and rates. The DHS is currently using rates negotiated for the period 1/1/06 - 6/30/06. The department is in negotiations with the plan for 7/1/06 - 6/30/07. The rate package is currently under review at DHS.

Background on the Rate Freeze

Beginning in 2001, and due to state budget problems, Medi-Cal has, with some exceptions, frozen its rates for managed care plans. This freeze has occurred during a time when healthcare inflation has been high and other State programs such as Healthy Families and CalPERS have negotiated plan rate increases. With the exception of policy adjustments, which are funded mandates that reflect increased costs associated with new regulatory or statutory requirements, and funding augmentations for a few financially distressed managed care health plans, Medi-Cal managed care rates have been held constant at July 2001 levels. Unlike the fee-for-service system, the Medi-Cal managed care plans also sustained a three year legislatively mandated reduction.

Rate Adjustments in 2006-07

Restoration of the Rate Decrease for all Medi-Cal Managed Care Plans. Medi-Cal managed care plans have sustained the equivalent of a 5 percent provider rate reduction since 2004 as required by law (AB 1762, Chapter 230 of 2003). Although this reduction was supposed to mirror a reduction in Medi-Cal fee-for-service rates, it was only applied to managed care plans due to a legal challenge. This reduction approximated an actuarial equivalent of 1.97 percent across all plans and terminated effective January 1, 2007. The Governor's Budget includes a total of $66 million in the current year and $133 in 2007-08 to restore this funding.

Financial Viability Adjustments. Due to concerns about the financial viability of some Medi-Cal managed care plans, the department conducted a financial review to determine whether funding increases were necessary to keep a number of health plans financially solvent through FY 2006-07. The review focused on identifying health plans whose tangible net equity (TNE) or financial reserves had been depleted to a level that would render the health plan noncompliant with state regulations prior to the FY 2007-08 rate period. The department's auditors conducted on-site visits to health plans that met the above criterion.

In determining recommendations for rate increases, the department considered whether plan management demonstrated good administration and appropriate cost controls and

whether depletion of reserves was due to business decisions such as directing reserves to non-Medi-Cal lines of business or other major assets. As a result of this process six Medi-Cal managed care plans receive funding increases in the 2006-07 Budget totaling $78 million ($39 million General Fund); including an approximate $7 million special increase for the Community Health Group. The Legislature provided an addition $9.3 million, which was vetoed. The rate increases were implemented effective with each plan's rate year as follows:

- Central Coast Alliance for Health--$17.4 million (July 2006)
- Health Plan of San Mateo-$7.7 million (July 2006)
- Partnership Health Plan (Yolo, Solano and Napa)-- $25.3 million (July 2006)
- Santa Barbara Health Plan--$11.2 million (July 2006)
- Contra Costa Health Plan--$2.9 million (October 2006)
- Community Health Group (San Diego)--$13.7 million (July 2006)

Rate Methodology and the Mercer Report

DHS makes its rate determinations for plans in the Two-Plan Model counties (the largest managed care group) using a simplified approach:

- Years-old data from several of the COHS plans on their utilization and cost of services (such as hospital inpatient, physicians, and pharmacy) by Medi-Cal eligibility category provides a cost base.

- Various adjustments are made to the base costs for geographic cost differences, differences in the mix of enrollees, coverage differences, and policy changes in order to derive a rate for an individual plan.

- The cost factors are brought up to the rate period using Medicaid price and utilization trends, and an allowance for administrative costs is added to yield an initial rate.

- The initial rate is reduced by a "budget adjustment factor" (currently about 11 percent)

in order to remain within DHS' budget constraint—keeping overall rate spending frozen aside from policy changes. As a result, the DHS rate setting process has primarily served to reallocate funds rather than increase funding.

- CMAC conducts confidential negotiations with plans to set rates. Nevertheless, some plans complain that this process is more of a black box than a negotiation in that they come out of the negotiation with a rate, but no specific explanation of how it was derived.

Mercer Report Recommendations. DHS contracted with Mercer Consulting to review its rate setting methodology and the adequacy of data, and to make recommendations for a rate setting approach. Mercer's recommendations were detailed and technical, but included the following general points:

1. Rates should be determined using recent encounter and cost data from each plan.
2. Implement standardized financial reporting for each Medi-Cal capitated risk group.
3. Perform a detailed review of health plan financial statements to identify appropriate costs or other factors to use in rate development.
4. Analyze specific risk factors and make appropriate adjustments for each plan.
5. Implement a maternity supplemental payment to cover the cost of deliveries.

Mercer also cited guidance from the American Academy of Actuaries that actuarially sound rates should be independent of budget issues although budget constraints may influence the selection of certain assumptions towards the low end of the range.

Congressional Concern. In a letter dated September 28, 2006 to the Governor, a bipartisan group of 19 members of the California Congressional Delegation (including now-Speaker Pelosi) expressed the view that the state's rate-setting methodology was not actuarially sound and violated federal regulations. They urged him to step in to correct the situation and correct inadequate rates that "threaten the continued viability of

the program."

The California Association of Health Plans (CAHP) and the Local Health Plans of California have both provided letters to the Committee urging the adoption of an actuarially sound rate-setting methodology, and specifically requesting the elimination of the budget adjustment factor. The plans also request that the Legislature direct DHS/DHCS to report to the fiscal committees regarding the methodology and assumptions it proposes to use for each rate year; what actions the department will take as a result of the Mercer Report; and to provide rates to plans in a timely manner (rather than months after the start of the rate year, as has often been the case).

STAFF COMMENTS

1.
The department has indicated that it intends to use a Mercer methodology to develop rates for the next rate year (starting October 1 for the Two-Plan counties).

a.
When will DHS provide the Legislature and the plans with its new rate methodology?
b.
Will plans be notified of their rates prior to the start of their rate year?

2.
What approach will DHS take in adjusting the 2007-08 rates? Does DHS intend to follow the same practice that it followed last year—wait until the May Revision and then provide rate increases only if needed to prevent plans from violating regulatory equity requirements?

3.
Many Medi-Cal managed care plans are struggling financially, especially the County Organized Health Systems (COHS) that serve the Aged, Blind, and Disabled (ABD). Does DHS have plans to address the financial situations many of these plans face?

4.
DHS claims that the 2006-07 rate adjustments brought plans up to 200 percent of Total Net Equity (TNE). However, the plans argue that they only were brought up to 160 percent of TNE.

5.
The Governor has proposed expanding Medi-Cal managed care into more counties. Several additional counties have expressed support for joining Partnership Health Plan, the COHS currently operating in Yolo, Solano and Napa Counties. When will DHS

and/or CMAC present rates to Partnership and other Medi-Cal managed care plans so that they can go forward with expansion?

ISSUE 3 : FAMILY PACT

The Family PACT 1115 Medicaid Demonstration Project Waiver was approved by the federal Centers for Medicare and Medicaid Services (CMS) on December 1, 1999, and expired November 30, 2004. California has been operating the program under CMS approved extensions since December 1, 2004. Family PACT provides family planning services, cervical and breast cancer screening, and testing and treatment of sexually transmitted diseases for low-income Californians. The Family PACT program helps Californians plan their family size and protect their fertility. The program does not provide pregnancy care or abortion-related services. In 2005-06, Family PACT provided services to 1.7 million clients.

The budget provides a total of $462 million ($150.5 million General Fund and $311.6 million federal funds) for the Family PACT Program. California presently receives a 90 percent federal match for family planning services and testing services for sexually transmitted infections, and a 50 percent federal match for most other services offered under the program. The federal government excludes about 18 percent of program costs from federal funding to account for services to undocumented persons.

The program prevents unplanned pregnancies to low-income women and families and reduces the financial and social impacts related to all unintended pregnancies and births. In addition, it serves to mitigate the spread of sexually transmitted diseases, and provides appropriate treatment for these diseases.

The Family PACT Program was first implemented in January 1997 as a state-only program. Under Family PACT, providers (private providers and clinics) assess a client's self-reported family size, income, need for confidentiality, and other eligibility criteria. If a client meets program criteria, the provider can enroll the client and provide services the same day. Eligibility data is transmitted to the state for review.

Cost-Effective. The federal government requires "budget neutrality" as a condition of approving any Medicaid Waiver. Budget neutrality means that the program must cost no more in federal financial participation than if the program did not exist and the target population instead utilized services through traditional Medicaid (Medi-Cal) programs**.** The federal CMS and federal Office of Management and Budget have concluded that California's Waiver has met this requirement each year. Based on the most recent year, the Family PACT Program saved $2.46 for every dollar paid in federal financial participation. The savings result primarily from avoiding Medi-Cal costs for labor and delivery and for ongoing care of a child.

No Federal Funds for Certain Services. The federal CMS has denied California federal matching funds provided under the Family PACT Program for the following

services: mammography screening; Hepatitis B vaccines; five procedures related to complications of particular contraceptive methods; and diagnostic testing to distinguish cancer from genital warts. The Governor's Budget includes $2.5 million (General Fund) to backfill for the loss of federal funds for these services, as required under state law, and participants will continue to receive these services.

Federal Funding in Jeopardy

The federal CMS has directed the State to apply certain provisions of the Deficit Reduction Act (DRA) of 2006 to the Family PACT waiver program. This would require the state to conduct *full* Medi-Cal eligibility determinations under the program, resulting in greatly increased administrative cost and complexity. Program participants would have to provide documentation of income and identity, including Social Security numbers and passports or birth certificates. Presently, Family PACT uses a simplified eligibility process initially conducted by the provider and verified by the state. This simplified process is done to facilitate access to services and care, and to avoid the high cost of doing a full eligibility determination for a program benefit which is very limited and low cost (i.e., basically family planning services and treatment for sexually transmitted disease when applicable).

According to the administration, it would cost the federal government, as well as the state, *more* money to perform a full eligibility determination for the Family PACT than to just continue with the simplified eligibility process and provide the services. Under the Family PACT, the average cost of a family planning benefit is $261 annually of which an average of 75 percent is borne by the federal government. If a full eligibility process is required as desired by the federal CMS, it would cost an *additional* $512 ($256 federal funds) per case for determining eligibility as done by county social services departments. Therefore, according to DHCS calculations, it would cost hundreds of millions more in federal funds to change to a full eligibility process. In addition, an equal state General Fund match for these added administrative costs would also be necessary.

This issue is still in negotiation between the administration and the federal CMS. If California does not prevail, an additional $300 million or more in state General Fund support *could* be needed in order to fund the existing Family PACT program.

STAFF COMMENTS

The department should update the Subcommittee regarding the status of the Family PACT Program and negotiations with the federal government.

1.
What is the administration's current agreement with the federal CMS as to the status of the Family PACT Waiver—i.e., how long can we continue to receive the month-to-month extensions?

2.
What are the key federal CMS concerns and why do they want to impose requirements that would not be cost-beneficial to the federal government or California?

3.
DHCS, Please briefly describe the changes California will be making to Family PACT to address certain federal CMS concerns.

4.
What are the next steps to be in resolving these issues with the federal CMS?

4280 MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB)

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without other health insurance. The MRMIB administers the: (1) Healthy Families Program (HFP); (2) Access for Infants and Mothers (AIM) Program; and (3) Major Risk Medical Insurance Program (MRMIP).

The budget proposes total expenditures of almost $1.3 billion ($394.7 million General Fund, $776.5 million federal funds and $111.1 million in other funds) for all MRMIB programs. This represents an increase of $82.5 million ($32.6 million General Fund) over estimated spending in the current-year. The net increase is due to changes in the Healthy Families Program and Access for Infants and Mothers (AIM) Program as discussed below.

Managed Risk Medical Insurance Board Proposed Spending by Program and Funding Source					
(dollars in thousands)	2006-07	2007-08	$ Change		% Change
Program					
Healthy Families Program (including state support)	$1,023,688	$1,099,685	$75,997		7.4
Major Risk Medical Insurance (including state support)	$44,652	$39,808	-$4,844		10.8
Access for Infants & Mother (including state support)	$128,403	$139,677	$11,274		8.8
County Health Initiative Program	$3,061	$3,168	107		3.5

Totals	**$1,199,804**	**$1,282,338**	**$82,534**		**6.9**
General Fund	$362,020	$394,669	$32,649		9.0
Federal Funds	$717,402	$776,529	$59,127		8.2
Other Funds	$120,382	$111,140	-$9,242		7.7

Background—SCHIP and the Healthy Families Program. Created by Congress in 1997, the State Children's Health Insurance Program (SCHIP), provides low-cost subsidized health coverage for uninsured children whose families make too much to qualify for federal Medicaid ("Medi-Cal" in California). SCHIP is nearly universally considered to have successfully expanded health insurance for low-income children across the United States and improved the health status of enrolled children. In California, SCHIP provides a 2-to-1 match (two federal dollars for every state dollar). The Healthy Families Program $1.1 billion 2007-08 budget consists of $690 million of federal funds and $440 million from the General Fund. Federal funds are set to expire for the program on September 30, 2007.

The Healthy Families Program in California. SCHIP pays for coverage of more than 1 million children in California, more than the combined total of New York and Texas, the next two largest programs. The Healthy Families Program (HFP) provides comprehensive health, dental; vision and mental health coverage to 800,000 children and the remainder receive services through Medi-Cal.

The HFP uses a managed care model of covering subscribers and MRMIB staff negotiates with health plans on the cost of coverage subscribers receive, much like many employers negotiate for their employees. The benefits are based on those provided to state employees by CalPERS. An applicant's eligibility is assessed by a private administrative vendor that processes applications, collects payment from subscribers, forwards applications, when appropriate, to Medi-Cal, and handles subscriber customer service calls.

Medi-Cal and HFP Coordination. California's SCHIP uses a joint mail-in application for the Medi-Cal (for children) and the Healthy Families Program. Children who receive services from the Child Health and Disability Prevention Program (CHDP) with family income below 200% FPL are granted "presumptive eligibility" (assumed to be eligible) for either HFP or Medi-Cal for up to two months while their eligibility is verified. If, however, their parent submits an HFP-Medi-Cal application during the two-month period, then their "presumptive eligibility" lasts until a final determination can be made for their eligibility in either Medi-Cal or HFP.

ISSUE 1: SCHIP REAUTHORIZATION NEEDED

Federal SCHIP funds expire September 30, 2007 unless Congress passes, and the president signs, reauthorization legislation before then. SCHIP is a block grant to states. The federal government caps the total and annual allotment of funds for each

state. Medi-Cal/Medicaid, in contrast, is an entitlement program with no federal funding caps.

In federal fiscal year, 2007 California received $791 million in federal SCHIP funds. During this same period, however, the state spent around $1.1 billion, nearly $300 million more, in federal funds. The state paid for these costs using federal funds that are allowed to be used for up to three years after they are awarded. California uses SCHIP funds to support the HFP (800,000 children); Access for Infants and Mothers (12,000 pregnant women and 401 newborns), and several local county initiatives (2,075 children). The MRMIB administers all of these programs. California also uses SCHIP funds for programs administered by the Department of Health Services (Department of Health Care Services starting July 1), which include Medi-Cal presumptive eligibility (245,000 children) and treatment services for disabled or chronically ill children who qualify for the California Children's Services Program. Diagnosis and treatment services for HFP children with serious emotional disturbances are provided by county mental health departments.

How Much Money Will California Need in SCHIP Federal Reauthorization? A pending California HealthCare Foundation report estimates that to maintain current eligibility levels California needs $2.7 billion to $4.1 billion over five years above the state's current 5-year allocation of $4 billion (the current allocation level is referred to as the "baseline") for a total of $6.7 to $8.1 billion over five years. In order to have sufficient funds to expand eligibility from 250 percent of poverty to 300 percent of poverty, the state would need $3.4 billion to $4.8 billion above baseline over five years.

The President's Proposed Budget Falls Short. The President's budget for federal fiscal year 2008 (which commences October 1, 2007) fails to provide sufficient funding for the federal SCHIP to sustain many state's programs, including California's. In addition, the President's proposal would restrict federal SCHIP funding to children in families with incomes at or below 200 percent of the federal poverty level. California's HFP covers children in families up to 250 percent of poverty, as well as infants born to women enrolled in the Access for Infants and Mothers (AIM) Program up to 300 percent of poverty.

Congress is presently discussing the reauthorization but has thus far focused on concerns regarding the current federal fiscal year. Fourteen states are projected to exhaust their SCHIP grants in the current federal fiscal year and efforts are underway to redistribute funds to provide assistance to them. (California is not one of these states.) Discussions regarding the federal budget year (commencing October 1, 2007) have not yet begun in earnest.

Policy Issues Being Considered by Congress. In addition to the total amount to be divided among all states, Congress is considering the following issues:

- Funding formula (low-income, uninsured and enrollment).

- Who is eligible – state flexibility versus limiting eligibility based on age (parents or other adults) and/or income levels.

- How long states will have to spend their allocation and any reallocation.

- Whether existing amendments to state plans and waivers granted to states continue to be honored after reauthorization.

- Will the requirement for face-to-face interviews as part of enrollment apply in Medi-Cal or SCHIP?

STAFF COMMENTS

The Subcommittee may wish to ask MRMIB to respond to the following questions:

1. Provide an update regarding the reauthorization of federal SCHIP funding, including both the perspective of the President's budget as well as discussions within Congress.

2. When does MRMIB expect the funding level to be known? What contingencies, if any, does the administration have in the event California cannot receive appropriate funding?

3. If California did not receive any additional funds, how long could we sustain our existing program (i.e., when might we fully expend our existing federal match)?