

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Dave Jones, Chair

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UPON ADJOURNMENT OF SESSION

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ITEMS ON CONSENT

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: INCREASE IN MEDICAID STATE PLAN AMENDMENT- ERROR CORRECTION

The Governor's May Revision requests the correction of an error made to the Increase in Medicaid State Plan Amendment. The proposal requests a decrease of \$3 million General Fund (GF) and an increase of \$3 million in reimbursements.

STAFF COMMENT

The adjustment reflects a revised estimate of the original programs covered by the Intermediate Care Facilities – Developmental Disabilities (ICF-DD)/State Plan Amendments (SPA). The Department of Developmental Services notes that an increase in federal funds was left out from the November estimates inadvertently.

ISSUE 2: ADDITIONAL FEDERAL FUNDS PARTICIPATION (FFP)

The Governor's May Revision requests a decrease of \$14.5 million GF and an increase of \$51.3 million in reimbursements to reflect the resources needed to obtain additional Federal Funds Participation associated with the Intermediate Care Facilities-DD/State Plan Amendment (SPA), as well as additional FFP resulting from an increase in services covered by the SPA.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: CALIFORNIA CHILDREN'S SERVICES PROGRAM

Background

The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including prematurity, birth defects, cancer, congenital heart disease, chronic illness, genetic disease and severe injuries due to accidents or violence. The CCS services must be deemed to be "medically necessary" in order for them to be provided.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. CCS depends on a network of Specialty Care Centers, specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).

The CCS Program provides specialized, pediatric health care services to about 200,000 low-income children and young adults annually. About 75 percent of CCS enrollees are Medi-Cal eligible. CCS enrollment consists of children enrolled as: 1) CCS and Medi-Cal eligible; 2) CCS- only (not eligible for Medi-Cal or the Healthy Families Program); and, 3) CCS and Healthy Families eligible. Where applicable, the State draws down a federal funding match and offsets this match against state funds as well as County Realignment Funds. CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

Need for Systems Review & Data Analysis

The CCS Program is a partnership of the State and Counties. The State establishes standards for pediatric facilities and providers, and oversees the regionalized system that ensures children are directed to physicians and hospitals with pediatric expertise to treat children with complex and rare conditions (CCS-eligible medical conditions).

Generally, program operations such as eligibility determination, authorizations for services and care coordination functions, are administered at the County level, except for a few smaller counties which are managed by State regional offices. Two years ago the DHCS recalculated how it funds CCS administrative functions at the local level. This has resulted in a limited allocation for these core functions.

Constituency groups have noted that many local CCS offices, along with State regional offices in Sacramento and the Central Valley, are struggling to complete key functions in a timely manner including CCS eligibility determinations, Service Authorization Requests (SARS), and Physician paneling. As such, the authorization of medical services has been delayed, as well as the timely discharge from hospitals and the acquisition of durable medical equipment. Enrollment of physicians into the program has also been significantly backlogged and can take

up to nine months to receive CCS approval. There is a shortage of pediatric sub specialists in California and these delays further reduce access to care for CCS children.

Constituency organizations have provided suggested improvements to the Department of Health Care Services (DHCS) related to streamlining paperwork and utilizing limited resources in a more cost-effective manner. One suggestion has been to implement "Hospital Liaison Teams" which would establish regional CCS nurses at pediatric tertiary centers to process service authorizations for all Counties located in the region. This has been done on a pilot basis in some areas and has proven to be cost-effective. More could be done in this area.

A significant on-going concern is the need for the DHCS to hire a Branch Chief for their Children's Medical Services Branch which is a key position that administers the CCS Program. This critical position has been vacant for over a year.

CCS Technical Advisory Meetings in 1115 Medi-Cal Waiver Demonstration Project—Pilot Projects

Discussion of the CCS Program has also occurred through a CCS Program Technical Advisory Committee established for development of CCS pilot projects to operate under the pending 1115 Medi-Cal Waiver. This 1115 Medi-Cal Waiver is to replace the existing Hospital Financing Waiver which expires in August 2010.

Though discussions are on-going, the DHCS proposes to proceed with four discrete models to test several delivery approaches. However, the core CCS Program would continue to operate as a discrete program while these pilot projects proceed. In discussions with this Technical Advisory Committee, the DHCS has noted that baseline data, quality metrics, and other data-driven factors are significantly lacking for the program overall and additional data mining and analysis is warranted. An analysis of the CCS Program conducted by a consultant in September 2009 ("*Considerations for Redesign of the California Children's Services Program*") also articulated that additional analyses of data are necessary in order to make informed decisions regarding CCS redesign options.

STAFF COMMENT

Various constituency groups, such as the Children's Regional Integrated Service System (CRISS), the Children's Specialty Care Coalition, the California Children's Hospital Association, and County CCS Program Director's have conveyed the need for selected improvements to the CCS Program for several years. Though some changes have occurred at the State-level, most of these have been relatively minor and incremental.

A more comprehensive approach to alleviating administrative burdens and focusing limited resources on core system functions is justified. In addition, with the advent of the State proceeding to test four delivery approaches to CCS Program services under the pending 1115 Medi-Cal Waiver, it is critical to also recognize the need to obtain baseline information on the CCS Program. Further, DHCS acknowledges that the business practices of the CCS Program need to be analyzed and has just begun to have DHCS internal auditors review the program to seek best practices and areas in which systems can be redesigned for streamlining purposes.

To facilitate a comprehensive approach, the following trailer bill and Budget Bill Language has been adopted by the Senate Budget Subcommittee on Health and Human Services and is proposed, as follows:

Proposed Uncodified Trailer Bill Language:

"The Department of Health Care Services (DHCS) shall seek support from one or more foundations to support and develop a study, or studies, of the California Children's Services (CCS) Program to be provided to interested stakeholders and the fiscal and policy committees of the Legislature by no later than March 2011. Issues to be addressed by these analyses may include the following:

- Systems analysis of core business processes and practices of the program, including service authorization requests (SARs), requests for durable medical equipment and reimbursement processing;
- Review of CCS Provider certification and enrollment process;
- Review of medical eligibility processing;
- Oversight and monitoring of quality of care;
- Identification of best practices for case management and care coordination functions, including discharge planning; and,
- Opportunities for the use of web-based tools, telemedicine, e-prescribing and other technologies to reduce costs and to streamline.

It is the intent of the Legislature for this study, or studies, to be used to: 1) administratively streamline the CCS Program; 2) serve as a tool to facilitate the development of statewide policies and procedures to improve the program; and, 3) serve as a baseline for development of CCS Program pilots implemented through the State's 1115 Medicaid Waiver."

Proposed Budget Bill Language:

"The department shall convene a diverse workgroup as applicable that, at a minimum, represents families enrolled in the CCS Program, counties, specialty care providers, children's hospitals, and medical suppliers to discuss the administrative structure of the CCS Program, including eligibility determination processes, the use and content of needs assessment tools in case management, and the processes used for treatment authorizations. The purpose of this workgroup will be to identify methods for streamlining, administrative cost-efficiencies, and better utilization of both State and county staff, as applicable, in meeting the needs of children and families accessing the CCS Program. The Department *may* provide the policy and fiscal committees of the Legislature with periodic updates of outcomes as appropriate."

ISSUE 2: FEDERAL “COMMUNITY LIVING/MONEY FOLLOWS THE PERSON” PROGRAM**Budget Issue**

The DHCS requests an increase of \$349,000 (federal funds) to support three new State positions (two-year limited-term) to meet increased workload demand attributable to community transitioning of individuals from nursing homes and other more restrictive environments when community-based support is appropriate and available. These efforts have been on-going for several years.

This includes two Nurse Evaluator II positions and an Associate Governmental Program Analyst. Key aspects of these positions include the following:

- Review medical histories and assess service needs of potential participants.
- Determine appropriate waiver/program eligibility for participants.
- Consult with transition coordinators to design alternatives for participants with complex needs.
- Serve as a resource to resolve transition issues.
- Consult with lead organizations to address quality management strategies.
- Review and adjudicate requests submitted through Medi-Cal treatment authorizations.
- Assist project team in compiling required State and federal reports.

Background

California was awarded a federal grant in 2003 to develop and pilot an intervention to facilitate the transition of residents in Skilled Nursing Facilities to community-based services. These funds, coupled with existing Medi-Cal Waiver programs (Assisted Living, Nursing Facility, In-Home Operations), are intended to facilitate the use of community-based services. These efforts are focused on diverting placement of Medi-Cal enrollees from health facilities and offer a menu of social and medically necessary services to assist them to remain in their home or community environments.

A federally required Operational Protocol has been implemented under the grant and a new 1915 (c) Waiver for a Community-Living Support Project for San Francisco is occurring (pertains to Laguna Honda). The overall purpose of these efforts is to transition 2,000 eligible individuals, who would otherwise have no option but to live in long-term health facilities, to live in the community. By providing participants long-term services and supports in their own homes for one full year after discharge from a health care facility, the State receives a 80.79 percent federal fund match.

STAFF COMMENT

The proposal is consistent with Olmstead implementation in California and the positions are warranted. However, a technical reduction of \$124,000 (GF) is necessary since the DHCS recently obtained federal approval for 100 percent financing of these positions. The Governor's January budget did not reflect this aspect of the funding.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: RAPID HIV TESTING BY HIV COUNCELORS

A significant concern has recently been identified regarding certain HIV testing sites that provide rapid testing to clients. Existing statute, as cited below, requires HIV testing sites where HIV counselors conduct rapid HIV tests to be trained by the Office of AIDS *and* to receive funding from the Department of Public Health. However, due to the Governor's veto of GF support for HIV Testing in 2009, there are possibly up to 40 Counties that can no longer provide rapid HIV tests because of the statute's requirement to receive funding from the department.

Existing statute is crafted to enable rapid HIV testing to be provided by HIV counselors, in lieu of meeting the more comprehensive Clinical Laboratory Improvement Act (CLIA) requirements which are intended for laboratories that provide substantive clinical testing. In addition, the statue is narrowly written to enable HIV counselors conducting rapid HIV tests to *not* be construed as a phlebotomy technician. Therefore, only the funding and training references need to be clarified.

Subcommittee staff believes it would be constructive and appropriate public health policy to adopt "placeholder" trailer bill legislation to modify existing statute to remove the reference to State funding but to retain the underlying training component for HIV counseling and testing sites.

ISSUE 2: DPH VACANCY REPORT

In the Budget Act of 2007, the Legislative Analyst's Office (LAO) recommended that the Legislature adopt "Supplemental Report Language" for the Department of Public Health (DPH) to provide the LAO and the fiscal committees of the Legislature with an annual vacancy report by no later than January 20 of each year. The purpose of this report was to serve as a tool for monitoring vacancies within the DPH and to facilitate annual budget discussions.

The DPH did provide the vacancy report in 2008 and 2009. The DPH did not provide the vacancy report for 2010 until an inquiry was sent by the Senate Subcommittee. Subcommittee staff was informed that since the report was crafted under Supplemental Report Language, it was not deemed to be required. It took two more inquiries to receive the report, provided on April 12th.

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: OSHPD REPAYMENT OF HOSPITAL BUILDING FUND LOAN

The May Revision proposes to defer repayment of a total of \$32 million in loans to the General Fund from the Hospital Building Fund (Item 4140-011-0121) and Health Data and Planning (Item 4140-011-0143) Special Funds. As a result, the state would receive \$32 million in GF relief during the 2010-11 budget year. For \$12 million of these loans, no repayment date is specified in law. However, for the remaining \$20 million in loans from the Hospital Building Fund, a repayment date of June 30, 2011 was specified in SBx3 2 (Chapter 2, Statutes of 2009). Therefore, to accomplish this proposal, the Subcommittee would need to adopt amended budget bill language to delay this date. OSHPD does not anticipate any material impacts on its operation of programs funded by these Special Funds in 2010-11 as a result of this proposal.

The Hospital Building Fund holds revenue from fees paid by hospitals when applying to OSHPD for approval of construction plans. The fee is equivalent to 2 percent of the total costs of construction and covers OSHPD's costs for plan review through completion of the construction project, which can take up to seven to ten years.

The projected fund balance for the end of 2009-10 is \$111.8 million and revenues for 2010-11 are projected at \$50.6 million, as compared to expenditures of \$55.9 million. Therefore, the repayment of \$20 million in loans from June 2011 to June 2012 will not impact OSHPD's ability to perform plan reviews.

4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: RATE FREEZE FOR INSTITUTIONS OF MENTAL DISEASE

Budget Issue

The Budget Act of 2009 (AB 5X 4, Evans, Chapter 5, Statutes of 2009), froze nursing home rates for many licensed facilities at 2008-09 levels; however, this rate freeze excluded Skilled Nursing Facility – Institutions of Mental Disease (SNF-IMDs). It is proposed to freeze the rates for IMDs which would have no state budget impact as these rates are paid by counties.

Background

IMDs are a type of SNF with 17 or more beds that provide 24-hour nursing care and supervision to mentally ill persons in need of continuous psychiatric and nursing care. Federal law excludes these facilities from eligibility for federal Medicaid funds when serving Medicaid clients. This federal IMD exclusion applies only to adult Medicaid beneficiaries between the ages of 21 and 65.

According to the Department of Public Health, which licenses SNFs, there are 15 SNF IMDs statewide that would be affected by the proposed rate freeze. These facilities range in size from 43-220 beds. The average length of stay is 12-15 months with more than 70 percent of patients staying longer than 60 days.

Federal law statutorily prohibits federal Medicaid funds from being used for the treatment of individuals who are in facilities that are licensed as IMDs. Due to this federal “IMD exclusion” and California's existing Realignment policies that make counties responsible for the provision of mental health services, California counties must pay for 100% of the cost of services for patients in IMDs. Current state law requires counties to indefinitely pay DHCS-licensed SNF IMDs a 4.7% increase to their annual rates. The County Mental Health Directors Association (CMHDA) maintains that this rate increase is unsustainable for counties given that every dollar spent by counties on the escalating costs of SNF IMD care, the most restrictive level of care available in the community, is one less dollar available to counties for other community-based services. CMHDA argues that, without a rate freeze for IMDs, counties must use significantly reduced funding streams to pay for IMD-level care.

ISSUE 2: DMH TBL RELATED TO MHSA AND WAIVERS

As discussed by the Subcommittee on May 3rd, the DMH receives substantial funding (approximately \$30 million) for the administration of the Mental Health Services Act (MHSA, Proposition 63), yet provides the Legislature minimal detail on the expenditure of these funds (May 3rd agenda, page 7). Furthermore, the federal government has had long-standing concerns with the Mental Health Services Waiver (May 3rd agenda, pages 30-31).

VOTE ONLY ITEMS

4265 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: FAMILY PLANNING RATE ROLLBACK

Budget Issue

This issue was heard by the Subcommittee on April 26th (April 26th agenda, page 21). The Governor proposes a reduction of \$343,000 (\$74,000 General Fund) in 2009-10, and \$88.7 million (\$15.3 million GF) in 2010-11 by reducing Medi-Cal rates for eight specified office codes billed for family planning services. The State receives a 90 percent federal match for family planning services, including these eight family planning office visits.

Background

Senate Bill 94, Statutes of 2007, provided an increase for these eight specified family planning office visits equal to the weighted average of at least 80 percent of the amount that the federal Medicare Program reimburses for these same or similar services. The rate became effective January 1, 2008. The Governor's proposal would restore the rates to the level they were prior to January 1, 2008. The proposed reduction includes fee-for-service providers, such as physicians and clinics, and managed care health plans. The Governor's proposal assumes that rate adjustments for managed care health plans will occur in 2010-11, including any needed adjustment for 2009-10. Prior to SB 94 in 2007, the rates for these services had been stagnant for approximately 20 years.

According to community clinics throughout the state that offer family planning services, the demand for such services far exceeds their capacity. Prior to the rate increase in 2008, California's clinics were turning away an estimated 10,000 people every month for lack of resources and capacity to serve them.

Family planning services save the state money by preventing unwanted pregnancies. According to a 2002 UCSF evaluation of the Family PACT program, within which a substantial portion of the state's family planning services are provided, 205,000 unintended pregnancies were averted which, collectively, would have cost the public \$1.1 billion up to two years and \$2.2 billion up to five years after birth.

ITEMS TO BE HEARD

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) is responsible under the Lanterman Act for ensuring that more than 240,000 Californians with developmental disabilities receive the services and supports needed to live independent and productive lives. To be eligible for services, the disability must begin before the consumer's 18th birthday; be expected to continue indefinitely; present a significant disability; and be attributable to certain medical conditions, such as, mental retardation, cerebral palsy, epilepsy or autism.

Services are delivered through four state-operated developmental centers (Fairview, Lanterman, Porterville, and Sonoma), two community facilities, and under contract with a statewide network of 21 nonprofit regional centers (RC's). Approximately 99 percent of consumers live in the community and slightly more than one percent lives in a State-operated Developmental Center.

ISSUE 1: ADDITIONAL 1.25% REDUCTION

The Governor's January 2010-11 Proposed Budget, included a \$48.2 million (\$25 million GF) reduction to the DDS. To achieve this savings, the Governor is now proposing increasing the 3 percent reduction on both the Purchase of Services and Regional Center Operations by another 1.25 percent, for a total reduction of 4.25 percent.

BACKGROUND

The 2010-11 Governor's Budget extended, by one-year, a three percent reduction to Regional Center (RC) funding, both for the Purchase of Services and for Operations. The proposal was adopted in the eight extraordinary session by both the Senate and the Assembly.

The adopted reduction accounted for the exemption of SSI and SSP consumers and consumers who regional centers demonstrate that a non-reduced payment is necessary to protect the "health and safety" of a consumer. The new sunset deadline adopted is June 30, 2011.

Additional Reduction. The additional 1.25 percent reduction would yield the desired savings of \$48.2 million, of this total, \$25.3 million is GF. Of the \$25 million reduction, \$20.7 million will be made to regional center POS and \$4.6 million would be made to Regional Center Operations.

Although the reduction is made to RC Operations and POS, in discussion with the department, a proposal to implement a provider relief program, based after a 1992 model implemented by SB 485 was shared with staff. The Trailer Bill Language for the additional 1.25 percent reduction is now provided by the Department.

Trailer Bill Language. The language provided by the DDS adds Section 4791 to the Welfare and Institutions Code to provide reductions in payments to specified providers and amends Section 3 of Ch. 4 statutes of the 8th Extraordinary Session to allow the provider relief to take effect July 1, 2010 and sunset along with the previous reduction on June 30, 2011.

The language allows providers to "temporarily modify personnel requirements, functions, or qualifications or staff training requirements for providers, except for licensed or certified residential providers." However, the language also specifies that the temporary modification may only be approved when the RC determines that the change will not: (1) adversely affect the health and safety of a consumer; (2) result in a more restrictive environment; (3) negatively impact the availability of federal financial participation; or, (4) violate state licensing or labor laws or other provisions on Title 17 of the California Code of Regulations.

To provide relief, the Department may suspend: (a) staffing ratios; (b) day programs and in-home respite annual self assessments of program effectiveness in relation to their program design and written reports; or, (c) quarterly and semiannual progress reports required in Title 17, Section 56026. The suspension shall be described in a written contract between the RC purchasing the service and the provider and documentation shall be retained by the provider and the regional centers purchasing the services from the vendor.

STAFF COMMENT

General Impact. The \$25 million GF savings is achieved after excluding those in the original 3 percent trailer bill language (SSI, SSP and upholding the "health and safety of a consumer"), Capitol People First settlement agreement, Independent Living Supplement, Supported Employment, Usual and Customary Services, and payments consumers.

Just as in the original 3 percent reduction made in February, the primary concern is how this reduction will impact consumers. The original 3 percent reduction adopted in the 8th extraordinary session excluded SSI and SSP consumers, as well as those who RC's demonstrate that a non-reduced payment is necessary to protect their "health and safety." The provider relief trailer bill accounts for these exclusions and more by excluding residential providers. Additionally, the trailer bill language addresses the consumer's best interest and relief for providers who have been capped for several years. A reduction across the board spreads impact throughout the developmental disabilities system.

PANELISTS

- DDS –Please respond to the questions below.
- DOF
- LAO
- Public Comment

QUESTIONS:

Please explain the "flex in service contracts."

How will this proposal impact consumers? Providers?

Who is excluded from the total 4.25% reduction?

Staff Recommendation: Staff recommends holding the item open until the May 26th hearing.

ISSUE 2: REGIONAL CENTER ECP ADJUSTMENTS

Governor's May Revision recognizes Regional Center (RC) adjustments in 2010-11 for enrollment, caseload and population (ECP). A total GF savings of \$30.9 million is presented as follows: RC Operations \$9.8 million and Purchase of Services (POS) \$21.1 million.

BACKGROUND

According to the Department, operations savings are primarily due to decreases in Targeted Case Management funding and projected decreases in caseload. POS savings primarily reflect changes in the Home and Community-Based Services (HCBS) Waiver, and projected decreases in caseload and utilization.

	2010-11 May Revision CY 2009-10	2010-11 May Revision BY 2010-11	Annual Change	Annual Percent Change
Total Community Caseload	236,858	243,704	6,846	2.9%
Total Developmental Center Population	2,151	1,979	-172	-8.0%
Total Regional Center caseload	239,009	245,683	6,674	2.8%

STAFF COMMENT

ECP adjustments are made every year during May Revision. Projections from the Department of Developmental Services show a May Revision caseload of 243,704, a difference of 6,271 from the projected 249,975 in November. Additionally, the Developmental Center population decreased by 29 consumers and is projected to be at 1,979. The LAO is in accordance with the May Revision ECP adjustments.

PANELISTS

- DDS –Please provide a high-level update on the ECP adjustments.
- DOF
- LAO

ISSUE 3: PROP 10 –FIRST 5 BACKFILL

The Governor's proposal to use First 5 funds in place of (GF) for RC's did not receive legislative approval during the Eighth Extraordinary Session. Now the Governor's May Revision proposes to backfill the need with GF's, for a total GF backfill of \$205 million.

BACKGROUND

The \$205 million would be distributed as follows:

	General Funds Increases	Details	Other changes
California Children and Families Trust Fund Account Funding	\$5 million	The Commission approved \$50 million for 2010-11 continued use of First 5 funds at the level funded in 2009-10. (A total of \$55 million was requested.)	\$5 million in decreased reimbursements
Backfill Counties Children and Families Account Funding	\$194 million	The Governor proposed the use of First 5 funds in place of General Funds, through a voter initiative, but the measure failed in the 8 th extraordinary session	Eliminate proposal to require Counties Children and Families Account to fund \$244 million for Purchase of Services
Backfill Mass Media Communications Account Funding	\$6 million	The Governor proposed the use of First 5 funds in place of General Funds, through a voter initiative, but the measure failed in the 8 th extraordinary session	None.
Total	\$205 million General Funds		

ISSUE 4: IMPACTS OF ADHC AND SSI REDUCTIONS TO THE DDS

The Governor's May Revision requests a GF decrease of \$40.2 million and a reimbursement increase of \$12.3 to reflect the costs associated with the elimination of Adult Day Health Care Services and reducing Supplemental Security Income payments to the federal minimum.

PANELISTS

- DDS –please respond to the questions below.
- DOF
- LAO
- Public Comment

QUESTIONS

How many DDS consumers will be impacted by the reductions to ADHC? SSI?

How will RC's be impacted by these reductions?

Has there been an update in the funding amounts included in this proposal? How realistic are these amounts?

ISSUE 5: IMPACT FROM THE ELIMINATION OF CALWORKS TO THE DDS

The Governor's May Revision request a GF increase of \$52.9 million and a matching decrease of \$52.9 million in reimbursements, to reflect the regional center budget impact from the elimination of the Cal WORKs program effective October 1, 2010.

STAFF COMMENT

The impact of the elimination of CalWORKs would create a net loss of \$74.1 million in Title XX Block Grant, Temporary Assistance to Needy Families (TANF) federal funding for the Department of Developmental Services.

The elimination would impact approximately 1,492,000 Californians. Additionally, the elimination would impact; poverty (the program currently serves between 500,000-600,000 families), increase utilization of general assistance programs and create job losses -through supported subsidized employment slots, subsidized child care and the 14,000 county employees and 170 state employees.

PANELISTS

- DDS –please respond to the questions below.
- DOF
- LAO
- Public Comment

Questions:

How will the elimination of CalWORKs impact DDS consumers? RC's? The DDS?

How many DDS consumers will be impacted?

ISSUE 6: FEDERAL STIMULUS FUNDS -OPERATIONS

The Governors May Revision requests GF adjustments to reflect matching American Recovery and Reinvestment Act (ARRA) funds, as they relate to Regional Center Operations. Adjustments are as follows:

	General Funds	Reimbursements
Operations	-\$307,000	\$307,000

STAFF COMMENT

Adjustments to RC Operations reflect adjustments to the enhanced Federal Medical Assistance Percentage (FMAP) by a temporary increase by ARRA through December 31, 2010.

PANELISTS

- DDS
- DOF
- LAO

ISSUE 7: FEDERAL STIMULUS FUNDS –PURCHASE OF SERVICES
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The Governors May Revision requests GF adjustments as they relate to Regional Center purchase of services (POS). Adjustments are as follows:

	General Funds	Reimbursements
Purchase of Services (POS)	-\$3,056,000	\$3,056,000

STAFF COMMENT

Adjustments to RC POS reflect the enhanced FMAP, due primarily to changes in Adult Day Health Care (ADHC) services and the HCBS Waiver.

DDS consumers currently use ADHC as a generic service. The GF savings for POS are dependent on the elimination of ADHC, as the estimate to purchase of service would impact the new FFP funds that could be generated and are expected in October 1, 2010.

PANELISTS

- DDS –please respond to the questions below.
- DOF
- LAO

QUESTIONS

Please explain this proposal.

What are the benefits of this proposal? How many DD consumers are impacted?

What should happen should the elimination of ADHC be rejected by the Legislature?

ISSUE 8: SELF DIRECTED SERVICES IMPLEMENTATION DELAY

The Governors May Revision notes a delay in the Self Directed Services program. The new implementation date of April 1, 2011 results in a current year GF decrease of \$1.0 million and a reimbursements decrease of \$1.6 million.

BACKGROUND

The Self Directed Services (SDS) program would implement a capped and finite individual budget, by which individuals who are eligible for state developmental disabilities services are empowered to gain control over the selection of services and supports, that meet their own needs.

SD Services programs are implemented nationwide and have garnered international and bipartisan support. The delay was filed on behalf of DDS, by DHCS, due to discussions with the federal government regarding the role of the regional center as a fiscal intermediary in the SDS program.

PANELISTS

- DDS –Please respond to the questions below.
- DOF
- LAO

QUESTIONS

How many times has this project been delayed?

Why was the project delayed?

Is the \$1.6 million in reimbursements guaranteed in later years?

How is this different from the ICB?

4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: MENTAL HEALTH SERVICES FOR SPECIAL EDUCATION PUPILS (AB 3632) PROGRAM

The Subcommittee discussed the AB 3632 program during its May 3rd hearing (see May 3rd agenda, page 33). Subsequently, the Governor proposed in his May Revision to suspend the AB 3632 mandate on counties in order to reduce General Fund expenditures on this program by \$52 million.

The federal government mandates that schools provide mental health services to special education students who need them. Specifically, the federal Individuals with Disabilities Education Act (IDEA) entitles all pupils with emotional and physical disabilities to a free, appropriate public education that prepares them to live and work in the community. The IDEA entitlement includes mental health treatment for children in need of them in order to benefit from public education; children can receive services irrespective of their parents' income level.

California, through AB 3632 (Statutes of 1984), chooses to meet this federal mandate by requiring counties to provide these mental health services to pupils who qualify for them. However, the state has not fully reimbursed counties for these services. According to the DMH, total claims submitted for the past three fiscal years amounts to a total of \$211.9 million, and the state paid counties \$51.2 million from the 2009-10 appropriation. This leaves a remaining balance of \$160.7 million still owed to counties.

Counties point out that while these mental health services to special education students are critical services, this federally-mandated program is not a "means-tested" program, meaning a family's income or other resources have no bearing on the student's qualification for free mental health services. Therefore, as a result of the state not reimbursing the counties fully for providing these services, counties must redirect realignment funds for this purpose, thereby reducing resources and services available specifically for low-income populations.

QUESTIONS

The Subcommittee has requested the DMH to respond to the following questions:

1. What will be the impact on schools of this proposal?
2. How might this proposal affect access to mental health services for IDEA students?

ISSUE 2: SHIFT OF COUNTY MENTAL HEALTH REALIGNMENT FUNDS

In the May Revision, the Governor proposes to shift \$602 million in county realignment funds to various social services programs. Specifically, these funds would pay for social service costs that would be shifted from the state to the counties. This proposal would increase the county share of cost for food stamp administration and child welfare services, resulting in General Fund savings of \$602 million in 2010-11.

Under this proposal, counties would retain approximately \$450 million in mental health realignment funds in 2010-11. According to the Legislative Analyst's Office (LAO), the use of these funds would be limited to paying for federally required benefits, namely the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the Mental Health Managed Care Program. The LAO explains that this proposal might violate the Mental Health Services Act maintenance of effort provision.

QUESTIONS

The Subcommittee has requested the DMH to respond to the following questions:

1. Please describe this proposal and specifically the anticipated impacts on counties.
2. What would be the impact on community mental health services?
3. Could this proposal be a violation of the MHSA MOE?

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: INCREASE PREMIUMS IN HEALTHY FAMILIES PROGRAM

Budget Issue

The Governor's May Revision proposes to increase monthly premiums paid by families with incomes between 200 and 250 percent of the federal poverty level, for increased revenue, and therefore General Fund savings, of \$13.3 million. The premium would increase by \$18 per child (\$54 maximum per family with 3 or more children).

Background

The Governor's January budget proposal included a proposal to increase premiums for children in families with incomes between 150 to 200 percent FPL. The proposal did not include a premium increase for children in families between 200 and 250 percent FPL because the January budget proposed to reduce eligibility in the Healthy Families Program from 250 to 200 percent FPL. However, this eligibility reduction proposal has been rescinded by the Governor as it would be a violation of federal health care reform. Therefore, the Governor's May Revision includes this proposal to increase premiums for the 200 to 250 percent FPL group of children in Healthy Families.

The Subcommittee discussed and rejected the January premium increase proposal at its hearing on April 19th (April 19th agenda, pages 16-17). At its hearing on May 10th, the Subcommittee approved a motion to redirect AB 1383 (hospital fee) revenue, designated for children's health services, to cover the cost of rejecting the various reductions to the Healthy Families Program proposed by the Governor in January, including the proposed premium increase. The chart below shows recent and proposed premium increases.

Premium Increase		Before Feb 1, 2009	After Feb 1, 2009	After Nov 1, 2009	After July 1, 2010
		Category A (134% FPL – 150% FPL)	1 Child	\$7	\$7
	2+ Children	\$14	\$14	\$14	\$14
Category B (151% FPL – 200% FPL)	1 Child	\$9	\$12	\$16	\$30
	2 Children	\$18	\$24	\$32	\$60
	3+ Children	\$27	\$36	\$48	\$90
Category C (201% FPL – 250% FPL)	1 Child	\$14	\$17	\$24	\$42
	2 Children	\$28	\$34	\$48	\$84
	3+ Children	\$42	\$51	\$72	\$126

QUESTIONS

The Subcommittee has requested the MRMIB to respond to the following questions:

Would premium increases violate the federal health care reform eligibility MOE?

ISSUE 2: HEALTHY FAMILIES CO-PAYMENTS FOR ER AND IN-PATIENT HOSPITAL CARE

The Governor's May Revision includes a proposal to increase the Healthy Families co-payment for emergency room visits from \$15 to \$50, for General Fund savings of \$2.5 million and, to institute a new co-payment on in-patient hospital stays of \$100 per day with a \$200 maximum, for General Fund savings of \$0.7 million. These co-payments are consistent with those proposed by the Governor for the Medi-Cal program.

QUESTIONS

The Subcommittee has requested the MRMIB to respond to the following questions:

1. How do these proposed co-payments compare to those utilized in CHIP programs in other large states?
2. What impact does MRMIB expect these co-payments to have on enrollment and retention of children in Healthy Families?
3. Please provide an overview of utilization of ER care and in-patient hospital care by children in Healthy Families.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL COST-CONTAINMENT PROPOSAL

In January, the Governor proposed legislation to authorize the Department of Health Care Services (DHCS) to negotiate with the federal government to implement various changes to Medi-Cal for a reduction of \$2.388 billion (total funds). This proposal would require federal law changes and other federal approvals. The amount of General Fund savings attributed to this action is contingent upon the Federal Medical Assistance Percentage (FMAP) provided for California. The January budget assumed a General Fund savings of \$750 million. A July 1, 2010 implementation date is assumed. The Governor also assumes continuation of the federal American Recovery and Reinvestment Act from December 30, 2010 to June 30, 2011 at 61.59% FMAP. The Governor's May Revision proposes the following detailed policies under the umbrella of this cost-containment proposal:

Utilization Controls (\$90.2 million in General Fund savings)

1. Elimination of certain over-the-counter drugs and nutritional supplements, for General Fund savings of \$13 million.
2. Establishment of a maximum annual benefit dollar cap, for General Fund savings of \$3.8 million, on:
 - Hearing aids – annual cap of \$1,510
 - Durable medical equipment – annual cap of \$1,604
 - Incontinence supplies – annual cap of \$1,659
 - Urological supplies – annual cap of \$6,435
 - Wound care supplies – annual cap of \$391

Cost Sharing (\$218.8 million in General Fund savings)

Establishment of co-payments as follows:

- Physician, clinic, dental, and pharmacy visits - \$5 co-payment
- Lower cost preferred drugs - \$3 co-payment
- Other drugs - \$5 co-payment
 - (General Fund savings of \$118.2 million for the above three)
- Emergency room visits - \$50 co-payment (General Fund savings of \$41.5 million)
- Hospital stays - \$100 per day and \$200 maximum (General Fund savings of \$59.1 million)

“Other Program Changes” (\$213.7 million in General Fund savings)

1. Enrollment of seniors and people with disabilities in managed care (General Fund savings of \$137.3 million).
2. Reduction in radiologist rates to 80 percent of Medicare rates (General Fund savings of \$10.5 million).
3. Freezing of hospital rates at the current level (General Fund savings of \$64.9 million).

4. Discontinuance of payment of Medicare Part B premiums for beneficiaries whose income exceeds the Medi-Cal eligibility threshold by less than \$500 per month (General Fund savings of \$1 million).

QUESTIONS

The Subcommittee has requested the DHCS to describe this proposal in detail and provide information on anticipated impacts of these proposed policies on Medi-Cal beneficiaries.

ISSUE 2: MEDICAID SECTION 1115 WAIVER**Budget Issue**

The Governor's May Revision requests approval of \$4.1 million ("including contract funds") and 53 limited-term positions within the DHCS to implement the pending federal Section 1115 Hospital Finance Waiver proposed for reauthorization.

Background

As a result of federal policy changes several years ago, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal CMS which was completed as of September 1, 2005 and expires as of *August 30, 2010*. This Waiver is to provide over \$2 billion in annual reimbursement to hospitals.

The federal requirements for this Hospital Finance Waiver are contained in the "*Special Terms and Conditions*" document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny, Chapter 560, Statutes of 2005), provides the state statutory framework for implementing it.

Under this Waiver, Public Hospitals certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals use Intergovernmental Transfers (IGT's) on a limited basis to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distressed Hospital Fund, and Medi-Cal per diem and cost-based payments.

With the existing Hospital Financing Waiver scheduled to sunset as of August 2010, trailer bill legislation — AB 4X 6, Statutes of 2009 — was adopted last year to commence with the framework for a new, more comprehensive Waiver for California. As established in this bill, the goals of this new Waiver are:

- Strengthening California's health care safety net;
- Reducing the number of uninsured individuals;
- Optimizing opportunities to increase federal financial participation;
- Promoting long-term, efficient and effective use of State and local funds;
- Improving health care quality and outcomes; and,
- Promoting home and community-based care.

The statute also directs for the Waiver to provide Medi-Cal enrollees with access to better coordinated and integrated care to improve outcomes and help slow the long-term growth in program costs. Among other things, it provides for the more comprehensive enrollment of individuals into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model.

The DHCS has developed a concept paper and an implementation plan for the Waiver and has been convening workgroups of stakeholders over the past several months.

AB 4X 6 requires the Administration to provide an implementation plan to the fiscal and policy committees of the Legislature prior to implementation of the Waiver, and at least 60-days prior to an appropriation by the Legislature for this purpose. The DHCS provided this plan on May 7th, 2010.

QUESTIONS

The Subcommittee has requested the DHCS to describe in detail: 1) this BCP; 2) the implementation plan; and 3) the proposed trailer bill language.

ISSUE 3: MANAGED CARE RATE INCREASE

The Governor, in his May Revision, proposes to increase rates to managed care plans by an estimated 3.7 percent, at a cost of \$174 million. The Administration states that this rate increase would take into consideration a pharmacy pricing adjustment.

QUESTIONS

The Subcommittee has requested the DHCS to describe and explain this proposal and the justification for a rate increase.

ISSUE 4: MANAGED CARE RATES IN TWO-PLAN COUNTIES

Beginning for the 2009-2010 rate year, the DHCS administratively implemented a risk-adjustment factor for the Two-Plan Model managed care capitation rates. The effect of this change was not fully recognized until December 2009 by many of the affected plans.

The DHCS contends the purpose of this risk-adjustment is to distribute Medi-Cal payments to health plans based on the health risk of the Medi-Cal enrollees in their plan. They state that it requires a county-wide rate because these rates represent the best estimate of the average cost of a Medi-Cal beneficiary that can enroll in the plan.

DHCS states they did not implement the full impact of their risk adjustment factor in 2009-2010. But instead, implemented a *20 percent risk-adjustment factor* and a no risk factor to 80 percent of a health plans' specific rate. The DHCS proceeded with this rate-adjustment in a "budget neutral" manner. As such, Medi-Cal capitation rates were reduced for some, and increased for others, based solely on this factor.

Key concerns are: 1) the methodology does not factor-in safety net provider payments appropriately; 2) it shifts \$7.2 million away from Local Initiatives who are core providers in Two-Plan Model counties and reallocates these funds to commercial health plans participating in the Two-Plan Model; and 3) the DHCS did not fully communicate this change in its budget materials presented to the Legislature.

When questioned as to why a 20 percent risk-adjustment was chosen, the DHCS contends it was to demonstrate their clear intent to move toward an entire county specific risk adjustment rate. No other rationale has been provided. The DHCS intends to increase this risk-adjustment factor in subsequent years.

The Local Health Plans of California (Local Initiatives) support a risk-adjustment factor. But they believe an additional factor needs to be included in the equation for determining Medi-Cal capitation rates in the Two-Plan Model system.

Specifically, the Local Initiatives are seeking adoption of trailer bill language to include a safety net adjustment factor within the risk-adjustment calculation for county-wide rates. The Local Initiatives have provided data to the DHCS which they contend illustrate the considerable network arrangements they have with Federally Qualified Health Centers (FQHCs) and designated Public Hospitals.

Medi-Cal capitation payments to Local Initiatives have in the past recognized that a portion of their reimbursement is needed to account for the Local Initiatives network arrangements with safety net providers. These safety net providers utilize these payments to support uncompensated care costs for the uninsured and for high volume Medi-Cal providers, among other public-focused expenditures such as medical training, certain case management for involved Medi-Cal enrollees, and access enhancements.

Under the DHCS 20 percent risk-adjustment factor, the Local Initiatives would be reduced by about \$7.2 million in Medi-Cal capitation payments. These funds would be shifted to the commercial health care plans participating in the Two-Plan Model.

STAFF COMMENT

Local Initiatives are a core component of the Medi-Cal Managed Care Program and need to be viably sustained as California proceeds through its development and implementation of its 1115 Medicaid Waiver. Health plan network expansion to address federal health care reform and the potential enrollment into managed care of vulnerable populations will be reliant upon safety net providers to provide specialty care, care coordination, and access to outpatient services.

Staff Recommendation

Adopt "placeholder" trailer bill language to include a safety net provider factor in statute. (Conforms with the Senate's action)

QUESTIONS

The Subcommittee has requested the DHCS to provide a summary of the Medi-Cal capitation rate process for the Two-Plan Model, and how the risk-adjustment factor is determined and calculated.