

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark DeSaulnier

**Senator Elaine K. Alquist
Senator Bill Emmeron**



January 26th, 2011

**10:00 AM or
Upon Adjournment of Session**

**Room 4203
(John L. Burton Hearing Room)**

(Diane Van Maren)

<u>Item</u>	<u>Department</u>
4120	Emergency Medical Services Authority <ul style="list-style-type: none">• Emergency System Registration of Volunteers
4260	Department of Health Care Services <ul style="list-style-type: none">• State Support• Medi-Cal Program, including fund redirections
4280	Managed Risk Medical Insurance Board <ul style="list-style-type: none">• Healthy Families Program• Pre-Existing Condition Insurance Program (PCIP)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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I. VOTE ONLY CALENDAR (Pages 2 through 4)

1. Emergency Medical Services Authority: Registration of Volunteers

Budget Issue. The budget proposes an increase of \$231,000 in Reimbursements (which are federal funds) to extend limited-term positions for an additional two-years in order to continue implementation of California’s Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP System). The two positions include a Health Program Specialist and a Staff Information Systems Analyst.

This ESAR-VHP System provides the needed volunteer health professionals necessary to augment a Hospital or other medical facility, staff alternate care sites and field treatment sites, and augment personnel for the State’s Mobile Field Hospitals to meet increased patient/victim care needs during a declared emergency.

States are required to meet specified federal ESAR-VHP operational requirements as updated in July 2009.

Key functions of the two positions are the following:

- Implement an enhanced recruitment and retention plan;
- Initiate a regular schedule of drills on the ESAR-VHP System, including drills for volunteer deployment protocols;
- Provide increased training opportunities for system administrators

Staff Comment and Recommendation—Approve. This is an important emergency preparedness program and the positions are justified. No General Fund support is required.

2. Department of Health Care Services: Delete Three Proposals

Budget Issue. The Department of Health Care Services has submitted three proposals that request General Fund augmentations as follows:

- \$2.0 million (\$948,000 General Fund) to support 17 positions for Health Care Reform.
- \$1.2 million (\$480,000 General Fund) to support 11 positions to implement a Hospital Diagnosis Related Group System Change.
- \$299,000 (\$150,000 General Fund) to support 3 positions to continue implementation of privacy operations according to the federal Health Insurance Protection and Accountability Act (HIPPA).

Subcommittee Staff Comment and Recommendation—Deny without Prejudice. Due to the fiscal crisis, it is recommended to delete these three proposals from the budget without prejudice. The General Fund cannot support increased expenditures for State administration at this time.

Further, the Governor's budget summary pages note that State Administration is being reviewed and consolidation and contraction will be occurring.

Therefore, it is recommended to delete these General Fund support requests from the budget *without prejudice* at this time.

3. Department of Health Care Services—Approve Requested Positions

Budget Issue. The Department of Health Care Services has submitted proposals requesting positions which utilize *special fund and federal funds*. These are as follows:

- *Specialty Mental Health Waiver.* Continue two existing positions to continue support of this Waiver which provides over \$2.5 billion in funds to California for specialty mental health services. A request of \$211,000 (total funds) is requested.
- *Implementation of 1115 Medicaid Waiver (SB 208, Statutes of 2010).* This Waiver, approved by the federal CMS in November 2010, will provide California with \$10 billion in funds over a 5-year period. This Waiver provides for the mandatory enrollment of seniors and individuals with disabilities into Medi-Cal Managed Care, restructures Hospital financing arrangements, and provides California with about \$500 million annually in General Fund support. A request of \$7 million (total funds) is proposed to fund a 39 positions of which 19 will be used to implement Medi-Cal coverage of eligible adult inmates in Inpatient Hospital settings (saves General Fund expenditures).
- *Bridge to Health Care Reform--Implementation of AB 342 (Perez), Statutes of 2010.* This comprehensive legislation, as well as provisions in the 1115 Medicaid Waiver, provides for the receipt of federal funds by counties to provide health care coverage for the Medicaid population of uninsured adults 19 to 64 years with incomes below 133 percent of poverty who are otherwise not eligible. These projects are an integral component of the Waiver. A request of \$4.3 million (total funds) is proposed to support 23 positions and external contracts.
- *Medi-Cal Managed Care Inter-Governmental Transfer Staffing.* A total of \$257,000 (total funds) is requested for 2.5 positions to managed complex calculations related to Intergovernmental Transfers (IGTs) for Hospitals, and Medi-Cal Managed Care Plans to obtain federal funds. According to the DHCS, in 2009-10, they processed about \$221 million in IGT transfers. The federal CMS requires a strict monitoring of these funds and additional staff is needed.
- *California Mental Health Managed Care Program (CalMEND).* A total of \$631,000 (total funds) is requested to extend 4 positions to continue work on this project which focuses on how to better serve Medi-Cal individuals with serious mental illness and co-occurring medical problems. These projects when fully implemented will involve over 200 clinical providers and researchers and 1,500 Medi-Cal enrollees.

Subcommittee Staff Comment and Recommendation—Approve. These proposals have been reviewed and no issues have been raised by Subcommittee staff or the Legislative Analyst's Office (LAO). The requested positions either provide assistance in obtaining increased federal fund support and result in General Fund savings. No General Fund support is needed for these positions.

II. Departments for Discussion

Department of Health Care Services-- Medi-Cal Program

A. Overall Background: Medi-Cal Program (Pages 5 through 7)

Purpose. The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

Medi-Cal is at least three programs in one: **(1)** a source of traditional health insurance coverage for low-income children and some of their parents; **(2)** a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and **(3)** a wrap-around coverage for low-income Medicare recipients (“dual” eligibles who receive Medicare and Medi-Cal services).

Who is Eligible and Summary of Medi-Cal Enrollment. Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state’s option.

Estimated Medi-Cal enrollment for the current year is 7.5 million people and for 2011-12 it is 7.7 million people. Medi-Cal provides health insurance coverage to almost 20 percent of Californians and almost 24 percent of insured Californians.

Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty (\$18,310 annually for a family of three).

Summary of Governor’s Budget for 2011-12. As shown in the table below, the Governor proposes total expenditures of almost \$42.5 billion (\$13.8 billion General Fund, \$26 billion federal Title XIX Medicaid funds, and \$2.7 million in other funds) for Medi-Cal in 2011-12.

This reflects a proposed *decrease* of almost \$13.2 billion (total funds), or 23.7 percent, as compared to the revised 2010-11 budget. There are several key aspects to this significant reduction as proposed by the Governor.

First is the significant change in federal funding. Both the federal American Recovery & Reinvestment Act of (ARRA) of 2009, and the Education, Jobs and Medical Assistance Act of 2010, provided States with enhanced federal funding for their Medicaid programs.

For California, the enhanced federal funding provided almost \$3 billion in General Fund relief within the DHCS Medi-Cal Program for 2010-11. However, the loss of this federal support (enhanced funding ends June 30, 2011) is estimated to increase General Fund support by \$2.544 billion in 2011-12.

Medi-Cal Funding Summary <i>(Dollars in Thousands)</i>	2010-11 Revised	2011-12 Proposed	Difference	Percent
Benefits	\$52,686,000	\$39,438,600	-\$13,247,400	-25.1%
County Administration (Eligibility)	\$2,691,300	\$2,717,300	\$26,000	+1.0%
Fiscal Intermediaries (Claims Processing)	\$281,800	\$322,200	\$40,400	+14.3%
Total-Local Assistance	\$55,659,000	\$42,478,000	-\$13,181,000	-23.7%
General Fund	\$12,759,100	\$13,842,500	\$1,083,400	+8.5%
Federal Funds	\$37,449,700	\$25,974,500	-\$11,475,200	-30.6%
Other Funds	\$5,450,300	\$2,661,100	-\$2,789,200	-51.2%

Second is the substantial cost-containment which is being applied to the Medi-Cal Program. The budget proposes over \$2.7 billion in reductions for 2011-12 through strategies that include:

- Placing limits on health care services;
- Elimination of certain benefits;
- Cost-sharing through Medi-Cal enrollee copayment requirements;
- Provider payment reductions;
- Mandatory enrollment of seniors and persons with disabilities in Medi-Cal Managed Care; and
- Additional sources of alternative funding (i.e., redirection of Proposition 10 Funds, Hospital Fee extension, increased federal funds through the new 1115 Medicaid Waiver).

The table below provides a summary of proposed reductions and cost shifts by major category. These Administration proposals are all directed at reducing General Fund expenditures in the program.

**Summary Chart of Key Medi-Cal Reductions & Cost Shifts in Budget
(General Fund Solutions)**

Major Category of Adjustment	Revised 2010-11 General Fund Solutions	Proposed 2011-12 General Fund Solutions
1. Reductions to Medi-Cal Enrollee Benefits (cost-sharing, limits and elimination of services)	-\$6.3 million	-\$994.4 million
2. Implementation of 1115 Medicaid Waiver**	-\$400 million	-\$500 million
3. Medi-Cal Provider Payment Reductions	-\$11.5 million	-\$733.6 million
4. Hospital Fee Extension: January to June 2011	-\$160 million	--
5. Redirection of Proposition 10 Funds (June Ballot Measure)	--	-\$1 billion
General Fund Solution Amount (reduction)	-\$221.8 million	-\$3.228 billion

Footnote: **Federal CMS approved California's 1115 Waiver in November 2010. The framework of this Waiver is contained in SB 208 (Steinberg), Statutes of 2010, AB 342 (Perez), Statutes of 2010, and federal Terms and Conditions. This savings level is consistent with these documents. Savings are reflected in a Non-Budget Control Item and do not totally accrue to the Medi-Cal Program directly. Some savings, which are due to the receipt of federal funds through the 1115 Medicaid Waiver, are used in certain public health programs and within the Department of Corrections.

Administration's Proposals Need Federal Approval. All of the DHCS mandatory copayment, utilization limits, and benefit reductions are contingent on federal approval of State Plan Amendments, and in some cases federal Waivers (mandatory copayments). State Plan Amendments are submitted for federal approval to document that California meets federal requirements set forth in law and regulation.

Federal Waivers allow States to Waive certain federal requirements generally to obtain programmatic flexibility while furthering the purposes of the Medicaid (Medi-Cal) Program. At a minimum, DHCS would need Waivers of federal laws and regulations for:

- (1) The types of populations affected (i.e., children, pregnant women, long-term care);
- (2) The federal poverty levels affected (including Medi-Cal enrollees with incomes below 100 percent of poverty); and
- (3) The level of copay to be charged—both from the nominal pay aspect and the exceeding five percent of family income per month aspect.

The federal government has never approved any State's request for a Waiver regarding mandatory copayments in Medicaid (Medi-Cal).

B. ISSUES FOR DISCUSSION: Medi-Cal (Pages 8 to 34)

A. Budget Issues Regarding Medi-Cal Benefits

Background. The budget proposes various reductions to health care services (Benefits category) provided to Medi-Cal enrollees. The table below provides a summary of these proposed reductions and reflects estimated General Fund reduction amounts (corresponding amounts of federal funds would be reduced as well).

The proposed reductions for Benefits fall into *three categories*: **(1)** limiting access to services; **(2)** requiring mandatory copayments for services; and **(3)** eliminating services. Almost all of these proposals were presented last year and rejected by the Legislature; however due to the State’s fiscal crisis, the Administration believes they warrant consideration.

All of these proposed Benefit reductions *require* federal Centers for Medicare and Medicaid (CMS) approval through “State Plan Amendments” (SPAs). *In addition*, all of the mandatory copayment proposals also require federal Waivers which are an additional threshold due to the need to bypass existing federal law.

Summary of Key Reductions to Medi-Cal Benefits (General Fund Component)

Proposed Reduction Issue	Effective Date	2010-11 General Fund Reduction Amount	2011-12 General Fund Reduction Amount
1. Hard Cap: 10 Visits for Physicians & Clinics	09/01/2011	--	-\$196.5 million
2. Mandatory Copays for Physicians & Clinics	10/01/2011	--	-\$152.8 million
3. Hard Cap: 6 Prescription Outpatient Drugs	10/01/2011	--	-\$11 million
4. Mandatory Copays for Pharmacy	10/01/2011	--	-\$140.3 million
5. Mandatory Copays for Hospital Services, including (a) Hospital Inpatient, (b) Non-Emergency Room, and (c) Emergency Room.	10/01/2011	--	-\$262.8 million
6. Copayment for Dental Services <i>Revised Calculation</i>	05/01/2011	-\$208,500 -\$4 million	-\$1.3 million -\$27.9 million
7. Proposed Elimination of Over-the-Counter Cough and Cold Products	06/01/2011	-\$97,000	-\$2.2 million
8. Eliminate Adult Day Health Care Services	06/01/2011	-\$1.7 million	-\$176.6 million
9. Limit Enteral Nutrition Products for Adults to Tube Feeding Only (conform with Medicare)	06/01/2011	-\$547,000	-\$14.5 million
10. Establishes Maximum Annual Dollar Limit for Durable Medical Equipment	10/01/2011	--	-\$7.4 million
11. Establishes Maximum Annual Dollar Limit for Medical Supplies	10/01/2011	--	-\$1.9 million
12. Establishes Maximum Annual Dollar Limit for Hearing Aid Expenditures	10/01/2011	--	-\$507,000
TOTALS (with revised calculation)		-\$6.3 million	-\$994.4 million

1. Hard Cap: 10 Visits for Physician Offices and Clinics for Adults

Budget Issue. The budget proposes a “hard cap” of 10 office visits per year for Medi-Cal enrollees in both Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. A reduction of \$392.9 million (\$196.5 million General Fund) is assumed from this action.

Trailer bill language is required for enactment and a September 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and federal CMS approval.

This hard cap would apply to Adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities are exempt.

This proposal affects outpatient primary care and specialty care provided under the direction of a Physician in the following settings:

- Hospital Outpatient Department;
- Outpatient Clinic;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Centers (RHCs); and
- Physician Offices.

DHCS states that a total of 3.3 million office visits were provided and *40 percent*, or 1.3 million office visits, would be above this proposed cap of 10 visits per year.

Subcommittee Staff Comment. Federal law *mandates* the provision of Physician services.

The Administration’s “hard cap” does not take into consideration any cost shifts to other services—such as Emergency Rooms and hospitalizations—that would likely occur from this action due to the lack of primary and specialty care which would result.

This proposal would negatively impact people with the greatest need for health care services. Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.

The fiscal calculation assumes an average cost per visit of \$143 in the outpatient setting. It would not take many emergency room visits or hospitalizations to negate the assumed savings from this “hard cap”.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, What happens if a significantly medically needy individuals exceeds this cap?
3. DHCS, Do any other States have similar caps to this?

2. Mandatory Copayments for Physician & FQHC/RHC Office Visits

Budget Issue. The budget assumes a reduction of \$305.7 million (\$152.8 million General Fund) by implementing *mandatory* copayments of \$5 per Physician Office visit and \$5 per Clinic Office visit (FQHC and RHC clinics) at the point of service.

These proposals apply to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

The Administration's reduction estimate of \$305.7 million (total funds) assumes savings from both a rate reduction to Physicians and Clinics, as well as an 8 percent reduction in utilization by Medi-Cal enrollees. Specifically, about \$219 million (total funds) is attributable to a rate reduction and about \$86 million for less Office Visits.

Under this proposal, the Physician would collect the \$5 copayment at the time of service and the providers would be reimbursed their Medi-Cal rate *minus* the \$5 copayment.

If the Medi-Cal enrollee does not pay the \$5 copayment, the Physician can deny the service.

Currently, Medi-Cal enrollees have a \$1 copayment per Office visit. It is a voluntary copayment and services cannot be denied if the enrollee doesn't pay.

DHCS states that the average cost of a Fee-for-Service Physician Office Visit is \$82.49 and the average cost of an FQHC or RHC Clinic Visit is \$140.16.

Subcommittee Staff Comment. A mandatory copayment for Physician Visits and Clinic Visits would serve more as a deterrent to obtaining preventive medical care services and would make health care access for low-income children, families and people even more problematic.

Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.

The Administration's proposal does not take into consideration any cost shifts to other services—such as emergency rooms—that would likely occur from this action.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, How would this policy be applicable to people with chronic health conditions?
3. DHCS, Please explain why a federal Waiver is necessary.

3. Hard Cap: Six Prescription Outpatient Drugs

Budget Issue. The budget proposes a “hard cap” on the *existing* six-prescription per month limit. A reduction of \$22.1 million (\$11 million General Fund) is assumed from this action.

This hard cap would apply to Adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities are exempt.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and federal CMS approval.

Medi-Cal would *not pay* for prescriptions beyond the six-prescription per month limit *unless* Medi-Cal deems the drugs to be life-saving, such as those used for the treatment of HIV/AIDS, cancer, hypertension, diabetes, coagulation disorders and mental health disorders.

Background—Existing Six-Prescription Limit. An existing six-prescription per month limit for Medi-Cal enrollees was effective in 1994 and is still in effect. Any prescription beyond this limit must receive “prior authorization” approval by the DHCS. Medi-Cal currently pays for drugs beyond the six prescription limit *after* a prior authorization is approved.

This existing prescription limit is *not* the number of different drugs dispensed in a month, or the number of drugs a recipient is currently taking. Rather, it is the limit of pharmacy drug claim lines submitted within a calendar month. For example, if the same drug is dispensed four times a month, it counts as four of the six prescriptions. There are exemptions to this existing limit, such as cancer drugs, HIV/AIDS, and others.

Subcommittee Staff Comment. *First*, it is presently unclear how the DHCS would make its determinations with regarding to life-saving medications to be exempted from the proposed “hard cap”. It is unclear how the DHCS would administer this proposal and how Medi-Cal patients with significant health care needs would not fall through the cracks.

Second, the Administration’s “hard cap” does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or Emergency Rooms—that may occur if appropriate medications are not provided.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, How would this policy be applicable to people with chronic health conditions?

4. Mandatory Copayments for Pharmacy

Budget Issue. The budget proposes a reduction of \$280.6 million (\$140.3 million General Fund) by implementing mandatory copayments of \$3 per prescription for preferred drugs (generics) and \$5 per prescription for non-preferred (brand) at the point of service.

This proposal applies to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

The Administration's reduction estimate of \$280.6 million (total funds) assumes savings from **(1)** a rate reduction to Pharmacists; **(2)** a 5 percent reduction in the number of prescriptions once the copayment is implemented; and **(3)** a shift of 25 percent from non-preferred (brand) to preferred (generics). This break out is as follows:

- \$135.1 million (total funds) from Pharmacy rate reduction.
- \$93.6 million (total funds) from a 5 percent reduction in the number of prescriptions.
- \$51.9 million (total funds) from the 25 percent shift to preferred (generics).

The Pharmacy would collect the copayment at the point of service, and the Pharmacists would be reimbursed their Medi-Cal rate *minus* the \$3 or \$5 copayment.

The mandatory copayment means the Pharmacist can deny the Medi-Cal enrollee their prescription medication unless the copayment is made at the point of service. This is the DHCS concept reflected in the 5 percent reduction in the number of prescriptions.

Presently, the average cost of a prescription is \$92.

Currently, Medi-Cal enrollees have a \$1 copayment per prescription. It is a voluntary copayment and services cannot be denied if the Medi-Cal enrollee doesn't pay.

Subcommittee Staff Comment. The no exemption policy, particularly for children and fragile medically needy individuals will likely result in people not seeking assistance and becoming potentially more medically involved.

The Administration's proposal does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or Emergency Rooms—that may occur if appropriate medications are not provided.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal and how it would operate.

5. Mandatory Copayments for Hospital Services: Three Issues

Budget Issue. The budget proposes implementation of *three* mandatory copayments related to Hospital Services for a total reduction of \$542.1 million (\$262.8 million General Fund). These proposals apply to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements.

All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and an October 1, 2011 implementation date is assumed. In addition to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

Under these proposals, the Hospital collects the copayment from the Medi-Cal enrollee as applicable. DHCS would then reimburse the Hospital the Medi-Cal rate *minus* the copayment. As such, it serves as a Medi-Cal rate reduction.

If the Medi-Cal enrollee cannot pay the copayment, as referenced below, then the Hospital *can deny* health care services to the individual. The DHCS notes that Hospitals must still comply with the Emergency Medical Treatment and Active Labor Act. As such, most care still would need to be provided by the Hospitals.

The *three* proposed mandatory copayments related to Hospital Services are as follows:

- A. Mandatory \$100 Copay for Hospital Inpatient Days. Medi-Cal enrollees would be required to pay \$100 per Inpatient Hospital day up to a maximum of \$200 per admission.

This mandatory copayment would apply to *all* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women. No exemptions would be provided.

The budget assumes a reduction of \$319 million (\$151.2 million General Fund) from this action.

A significant aspect of this proposal is an assumed reduction in Hospital Inpatient admissions. Specifically, a 5 percent reduction is assumed once the copayment is implemented, which is about 30 percent of the proposed reduction.

It should be noted that only 21 percent of Medi-Cal Hospital Inpatient days are for only one day, with the remaining 78 percent for two or more days. This reflects the more medically needy population. Further, Medi-Cal's treatment authorization system and reimbursement method for Hospital Inpatient days serves to already dissuade frequent use by Medi-Cal enrollees or Hospitals.

- B. Mandatory \$50 Copay for Non-Emergency Room Visits. Medi-Cal enrollees would be required to pay \$50 for Non-Emergency Room use of Emergency Rooms. This mandatory copayment would apply to *all* Medi-Cal enrollees. No exemptions would be provided.

The budget assumes a reduction of \$146.4 million (\$73.2 million General Fund) from this action.

For this calculation, the DHCS assumed a reduction of 8 percent in utilization once the copayment is implemented, which reflects a reduction of \$22 million (total funds) in expenditures. The remaining amount—about \$125 million (total funds)—would occur from the rate reduction (i.e., offset of the copayment).

DHCS states the average cost of a Non-Emergency Room visit is \$125.94.

It should be noted that the federal CMS regulations provide for States to charge copayments for Non-Emergency services provided in a Hospital Emergency Room. But the following requirements must be met (Federal Register of May 28, 2010, page 30245):

- Patient is to receive an appropriate medical examination to determine patient has no emergency;
- Patient has access to a non-emergency services provider without the imposition of the same cost-sharing requirement;
- Hospital must coordinate a referral to the non-emergency services provider.

It is not clear from the DHCS proposal, if the above federal criteria would be met.

- C. Mandatory \$50 Copay for Emergency Room Visits. Medi-Cal enrollees would be required to pay \$50 for Non-Emergency Room use of Emergency Rooms. This mandatory copayment would apply to *all* Medi-Cal enrollees. No exemptions would be provided.

The budget assumes a reduction of \$76.7 million (\$38.4 million General Fund) from this action.

For this calculation, the DHCS assumed a reduction of 8 percent in utilization once the copayment is implemented, which reflects a reduction of \$10.8 million (total funds) in expenditures. The remaining amount—about \$65.9 million (total funds)—would occur from the rate reduction (i.e., offset of the copayment).

DHCS states the average cost of an Emergency Room visit is \$143.57.

It should be noted that this mandatory copayment is for *medically necessary* emergency room visits. Clearly, significant medical treatment is required for individuals needing

emergency services and to mandate a \$50 copayment, particularly coupled with no exemptions and the low-income level of Medi-Cal enrollees is extreme.

Subcommittee Staff Comment. The Administration's three proposal for mandatory copayments related to Hospitals do not take into consideration any cost shifts to other services that would likely occur from this action, or that people will become more ill and require more services.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of each of the mandatory copayment proposals for Hospital Services, as noted above.
2. DHCS, Please briefly explain why a federal Waiver is necessary for these mandatory copayment proposals.

6. Mandatory Copayments for Dental Services

Budget Issue. The budget proposes a reduction of \$417,000 (\$208,000 General Fund) in the current-year, and \$2.5 million (\$1.3 million General Fund) in 2011-12 by implementing mandatory copayments of \$5 per Dental Office Visit at the point of service.

This proposal applies to Medi-Cal Fee-for-Service and Medi-Cal Managed Care arrangements. *All* Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.

Trailer bill language is required for enactment and a May 1, 2011 implementation date is assumed. *In addition* to statutory changes, this proposal requires a State Plan Amendment and a federal Waiver which *both* require federal CMS approval.

Under this proposal, the Dental Office would collect the copayment at the point of service, and the Dentist would be reimbursed their Medi-Cal rate *minus* the \$5 copayment.

The mandatory copayment means the Dentist *can deny* the Medi-Cal enrollee their dental service unless the copayment is made at the point of service.

The Adult Dental Services benefit, other than certain federally required services, was eliminated from Medi-Cal in 2009 as a cost-cutting measure. As such, most of the copayment reduction pertains to dental services provided to Children, along with pregnant women, and a few Adults in managed care arrangements.

Subcommittee Staff Comment. *First*, it has been well documented that a lack of dental care can lead to serious health care issues. The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits or Emergency Rooms—that may occur if appropriate dental care is not received.

Second, a calculation misstep occurred and the amount of the reduction should actually be \$9.3 million (\$4 million General Fund) in the current-year, *and* \$55.8 million (\$27.9 million General Fund) in 2011-12.

As such, if adopted, this proposal would provide for a further reduction of \$30.4 million (General Fund) off of the Governor's budget.

It should be noted that most of this savings is primarily directed at children having to provide a copayment.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal and how it would work.

7. Proposed Elimination of Over-the-Counter Cough and Cold Products

Budget Issue. The budget reduces by \$194,000 (\$97,000 General Fund) in the current-year and \$4.4 million (\$2.2 million General Fund) in 2011-12 by eliminating “non-prescription” cough and cold products for Adults.

Specifically, these would be so called “over-the-counter” products such as Nyquil, Robitussin, Alka-Seltzer, and similar cough and cold products. Trailer bill language is required for enactment and a June 2011 implementation date is assumed.

Under the DHCS proposal, Medi-Cal enrollees could choose to pay out-of-pocket for these cough and cold products, *or* seek medical attention and obtain a prescription product as medically necessary. Prescription drug products are not affected by this proposal.

Over-the-counter cough and cold products for children would remain unchanged (i.e., available through Medi-Cal).

Subcommittee Staff Comment. The LAO recommends adoption of this proposal.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal.

8. Proposed Elimination of Adult Day Health Care Services

Budget Issue. The budget assumes elimination of Adult Day Health Care Services (ADHC), effective June 1, 2011, for a reduction of \$3.4 million (\$1.7 million General Fund) in the current-year, and \$353.2 million (\$176.6 million General Fund) in 2011-12. Trailer bill language is required for enactment.

Under federal Medicaid law, ADHC services are considered “Optional” benefits for States to provide. California is one of few States that currently offers this service.

ADHC services are a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home.

There are about 325 active ADHC providers in Medi-Cal who serve about 27,000 average monthly users. The estimated cost per ADHC beneficiary is \$1,128 per month, or \$13,536 annually.

DHCS states that other Medi-Cal services would still be available if ADHC services were eliminated. Specifically, the following Medi-Cal services, which are similar to ADHC services, would still be available to individuals:

- Home Health Services
- In-Home Supportive Services
- Physical and occupational therapy
- Clinic services that would include dietitian, physician, social worker and nursing services
- Physician Services through the individual’s Medical health care provider

Previous cost-containment efforts regarding ADHC services have included the following:

- *Moratorium.* In 2004, a statutory moratorium as directed by the DHCS was placed on the expansion of ADHC providers. This remains in place and only the Director of the DHCS has the discretion to add more providers.
- *Treatment Authorization Reviews (TARS).* In 2009 onsite treatment authorization reviews were implemented and are anticipated to reduce expenditures by \$1.6 million (\$824,000 General Fund) in 2011-12.
- *Medical Acuity Eligibility Criteria—Enjoined by Court.* In 2009 trailer bill legislation enacted specific medical acuity eligibility criteria. The intent of this action was to focus ADHC services on the most medically acute individuals. DHCS has estimated this would reduce expenditures by about 20 percent. This action was enjoined by the court (in the case of *Brantley v Director Maxwell-Jolly*, superseded by *Carry Cota, et. Al v Maxwell-Jolly*).
- *Limit ADHC Benefits to Three-Days per Week—Enjoined by Court.* In 2009 trailer bill legislation limited the number of days an individual could receive ADHC services to

three days per week, except for individuals with developmental disabilities receiving services through Regional Centers (these individuals were not limited). This action was enjoined by the court (in the case of Brantley v Director Maxwell-Jolly).

Subcommittee Staff Comment. Elimination of ADHC services has previously been rejected by the Legislature.

If this benefit is eliminated, the DHCS should work with ADHC facilities and other providers to transition Medi-Cal enrollees to other medically necessary services.

Further, *if* this benefit is eliminated from the Medi-Cal Program, there would need to be a corresponding reduction in State staff, both within the DHCS (in Medi-Cal, and Audits & Investigations) and the Department of Aging (administers and certifies the program).

The Administration should please provide this information to the Subcommittee since it was not addressed in the proposed budget though elimination of ADHC services is assumed.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please briefly describe the budget proposal, *and* comment on prior cost-containment proposals regarding ADHC services. What about operating ADHC services under a federal Waiver?
2. DHCS, Please comment on the availability of other Medi-Cal services as referenced if the ADHC benefit is eliminated.
3. DHCS, Please clarify the interaction between ADHC services and the upcoming mandatory enrollment of individuals in Medi-Cal Managed Care—i.e., would services overlap or what exactly--?

9. Limit Enteral Nutrition Products for Adults to Tube Fed

Budget Issue. The budget reflects a reduction of \$1.1 million (\$547,000 General Fund) in the current-year and \$28.9 million (\$14.5 million General Fund) in 2011-12 through enactment of trailer bill language to limit Enteral Nutrition products provided to Adults. An implementation date of June 1, 2011 is assumed.

Specifically, these products would only be provided for those Adults who must be tube-fed. Conditions which require tube feeding include, but are not limited to, anatomical defects of the digestive tract or neuromuscular diseases.

DHCS states that Children, pregnant women and individuals in Long-Term Care facilities would be *exempt* from this limitation. DHCS also states that a product *may be exempted* from their proposed limit when used as part of a therapeutic regimen for patients with conditions for which regular good, or standard processed foods cannot be consumed without causing risk to the health of the patient.

Under federal law, Enteral Nutrition products are a Medicaid “optional” benefit. DHCS states this proposal would more closely align Medi-Cal with the current Medicare benefit which limits these products to those individuals who are tube fed.

Currently, Medi-Cal Enteral Nutrition products are covered only when supplied by a Pharmacy provider upon the prescription of a licensed practitioner within the scope of their practice. All Enteral Nutrition products require prior authorization approval before Medi-Cal reimbursement.

Subcommittee Staff Comment. It is unclear from the DHCS proposal what medically needy individuals would be exempted or how this process would be determined and administered.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please briefly describe the budget proposal and how both the proposed limit and exemptions would be applied.

10. Establishes Maximum Annual Dollar Limit for Durable Medical Equipment

Budget Issue. The budget assumes a reduction of \$14.7 million (\$7.4 million General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for Durable Medical Equipment (DME). The maximum dollar limit would be \$1,604 annually per Medi-Cal enrollee. An implementation date of October 1, 2011 is assumed.

In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states this DME limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women. Children (21 years and under) and Pregnant women are exempt.

DME items include ambulation devices (such as walkers), bathroom equipment, decubitus (bedsore) care equipment, hospital beds and accessories, patient lifts, traction and trapeze equipment, communication devices, IV equipment, oxygen and respiratory equipment, and wheelchairs and accessories.

The *only* DME products exempt from the proposed dollar limit are Respiratory and Oxygen equipment.

DHCS contends their proposed DME limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary DME products because they are presently at or below the proposed dollar limit of \$1,604 per enrollee. Excluding those exempt from the budget proposal, this 90 percentile consists of about 60,100 Adult DME users with expenditures of \$11.7 million (total funds).

In comparison, the DHCS states 6,773 people, or about 10 percent of those needing DME products, would exceed the limit. These individuals have an average cost of \$4,666 annually, or *almost 3 times* the amount of the proposed dollar limit. Specifically, this 10 percentile consists of 6,773 Adult DME users with expenditures of \$31.6 million (total funds).

Under federal law, DME products are considered a Medicaid “optional” benefit. Medi-Cal has covered DME products since 1988. Medi-Cal requires DME

Subcommittee Staff Comment. This proposal was denied by the Legislature last year.

A key concern with this limit is for people who require a combination of DME products due to their fragile medical state, as well as people who need more costly customized wheelchairs in order to live independently and to be mobile (access to school, work and quality of life issues).

The Administration’s proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur if appropriate DME products are not provided.

Further, it does not take into account cost shifts to the Department of Developmental Services for the provision of DME products needed for people who are clients of the Regional Center system and entitled to services.

The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future which is not particularly workable.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please briefly describe the budget proposal.
2. DHCS, Please briefly describe the people who would be affected by the dollar limit. Do we know why they are higher-need users of these products (or which products)?

11. Establishes Maximum Annual Dollar Limit for Medical Supplies

Budget Issue. The budget proposes a reduction of \$3.9 million (\$1.9 million General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for certain Medical Supplies. An implementation date of October 1, 2011 is assumed.

In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states this DME limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women.

The annual dollar limit would apply to wound dressings, incontinence products, and urinary catheters for Adults *not* residing in Long-Term Care facilities. Children and pregnant women are exempt from the proposed limit.

The table below lists the proposed annual dollar limits. The annual limit is based on State fiscal year, not a calendar year.

Table: Proposal to Limit Medical Supplies

Medical Supply Item to be Capped	Proposed Annual Dollar Limit	People Affected by Limit (10 Percent)
Wound Care	\$391	882
Incontinence Supplies	\$1,659	9,050
Urologicals--catheters	\$6,435	459
TOTAL		10,391

DHCS contends their proposed Medical Supply limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary Medical Supplies because they are presently at or below the proposed dollar limits as shown in the table, above.

In comparison, the DHCS states 10,391 people, or about 10 percent of those needing Medical Supplies, would exceed the limit. These individuals have an average costs as follows:

- \$1,191 for Wound Care as compared to \$391 proposed limit, or over 3 times the limit.
- \$1,872 for incontinence Supplies as compared to \$1,659 proposed limit.
- \$7,295 for Urologicals as compared to \$6,435 proposed limit.

Federal law considers Medical Supplies to be an Optional benefit. Medi-Cal has included Medical Supplies in its program since 1976.

Currently, Medical supplies are a benefit in Medi-Cal when prescribed by a Physician. Certain prior authorization approvals also apply. In addition, the DHCS has authority to contract with providers for certain supplies, including incontinence supplies.

Subcommittee Staff Comment. The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur from this action.

The people who fall outside of the 90 percentile are people who have significant medical conditions. Without these medical supplies it is likely that infections and other more severe medical conditions may occur.

The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future which is not particularly workable.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please briefly describe the budget proposal.
2. DHCS, Please briefly describe the people who would be affected by the dollar limit.

12. Establishes Maximum Annual Dollar Limit for Hearing Aid Expenditures

Budget Issue. The budget proposes a reduction of \$1 million (\$507,000 General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for hearing aid expenditures.

The maximum dollar limit would be \$1,510 annually per Medi-Cal enrollee. This includes expenditures for the Hearing Aid, ear molds, and repairs.

An implementation date of October 1, 2011 is assumed. In addition to statutory change, this proposal also requires a State Plan Amendment and federal CMS approval for implementation.

DHCS states the Hearing Aid expenditure limit would apply to Adults (21 years and older) who are *not* in Long-Term Care Facilities or pregnant women.

DHCS contends the expenditure limit would enable 90 percent of the Medi-Cal population to continue to receive Hearing Aids and most servicing of the device because they are presently at or below the proposed expenditure limit of \$1,510 per enrollee. DHCS data reflects that 20,600 people would be within the proposed limit.

Medi-Cal reimbursement for Hearing Aids varies but the maximum reimbursement for the device is \$884 (monaural) and \$1,480 (binaural). In addition to the device, many people also need ear molds.

According to DHCS data, there would be 2,293 people above the proposed expenditure limit. The average amount expended by this 10 percentile group is \$1,579 annually, or about \$80 higher than the proposed cap.

Federal law considers Hearing Aids to be an Optional benefit. Medi-Cal has included Hearing Aids in its program since 1988.

Hearing Aids are a benefit in Medi-Cal when supplied by a Hearing Aid Dispenser through the prescription of Otolaryngologist or attending Physician.

Subcommittee Staff Comment. Though caps on services are not desirable, the level proposed by the DHCS would enable one to obtain a hearing aid (binaural) with some modicum of adjustment being available.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please briefly describe the budget proposal, and whom it would affect.

B. Proposed Medi-Cal Provider Payment Reductions

1. Proposed Medi-Cal Provider Payment Reductions (See Hand Out)

Budget Issue. The budget reflects a reduction of \$18.2 million (\$9.4 million General Fund) in the current-year and \$1.1 billion (\$537.1 million General Fund) in 2011-12 through enactment of Medi-Cal Provider Payment reductions. An implementation date of June 1, 2011 is assumed. In addition to statutory changes, this proposal also requires a State Plan Amendment and federal CMS approval.

The proposed Provider Payment reductions are applicable to *both* Medi-Cal Fee-for-Service and Medi-Cal Managed Care providers.

The Provider Payment reductions vary by Provider Type. As shown in the *Hand Out*, this is due to Provider Payment reductions enacted in prior years (see AB 3X 5 column) which were enjoined by various Court actions and then partially restored (see AB 1183 column). As such, the budget proposes to enact an additional percentage reduction as shown (see "Proposed Additional Reduction" column). The *general* intent of the Provider Payment reductions as contained in the budget is to reflect an overall 10 percent *ongoing* Provider Payment reduction.

Subcommittee Staff Comment. Medi-Cal Provider Payments are some of the lowest in the United States. Federal law requires Medicaid payments (Medi-Cal in CA) to be sufficient to enlist providers so that care and services are available to the extent that such care and services are available to the general public in a geographic region. Concerns regarding Medi-Cal enrollee access to health care services, including various specialists, have been of concern in the past in California.

There is a long history of legal challenges and actions regarding the various methodologies used in developing Medi-Cal Provider Payments, as well as the various reductions which have been enacted over the past few years.

The United States Supreme Court recently agreed to hear California's appeal of a Ninth Circuit Court of Appeals ruling involving Medi-Cal's Provider Payments. This involves three cases — (1) Director Maxwell Jolly v. Independent Living Center; (2) Director Maxwell Jolly v. California Pharmacists Association; and (3) Director Maxwell Jolly v. Santa Rosa Memorial Hospital. It is anticipated the United States Supreme Court will provide its decision by *late Fall 2011*. The key issue is whether the Supremacy Clause of the Constitution confers a private right of action on providers and Medicaid enrollees to challenge rates for compliance with certain federal law.

It should also be noted that a calculation misstep is in the Medi-Cal budget and a 10 percent Provider Payment reduction for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD Facilities) should have been included for a reduction of \$41.1 million (\$20.5 million General Fund) for these facilities.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary, including the aspect of the U.S. Supreme Court hearing California's case and when a ruling may occur.

2. 10 Percent Medi-Cal Payment Reduction to Nursing Homes (Level B's)

Budget Issue. The budget reflects a reduction of \$4.6 million (\$2.3 million General Fund) in the current-year and \$392.9 million (\$172 million General Fund and \$24 million Quality Assurance Fee) in 2011-12 through enactment of a 10 percent Provider Payment reduction to Nursing Homes (Level B's).

An implementation date of June 1, 2011 is assumed. In addition to statutory changes, this proposal also requires a State Plan Amendment and federal CMS approval.

As referenced below, Nursing Home (Level B) facilities are reimbursed using methodology established under AB 1629, Statutes of 2004. This methodology uses General Fund support, coupled with Quality Assurance Fees (QA Fees), to obtain federal matching funds. As required under the methodology, each Nursing Home has an individual facility specific rate based upon previous cost reports which reflect labor and operations expenditures.

Under existing statute, these Nursing Homes are to receive an average 3.93 percent rate adjustment for 2010-11 and an average 2.4 percent adjustment for 2011-12.

The DHCS states the proposed budget reduction of 10 percent to the Provider Payment would be applied to a Nursing Home's bottom-line, *after* the existing statutory rate adjustments (average of 3.93 and average of 2.4) are calculated.

Background—Nursing Home Reimbursement (AB 1629, Statute of 2004). Certain Nursing Home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund and revenues collected from Quality Assurance Fees (QA Fee). Use of QA Fees has enabled California to provide reimbursement increases to certain Nursing Homes with *no* added General Fund support.

This existing reimbursement method established under AB 1629, Statutes of 2004, requires the DHCS to implement a facility-specific rate system for certain Nursing Homes and it established the QA Fee. Revenue generated from the QA Fee is used to draw federal funds and provide additional reimbursement to Nursing Homes for quality improvement efforts.

The *current* QA Fee structure sunset as of July 31, 2012. If the QA Fee sunsets, over \$400 million in General Fund support is at risk.

Summary of Budget Act of 2010 Actions. Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following key components:

- *Rate Adjustments.* Provides for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.
- *Quality & Accountability.* Begins to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A

comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information.

A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be \$50.9 million (total funds).

- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of \$15,000. This increases to \$30,000 for those who are non-compliant from 50 percent or more of audited days.
- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.
- *Expanded the Quality Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

Subcommittee Staff Comment. Based on information received to date, it is unknown how the budget proposal may affect quality and accountability aspects at the Nursing Homes or unravel efforts made last year to improve the system overall.

In addition, the Quality Assurance Fee sunsets as of July 31, 2012 and will need to be extended or up to \$400 million in General Fund support could be jeopardized. It is unknown how the Administration's proposal could affect this aspect.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal, including how the reduction would be applied, the interactions with the updated quality assurance changes from last year, as well as how the reduction affects the Quality Assurance Fee.
2. DHCS, Could this proposed reduction be affected by the pending U.S. Supreme Court review regarding California's Medi-Cal reimbursement?

C. Other Issues & Alternative Funding Proposals

1. Proposed Trailer Bill Language: Federal Roger's Amendment Issue

Budget Issue. The Administration proposes a reduction of \$6.4 million (General Fund) by extending the sunset date of Section 14091.3 of the Welfare and Institutions Code by one-year (to January 2013).

Specifically, this code section is based on federal law and regulation (known as the Roger's Amendment) that requires State Medicaid Programs (Medi-Cal) to establish separate payment amounts for emergency services and post-stabilization services.

The intent of the law is to establish a basis for Medi-Cal Managed Care Plans to make reasonable payments to Hospitals who are "out-of-network" for these services. Historically, some Hospitals have litigated payments from Managed Care Plans that were high enough for the federal CMS to determine them to be unreasonable for the services provided.

Subcommittee Staff Commend and Recommendation. It is recommended to adopt this proposal.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal.

2. Two Issues Regarding Medi-Cal Managed Care Tax

Budget Issues. *First*, the Administration proposes to *permanently* establish the existing tax on the total operating revenue of Medi-Cal Managed Care Plans as originally enacted in AB 1422, Statutes of 2009. Existing statute sunsets as of July 1, 2011.

The budget projects revenues of \$194.5 million to be generated in 2011-12 from this tax. Revenues from this tax are matched with federal funds and are used to (1) provide a reimbursement rate increase to Medi-Cal Managed Care Plans; and (2) fund health care coverage for children in the Healthy Families Program.

For the Medi-Cal Program, half of the generated revenues, or \$97.2 million, will be matched with federal funds to provide for capitation payments. A total of \$194.4 million (total funds) is available for this purpose. These funds are necessary in order to keep the participating plans whole.

Second, based upon a revised Fund Condition analysis, it has been determined that an *additional* \$89.9 million in Special Fund support is available to *offset* (save) General Fund support in 2011-12 *above* the Governor’s proposed January budget.

This is because in 2009-2010, General Fund support was used to provide for a transition period while the new tax revenue was being obtained from the Medi-Cal Managed Care Health Plans. Therefore, there was an unexpended balance in the Special Fund that can be used to offset General Fund for Medi-Cal Managed Care rates. This meets existing statutory requirements for expenditure of these revenues. The table below displays this information.

Summary Table: Children’s Health and Human Services Fund (Medi-Cal Managed Care Plan Tax Revenues)			
	2009-10 Prior Year	2010-11 Current Year	2011-12 Budget Year
Beginning Balance	\$0	\$152.2 million	\$0
Revenues, Transfers, Adjustments	\$234 million	\$192.3 million	\$194.5 million
Total Revenues, Transfers, and Adjustments	\$234 million	\$344.5 million	\$194.5 million
Expenditures:			
MRMIB	\$81.8 million	\$177.1 million	\$97.2 million
DHCS	\$0	\$77.5 million	\$97.2 million
Total Expenditures	\$81.8 million	\$254.6 million	\$194.5 million
Balance Remaining	\$152.2 million	\$0	\$0
Additional Available to Offset General Fund to DHCS		\$89.9 million	

Constituency Concerns. Managed Care Plans have expressed their support for continuation of the tax established under AB 1422 *but desire a sunset* in lieu of the Administration's proposal for permanently establishing.

They note the federal CMS is presenting reviewing California's methodology for the tax and that federal funding formulas will be evolving in 2014 forward with implementation of the federal Affordable Care Act and reauthorization of the State Children's Insurance Program (Healthy Families in CA).

Therefore, they are seeking a sunset date.

Subcommittee Staff Comment and Recommendation—Modify. *First*, it is recommended for the existing sunset date to be extended of permanently establishing the tax. A new sunset date of January 1, 2014 is recommended (three years).

Second, it is recommended to reduce Medi-Cal by \$89.9 million (General Fund) to reflect the availability of Special Fund revenues. (These Special Fund revenues are continuously appropriated.)

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the proposal, including the proposed trailer bill and the potential to use \$89.9 million in revenues as an offset to General Fund support.
2. DHCS, Please provide an update regarding any federal CMS concerns regarding the tax.

3. Use of Proposition 10 Reserves to Fund Medi-Cal Services for Children

Budget Issue. The budget proposes to use \$1 billion (Proposition 10 Funds) to fund Medi-Cal services for children (aged five and under) to offset General Fund support in the program for 2011-12. A new Special Fund—Proposition 10 Health and Human Services Fund (4260-101-3148) has been established in the Budget Bill for this purpose.

Of the \$1 billion (Proposition 10 Funds) for 2011-12, the Department of Finance (DOF) assumes that approximately \$233.9 million (Proposition 10 Funds) is obtained from the State Commission and the remaining amount of \$766.1 million (Proposition 10 Funds) is obtained from local commission reserves. However the amount obtain from the State Commission and local commissions may be adjusted based upon pending updated information.

In addition, beginning July 2012, fifty percent of local Proposition 10 Funds would be transferred to the new Special Fund to help support Medi-Cal services for children (aged five and under) on an ongoing basis.

As the Administration notes, this proposal requires voter approval. A June 2011 ballot initiative is assumed.

Background. The California Children and Families Program (known as First 5) was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions and 20 percent is allocated to the State Commission.

Unspent funds are carried over for use in subsequent fiscal years. According to the DOF, over time, both the State and local fund balances have grown. The DOF contends as of June 30, 2009, county commissions held more than \$2 billion in reserves.

County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: (1) Family Functioning; (2) Child Development; and (3) Child Health.

Most recently, Proposition 1D was on a special statewide May 2009 ballot to redirect a portion of Proposition 10 Funds to support certain health and human services programs and it was not successful. However, the fiscal crisis has deepened since this time.

Constituency Concerns. County commissions are very concerned that the amount of reserve assumed by the DOF is too high since some County commissions have maintained prudent reserves for their future obligations. In addition they note that any redirection could create job loss and disruption, and eliminate some vital services that have been determined at the local level.

Subcommittee Staff Comment. In previous analyses, the LAO has recommended a redirection of Proposition 10 Funds to support certain health and human services programs. They noted that Proposition 10 was approved by voters during a healthier fiscal period for California, and with the State facing continued hardship with the Great Recession, it would make fiscal sense to prioritize core children's programs.

Questions. The Subcommittee has requested the DOF/DHCS to respond to the following questions.

1. Administration, Please provide a brief summary of this proposal, including a discussion of the proposed Proposition 10 Fund shifts. Please explain both the proposed 2011-12 shift as well as the proposed on-going shift.

4. Health Information Technology for Economic & Clinical Health (HITECH) Act

Budget Issues. *First*, the budget reflects an increase of \$634.8 million (federal funds) in Medi-Cal from the HITECH Act. These federal funds are available to California as approved by the federal CMS and reflect California’s Health Information Technology Planning and Advance Planning document.

These funds are to be used as federal incentive payments for Hospitals, Physicians, and other eligible clinical health care professionals who participate in the Medi-Cal Program. The DHCS has identified 435 Hospitals and more than 10,000 Medi-Cal providers who will qualify to receive incentive payments.

DHCS has proposed trailer bill language to structure an incentive payment program for this purpose.

Second, the DHCS is requesting an increase of \$2.2 million (\$2 million federal funds and \$217,000 in Reimbursements from the CA Health Care Foundation) to support 16 positions and specified contract funds to implement this new program. The request includes the following 16 positions and contract funds:

- Staff Services Manager I 2
- Health Program Auditor IV 2
- Associate Governmental Program Analysts 8
- Research Program Specialists II 4
- External Consulting \$450,000

Background—HITECH Act. This federal Act authorizes the outlay of federal money for, among other things, Medicaid (Medi-Cal) incentive payments to qualified health care providers who adopt and use electronic health records in accordance with provisions in the Act, including electronic prescribing, submission of information on clinical quality measures, reporting to immunization and disease registries, and exchanging health information to improve the quality of care.

Subcommittee Staff Comment and Recommendation. It is recommended to approve both the increase of \$634.8 million (federal funds) in the Medi-Cal Program and the increase of \$2.2 million (total funds) for DHCS support in order to proceed with implementation of this new program. *However*, it is recommended to deny the proposed trailer bill (without prejudice) to establish this new program since this should be done through the policy committee process.

Providing for appropriation of the funds beginning in July will enable the DHCS to begin to hire staff and work with contractors while the policy legislation is being finalized.

Questions. The Subcommittee has requested the DOF/DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of this proposal.

Managed Risk Medical Insurance Board (MRMIB)

A. Overall Background (Pages 35 through 36)

Summary of Budget Appropriation. The budget proposes total expenditures of almost \$1.1 billion (\$128.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2010-11 as shown in the chart below.

Summary of Expenditures (dollars in thousands)	2010-11	2011-12	\$ Change
Major Risk Medical Insurance Program	\$51,527	\$37,084	-\$14,443
Access for Infants & Mother	\$123,953	\$122,465	-\$1,488
Healthy Families Program	\$1,125,440	\$1,054,124	-\$71,316
County Health Initiative Program	\$1,764	\$1,773	-\$9
Pre-Existing Conditions Plan (PCIP) Program	\$217,372	\$341,376	\$124,004
Totals Expenditures	\$1,520,056	\$1,556,822	-\$36,766
General Fund	\$130,801	\$267,469	\$136,668
Federal Funds	\$796,737	\$749,563	-\$47,174
Federal Funds—High Risk Health Insurance	\$217,372	\$341,376	\$120,004
Children’s Health & Human Services Special	\$176,841	\$97,226	-\$79,615
Managed Risk Medical Insurance Fund	\$51,527	\$37,084	-\$14,443
Other Funds	\$146,778	\$64,104	-\$82,674

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers *five programs* as follows:

- Healthy Families Program;
- Pre-Existing Conditions Insurance Program (PCIP).
- Major Risk Medical Insurance Program (MRMIP);
- Access for Infants and Mothers (AIM) Program; and
- County Children’s Health Initiative Matching Program (CHIM).

The Governor's budget proposes changes to Healthy Families and the newly created PCIP. As such, these programs are discussed further in this Agenda (See Discussion Issues).

The Major Risk Medical Insurance Program (MRMIP). MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP. The budget proposes no policy changes for MRMIP. The changes between the two fiscal years reflect technical adjustments from prior years and payments to health plans.

Access for Infants and Mothers (AIM). AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost. The budget proposes no policy changes for AIM.

County Children's Health Initiative Matching Fund Program (CHIM). Established by AB 495, Statutes of 2001, this program provides four counties the ability to obtain federal funds for their Healthy Children's Initiatives by providing local funds to match the federal dollars. The budget proposes no policy changes for CHIM.

B. Background on Healthy Families Program (Pages 37 through 38)

Background—Description of Healthy Families Program. The HFP provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to State employees. Eligibility is conducted on an annual basis.

A 65 percent federal match is obtained through a federal allotment (Title XXI funds). The HFP is *not* an entitlement program. The MRMIB Board has authority to established waiting lists if necessary.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until age two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Table: Summary of Eligibility for Healthy Families Program

Type of Enrollee in the HFP	Income Level	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers (AIM).	200 % to 300 %	<ul style="list-style-type: none"> • Income from 200% to 250%, covered through age 18. • Income is above 250%, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100%. Families with two children may be “split” between programs due to age.
Children enrolled in County “Healthy Kids” programs include children without residency documentation; and children from 250% to 300%.	Not eligible for HFP, including 250% to 300%.	State provides federal funds to county projects as approved by the MRMIB. Counties provide the match for the federal funds. Conforms to existing law.

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State’s Children’s Health Insurance Program (S-CHIP)—required states to use this “benchmark” approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available.

In addition to these HFP benefits, enrolled children can also access the California Children’s Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California’s Healthy Families Program (i.e., California’s S-CHIP). These services are also available to children enrolled in Medi-Cal.

Summary of Budget Appropriation. A total of \$1.044 billion (\$264.8 million General Fund) is proposed for 2011-12 to provide health care coverage to an estimated 916,029 children. This proposed funding level reflects a series of cost-containment proposals as shown in the table below.

Table: Proposed Reductions to the Healthy Families Program

Budget Proposals	Effective Date	2010-11		2011-12	
		GF	Total	GF	Total
Eliminate Vision Coverage	June 1, 2011	-\$900,000	-\$2.6 million	-\$11.3 million	-\$32.3 million
Increase Premiums	June 1, 2011	-\$1.9 million	-\$5.3 million	-\$22.2 million	-\$63.3 million
Increase Co-Pays for Emergency Room Visits & In-Patient Hospital Stays	October 1, 2011	0	0	-\$5.5 million	-\$15.9 million
Subtotal Subscriber Changes		-\$2.8 million	-\$7.9 million	-\$39 million	-\$111.5 million
Managed Care Plan Tax	July 1, 2011	0	0	-\$97.2 million	-\$97.2 million
Total Proposals		-\$2.8 million	-\$7.9 million	-\$136.2 million	-\$208.7 million

Each of these issues is discussed in detail below.

C. Issues for Discussion on Healthy Families (Pages 39 through 46)

1. Proposed Elimination of Vision Coverage in Healthy Families

Budget Issue. The budget eliminates Vision coverage as presently provided for children enrolled in Healthy Families for a reduction of \$2.6 million (\$900,000 General Fund) in 2010-11, and \$32.3 million (\$11.3 million General Fund) in 2011-12.

The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011. Families need to be notified of the elimination of the coverage and the contracts with the Vision Plans would need to be closed-out.

This proposal also requires federal approval of a State Plan Amendment for implementation.

Currently, HFP provides Vision coverage through a separate Vision Plan, as done in the employer-based insurance market. There are three Vision Plans for HFP subscribers to choose from, including (1) Vision Service Plan (VSP); (2) EyeMed Vision Care; and (3) SafeGuard vision. About 900,000 children are presently enrolled in a Vision Plan.

According to the MRMIB, Vision Plan coverage includes the following services:

- Case History
- Evaluation of the health of the visual system including:
 - External and internal examination
 - Assessment of neurological integrity
 - Biomicroscopy of the anterior segment of the eye
 - Screening of gross visual fields; and
 - Pressure testing through tonometry.
- Binocular function test
- Diagnosis and treatment plan, if needed
- Corrective lenses, limited to once each twelve consecutive month period
- Contacts are covered with prior authorization and under certain conditions, such as cataract surgery.

If Vision coverage is eliminated as proposed by MRMIB, only a more limited set of sensory Vision services would be available. The HFP Health Plan benefit includes some preventive vision services, including some vision testing, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.

California's Knox Keene Act requires Health Plans to "provide benefits for the comprehensive preventive care of children 16 years of age or younger.." that comply with recommendations for preventive pediatric health care, as adopted by the American Academy of Pediatrics; these sensory Vision screenings are to be performed at ages 3 to 6, 8, 10, 12, 15 and 18 years.

Further, medically necessary services for the treatment of eye illnesses or eye injuries would also be provided under the HFP Health Plan benefit.

Subcommittee Staff Comment. Elimination of separate Vision coverage would mean that only a more limited set of sensory Vision services would be available. Annual eye exams and glasses would not be covered by Health Plans as they are covered under the HFP Vision Plan (as is comparable under the employer-based insurance market).

There may be other options available for reducing Vision Plan expenditures that could be explored, such as cost containment with eye-glass frames or the like.

The LAO recommends approval of the Administration's proposal to eliminate the Vision benefit due to the State's fiscal condition since it is not a required benefit of the federal Children's Health Insurance Program (HFP in CA).

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

1. MRMIB, Please briefly describe the proposal.
2. MRMIB, Please discuss the differences in Vision services provided under the Vision Plan and as provided under the Health Plan.
3. MRMIB, Are other options for reducing Vision Plan expenditures available?

2. Proposed Increases to Premiums

Budget Issue. The budget significantly increases the monthly premiums paid by families with incomes from 151 percent up to 250 percent for a total reduction of \$5.3 million (\$1.9 million General Fund) in 2010-11, and a reduction of \$63.3 million (\$22.2 million General Fund) in 2011-12.

The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011. A State Plan Amendment must also be approved by the federal CMS for this purpose.

This federal approval is necessary for two purposes: **(1)** To ensure California conforms to federal requirements regarding family cost sharing (premiums and copays cannot exceed 5 percent of family income); and **(2)** To ensure the proposed premium increases would not violate federal maintenance of effort (MOE) provisions as contained in the federal Patient Protection and Affordable Care Act (Affordable Care Act) of 2010.

The table below provides a summary of the proposed premium changes. It should be noted that premiums were increased in 2005 and twice in 2009.

Table: Proposed Monthly Premium Increases

HFP Subscriber Family Income %	Existing Monthly Premium	Proposed Budget Increase to Premiums	Proposed Revised Monthly Premium (effective June 1, 2011)
100 to 150 % (Category "A")	\$7 per child Family Maximum of \$14	No change Federal law prohibits	No change Federal law prohibits
151 to 200 % (Category "B")	\$16 per child Family Maximum of \$48	\$14 per child Family Maximum of \$42	\$30 per child Family Maximum of \$90
201 to 250 % (Category "C")	\$24 per child Family Maximum of \$72	\$18 per child Family Maximum of \$54	\$42 per child Family Maximum of \$126

Monthly premiums for families from 151 percent to 200 percent of poverty (Category B) would be increased by \$14 per child, or by *87 percent*, for a total of \$30 per child per month, with a family maximum of \$90 for three or more children.

The increase to Category B families results in an expenditure reduction of \$35.7 million (\$12.5 million General Fund) to HFP.

Monthly premiums for families from 201 to 250 percent of poverty (Category C) would be increased by \$18 per child, or by 75 percent, for a total of \$42 per child per month, with a family maximum of \$126 for three or more children.

The increase to Category C families results in an expenditure reduction of \$27.6 million (\$9.7 million General Fund) to HFP.

Background: Federal Maintenance of Effort (MOE) Requirement (See Hand Outs). The Affordable Care Act of 2010 requires States to retain current income eligibility levels, including processes and procedures for enrollment, for children in Children’s Health Insurance Programs (HFP in CA).

As noted in the hand out package, two federal CMS letters—one to California and the other to Georgia—raise question as to whether increases to premiums may potentially violate these federal MOE provisions. At risk to California is over \$750 million in federal funds within the HFP, as well as over \$26 billion in federal funds within the Medicaid Program (Medi-Cal).

Background: Federal Law Limits Cost-Sharing Amounts Charged to 5 Percent. Federal law imposes limits on the total aggregate amount of all cost-sharing, including premiums and co-payments, at a maximum of 5 percent of family income on a monthly basis.

According to MRMIB, the federal CMS has previously expressed concerns that the higher the cost-sharing imposed on families becomes (close to the 5 percent threshold), the more likely the federal CMS will require MRMIB and participating Health Plans to more directly track and monitor individual family out-of-pocket expenses. This could become a closely enterprise for the State and for participating Health Plans, if ever required.

Background: Discounts Offered for HFP Subscribers. HFP does offer subscribers “premium discount options” to offset some costs associated with premiums and co-payments. Discounts offered include (1) \$3 per child per month discount for enrollment in a “community provider plan”; (2) subscriber paying 3 months in advance to get one month “free”; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer.

Further, HFP subscribers can choose a community provider health plan, in most regions of the State, which have lower-cost monthly premiums.

Subcommittee Staff Comment. First, federal CMS approval of the viability of any premium increases should be explored and clarified by the RMMIB.

Second, the proposed premium increases are substantial for low-income families. The Category B premiums reflect an increase of 87 percent, and the Category C premiums reflect an increase of 75 percent. Other premium adjustments may be an option if further direction can be obtained from the federal CMS.

Further, it should be noted that the Administration's cost savings estimate for the premium increases to families do not assume any reductions to caseload. Due to the level of increase, it seems likely that some families will drop HFP coverage due to cost.

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

1. MRMIB, Please provide a brief summary of the proposal.
2. MRMIB, What is the viability of the federal CMS to approve any premium increases within the context of California meeting its MOE provisions.
3. MRMIB, Are other options potentially available?

3. Proposed Increases to Copayments to Conform to Medi-Cal Program

Budget Issue. The budget proposes a reduction of \$15.9 million (\$5.5 million General Fund) by increasing HFP copayments to conform to a similar proposal within Medi-Cal, as noted above. An October 1, 2011 implementation date is assumed.

This reduction includes the following two proposals:

- Emergency Room visits which do not result in hospitalization or outpatient observation would increase from \$15 to \$50; and
- Hospital Inpatient days would have copay of \$100 per day (maximum of \$200 per stay).

This proposal requires federal approval through a State Plan Amendment, as well as a federal Waiver (to be done by the DHCS through the Medi-Cal Program as previously referenced).

Background on Copayments. In addition to monthly premiums, families must also provide copayments for their children to receive services. Copayments count towards the federal cost-sharing calculations of five percent of monthly family income.

As of November 2009, copayments were increased for families with incomes from 150 percent to 250 percent as follows:

- Non-preventive health, dental, and vision services—from \$5 to \$10.
- Generic prescription drugs—from \$5 to \$10.
- Brand name prescription drugs-- \$5 to \$15, unless no generic is available or brand name drug is medically necessary.
- Emergency room visits—from \$5 to \$15, unless child is admitted to hospital.

Subcommittee Staff Comment. Existing statute and HFP regulation have a cap of \$250 annually on the amount of out-of-pocket copayments. It is up to families to track this information and if the cap is reached, the family informs the HFP that it has been reached.

The MRMIB notes that the \$250 annual copayment cap would not be modified under this proposal in order to meet the existing federal requirement of not exceeding 5 percent of a family's income in all cost-sharing arrangements (meaning premiums and copays collectively).

This issue should conform to actions taken in Medi-Cal.

D. Issue for Discussion: Pre-Existing Condition Insurance Program

1. Request for Resources for California's Pre-Existing Condition Insurance Program

Budget Issue. MRMIB requests an increase of \$3.5 million (federal funds) to support 28 positions to continue implementation and operation of California's Pre-Existing Condition Insurance Program (PCIP) as recently authorized in both federal and State statute.

California received federal approval in August 2010, along with an allocation of \$761 million (federal funds) to operate a high risk health insurance pool (PCIP in California). The federal Department of Health and Human Services (DHHS) will reimburse MRMIB for administrative expenses and claims for covered medical services that are in excess of the premiums collected from enrollees in the PCIP.

PCIP is to provide health care coverage for eligible individuals through December 31, 2013, with a final closeout period that will run from January 1, 2014 through June 30, 2014.

The requested \$3.5 million (federal funds) would support 28 permanent positions, and provide for \$629,000 in external contract expenditures. The requested positions are as follows:

- 4 Staff Services Analysts Manager I
- 6 Associate Governmental Program Analysts
- 5 Research Program Specialists
- 2 Staff Services Analysts
- 3 Associate Accounting Analysts
- 2 Staff Program Analysts
- 1 Legal Staff Counsel IV
- 1 Legal Staff Counsel III
- 1 Legal Assistant
- 1 Information Officer
- 1 Associate Personnel Analyst
- 1 Associate Management Auditor

Key responsibilities and functions of these positions include:

- Administer an eligibility system, including establishing policies and procedures for enrollment, disenrollment and appeals;
- Develop and operate subscriber service functions, including plan enrollment, providing customer service, and conducting marketing and outreach;
- Oversee all aspects of premium administration;
- Develop and maintain program regulations;
- Conduct various contractual and legal activities, including Administrative Vendor contracts, health plan contracts, matters related to subpoenas, appeals and hearings, and Public Record Act requests.

- Ensure compliance with federal program requirements, including routine monitoring and identification of compliance risks, internal monitoring, data reporting, and federal DHHS requirements.

The \$629,000 (federal funds) for external contracts would be for certain expertise including actuarial services, legal services and auditing services.

Background—Establishing CA’s PCIP. The federal Patient Protection and Affordable Care Act of 2010 established a *temporary* federal high risk pool program (June 2010 through December 31, 2003) and provided States flexibility to operate their own program.

SB 227 (Alquist), Chapter 31 of 2010 and AB 1887 (Villines), Chapter 32 of 2010 required the MRMIB to establish and administer California’s program. Implementation was contingent on an agreement with the federal government and receipt of adequate federal funds for this purpose. The legislation prohibits the use of any State funds for this new federal program.

PCIP is governed by terms of a contract with the federal Department of Health and Human Services which was approved in August 2010. An allocation of \$761 million (federal funds) was provided for California to operate the program.

PCIP offers health coverage to *medically uninsurable* individuals 18 years or older who live in California. It is available for people who did not have health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant’s age and the region where the applicant lives.

Subcommittee Comment and Recommendation-- Approve. It is recommended to approve the \$3.5 million (federal funds) and the 28 positions. MRMIB states that by the nature of the program phasing-out, the positions will also phase-out as of June 30, 2014.

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

1. MRMIB, Please provide a brief summary of the key aspects of the program and this request.