SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 26th, 2011

Upon Adjournment of Appropriations

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Vote Only Calendar: Listed by Department (Pages 2 to xx)

A. Department of Health Care Services (Items 1 through 12)

1. Medi-Cal Estimate: Adjustments Due to Erosion of Solutions (DOF issue 401)

Governor's May Revision. The May Revision reflects an increase of $313.2 million ($156.6 million General Fund) due to erosions in the solutions which were adopted in March.

The erosion is mainly caused by the one-month delay in implementation of budget solutions and the revised costing by the DHCS at the May Revision of enacted policies.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to adopt the May Revision to properly align the Medi-Cal Program with necessary adjustments due to the one-month delay in implementing solutions and other related May Revision costing adjustments. No issues have been raised.

2. Medi-Cal Estimate: Balance of the Estimate (DOF issue 420)

Governor's May Revision. The May Revision proposes two sets of technical adjustments related to caseload and cost changes, and non-budget act items which are continuously appropriated and are in statute.

Caseload and cost changes not highlight in other Medi-Cal issues:

- Item 4260-101-0001 be decreased by $81,609,000 and Reimbursements be decreased by $32,484,000
- Item 4260-102-0001 be decreased by $1,908,000
- Item 4260-105-0001 be decreased by $1,777,000
- Item 4260-113-0001 be decreased by $51,403,000
- Item 4260-117-0001 be increased by $1,145,000
- Item 4260-101-0890 be increased by $2,910,336,000
- Item 4260-102-0890 be decreased by $1,908,000
- Item 4260-106-0890 be increased by $15,323,000
- Item 4260-113-0890 be increased by $71,328,000
- Item 4260-117-0890 be increased by $6,199,000
- Item 4260-101-0080 be increased by $689,000

Additionally, the following items have been adjusted to fund Medi-Cal costs that are reflected in non-budget act items. No amendments to the Budget Bill are required for these changes because these items are continuously appropriated:

- Welfare and Institutions Code section 14166.12 is increased by $1,804,000
- Government Code section 13340 is increased by $79,647,000
- Welfare and Institutions Code section 14166.9 is decreased by $44,656,000
- Welfare and Institutions Code section 14166.21 is decreased by $165,801,000
- Welfare and Institutions Code section 14167.32 is increased by $320,000,000
- Revenue and Taxation Code section 12201 is increased by $105,788,000
- Welfare and Institutions Code section 14126.022 is decreased by $3,177,000
- Welfare and Institutions Code section 15910.1 is increased by $325,000,000

Subcommittee Staff Comment and Recommendation—Approve May Revision. These May Revision adjustments are technical and are necessary to properly align Medi-Cal Program expenditures. No issues have been raised.

3. Medi-Cal Program: Technical Trailer Bill for Correction to SB 90, Statutes of 2011

Governor's May Revision. The May Revision proposes technical trailer bill due to a drafting error in SB 90, Statutes of 2011, related to the implementation of hospital inpatient payment methodology for General Acute care services based upon diagnosis related groups (DRGs).

Specifically, SB 90 inadvertently repealed the requirement (established though the Budget Act of 2010) for the new DRG payment methodology be implemented by July 1, 2012 by means of a reconciliation process. The May Revision proposes technical trailer bill to clarify that July 1, 2012 is still assumed for the implementation date of the DRG payment methodology as noted.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The proposed technical trailer bill is consistent with actions adopted in the Budget Act of 2010 and accompanying trailer bill legislation. The May Revision trailer bill language would correct the error contained in SB 90, Statutes of 2011. No issues have been raised.

4. Maddy Fund Shift (DOF Issue 424)

Background. Existing law authorizes collection of assessments on certain traffic and criminal violations, and revenue from traffic school fees. These funds are deposited in the Emergency Medical Services Fund (known as the "Maddy Fund"). These funds are used to compensate physicians and hospitals that provide emergency medical services to the uninsured and cannot pay for their medical care.

Legislative Actions Contained in SB 69 Budget Bill. The SB 69 Budget Bill reflects a reduction of $55 million (General Fund) by shifting a portion of the Maddy Funds to the State to offset General Fund support within the Medi-Cal Program.

This action was taken due to the fiscal crisis and implementation of the 1115 Medicaid Waiver which provides additional federal funds to local government for uncompensated care, including physicians and hospitals.

It should be noted that necessary statutory changes to affect this change *did not occur* in trailer bill.

Governor's May Revision. The May Revision increases by $55 million (General Fund) and decreases by $55 million special fund since it does *not* include the redirection of the Maddy Funds as contained in the SB 69 Budget Bill.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to adopt the May Revision to *no*t include the redirection of the Maddy Funds since necessary statutory changes were not enacted.

5. Medi-Cal Program: Technical Trailer Bill for 10 Percent Rate Reduction

Legislative Actions Contained in SB 69 Budget Bill—Conformed to Governor. The Legislature approved the Governor's January budget proposal to reduce Medi-Cal Provider reimbursement up to 10 percent as contained in AB 97, Statutes of 2011 (signed into law on March 24, 2011).

Except for those specialty exempted providers, the Provider payment reductions would apply to services rendered by any provider that is authorized to bill for Medi-Cal services. Federal approvals must be received before the 10 percent reductions can be implemented in order to comply with federal law.

The language also sunset the 1 percent and 5 percent Provider payment reductions, enacted previously, effective on or after June 1, 2011 with repeal date of July 1, 2014. This sunset language was included so previous payment reductions would not conflict with June 1, 2011 implementation date of the 10 percent reductions.

Governor's May Revision. The May Revision proposes clarifying adjustments to the 10 percent Medi-Cal Provider reimbursement reduction as contained in AB 97, Statutes of 2011, since the DHCS *will not be able* to obtain federal approvals by the implementation date of June 1, 2011.

Subsequently, this creates a transition period wherein neither a 1 percent and 5 percent Provider payment reduction nor a 10 percent provider payment reduction will be in effect, which was not the intent of AB 97, Statutes of 2011.

Therefore, the DHCS proposes clarifying trailer bill to maintain the 1 percent and 5 percent Provider payment reduction which had been in effect until the implementation of the 10 percent Provider payment reduction. The 1 percent and 5 percent Provider payment reductions have been in place since March 1, 2009; it is to remain operative.

Further, the trailer bill makes a correct to a minor citation error in the statute.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to approve "placeholder" trailer bill language as provided by the DHCS to ensure that the 1 percent and 5 percent Provider reimbursement reductions are maintained pending federal approval of the 10 percent Provider reimbursement reduction as noted above.

6. Medi-Cal Program: Adjustment for 10 Percent Rate Reduction (DOF 464)

Governor's May Revision. The May Revision requests that Item 4260-101-0001 be decreased by $30,122,000 to provide for the correction of a technical error associated with pharmacy rebates and the 10 percent provider payment solution proposed in the Governor's budget and contained in SB 69 Budget Bill.

The May Revision Medi-Cal baseline reduced pharmacy rebates associated with the 10 percent provider rate reduction. However, rebates are contracted with manufacturers and should not decrease because of a reduction in pharmacy reimbursements. This adjustment would correct the initial estimate provided in the May Revision.

Subcommittee Staff Comment and Recommendation—Approve May Revision. It is recommended to correct for this technical error and to adopt the May Revision. Previous calculations inadvertently included Pharmacy Rebates and these rebates are contract with the Manufacturers and should not have been included in the 10 percent calculation.

7. Adult Day Health Care (ADHC) Transition Program (DOF Issue 432)

Legislative Actions Contained in SB 69 Budget Bill. The Legislature appropriated $170 million ($85 million General Fund) to provide for a transition for existing ADHC enrollees to other Medi-Cal appropriate services, and to facilitate when applicable, transition to newly developed Waiver services.

The Budget Bill also contains language that states the Legislature's intent to proceed with legislation in the 2011-12 Session to develop a federal Waiver to provide a more narrow scope of services and to specify level of medical acuity for enrollment into this Waiver program.

AB 97, Statutes of 2011 (Health Trailer Bill), provides for a transition program as specified and provides the DHCS with broad discretion to implement the program through the use of grant funding. The purpose of the transition program is to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated.

In addition, AB 97, Statutes of 2011, also specifies the Legislature's intent to proceed with legislation to establish a Waiver program for Keeping Adults Free from Institutionalization (KAFI). Presently there are *two policy bills*—SB 73 by Senator DeSaulnier, and AB 96 by Assembly Member Blumenfield—which are moving on this topic.

Governor's May Revision. The Governor's May Revision proposes to appropriate *only* $50 million ($25 million General Fund) for expenditures associated with the ADHC transition. No trailer bill language is proposed. DHCS states these funds may be used for assessment, placement, and the provision of services.

The May Revision reflects *a reduction of $120 million* ($60 million General Fund) as compared to the Legislature's action contained in the SB 69 Budget Bill.

Subcommittee Staff Comment and Recommendation--(1) *Reject* May Revision; (2) Adopt KAFI Trailer Bill, and (3) Retain SB 69 Budget Bill Action. It is recommended to *reject* the Governor's May Revision and to *retain* the full $170 million ($85 million General Fund) appropriation as contained in the SB 69 Budget Bill.

The SB 69 Budget Bill appropriation level will provide for a longer transition process and will assist in ensuring consumer health and safety. Therefore it is necessary to retain this level of funding.

In addition, in order to expedite implementation of a Waiver and KAFI, it is recommended to adopt placeholder trailer bill (language similar to the two policy bills).

8. Restoration of General Fund in Lieu of Proposition 10 Funds (DOF Issue 448)

Legislative Actions Contained in SB 69 Budget Bill. The SB 69 Budget Bill conformed to the Governor's January budget proposal and included his proposal to use $1 billion in Proposition 10 Funds—California Children and Families First Act— to backfill for General Fund support within the Medi-Cal Program. AB 100, Statutes of 2011, made necessary statutory changes for this action to occur.

Governor's May Revision. The May Revision proposes to increase by $1 billion (General Fund) and to reduce by $1 billion Proposition 10 Funds within the Medi-Cal Program. This proposal is intended to be a "prudent budgetary approach" given that the Proposition 10 Fund shift is currently being challenged in Court.

The Administration states they are continuing to pursue these Proposition 10 Fund savings by defending all legal challenges at this time. Therefore, they have *not* proposed any statutory changes in trailer bill.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to adopt the May Revision to increase by $1 billion (General Fund) to backfill for the Proposition 10 Fund expenditure which is being challenged in Court.

9. Extension of Hospital Fee to June 2012 (DOF issue 423)

Governor's May Revision. The May Revision reflects a savings of $320 million (General Fund) to Medi-Cal for Children through extension of the existing Hospital Quality Assurance Fee to June 30, 2012.

SB 90 (Steinberg), Statutes of 2011, allows for an acute care hospital building that is classified as a Structural Performance Category 1 building to be used for non-acute care hospital purposes after January 1, 2010, contingent upon the hospital Quality Assurance Fee being extended for one year, along with $320 million in fee revenue being used for children's health care services within Medi-Cal.

Policy legislation is proceeding on the continuation of the Quality Assurance Fee.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The May Revision is consistent with SB 90 (Steinberg), Statutes of 2011, and policy legislation is proceeding on the continuation of the fee. No issues have been raised.

10. May Revision Updates for Family Health Programs (DOF issues 501, 502, 503 & 504)

Governor's May Revision. The May Revision proposes an overall *net* reduction of $132.9 million (General Fund) in the Family Health Programs which includes the Genetically Handicapped Persons Program (GHPP), the California Children's Services (CCS) Program, and the Child Health and Disability Prevention (CHDP) Program.

The $132.9 million General Fund reduction results from the following key factors:

- A reduction in estimated caseload for each of the programs;
- Reflection of federal Safety Net Care Pool Funds transferred into each of the programs which results in a reduction of $106 million General Fund (i.e., a fund shift). This fund shift occurs in the CCS Program and the GHPP. There is no policy change associated with this shift.
- Adjustment to reflect a 10 percent Provider reimbursement reduction as contained in AB 97, Statutes of 2011, which conformed to the Medi-Cal Program.

The budget proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

- *Genetically Handicapped Persons Program (GHPP).* Total expenditures of $75.6 million ($36.1 million General Fund, $ 35.2 million federal Safety Net Care Pool, $4 million Rebate Fund, and $367,000 Enrollment Fees) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only. Total caseload is 976 people.

- *California Children's Services Program (CCS).* Total expenditures of $230.4 million ($48.5 million General Fund and $181.9 million federal funds) are proposed for 2011-12. This reflects technical fiscal adjustments, including the 10 percent Provider reimbursement reduction and the Safety Net Care Pool federal fund shift, and caseload adjustments only. In addition, a total of $117.2 million (County Realignment Funds) are estimated for expenditure in 2011-12 but these funds do not flow through the State's budget. Total caseload is estimated to be 40,559 children.

- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of $2.3 million ($2.2 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds) are proposed for 2011-12. This reflects technical adjustments, including the 10 percent Provider reimbursement reduction, and caseload adjustments only. Total caseload is estimated to be 34,550 children.

In addition, the May Revision proposes a reduction of $79.4 million ($44.3 million General Fund) by shifting children in the Healthy Families carve-out portion of the CCS Program to Medi-Cal to coincide with the Administration's proposal on merging the Healthy Families Program into the Medi-Cal Program based on a phase-in transition beginning January 1, 2012. No net statewide savings will result from this shift. This is discussed more comprehensively within the Transition to Health Families document. *It should be noted that any Subcommittee #3 action taken with regards to the merger of the Healthy Families Program into the Medi-Cal*

Program will conform to the CCS Program where applicable to ensure continuity of services for children enrolled in the CCS Program.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

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

CCS focuses specifically on children with special health care needs. It depends on a network of 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). 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.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); **(2)** CCS and Medi-Cal eligible; and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

Background: The Child Health & Disability Prevention Program (CHDP).
The CHDP provides pediatric prevention health care services to (1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and (2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent.

This program serves as a principle provider of vaccinations and facilities enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. No issues have been raised regarding this estimate package for these three programs. It is consistent with prior actions and appropriately reflects federal fund adjustments and Provider reimbursement reductions. *This action will be adjusted to conform where necessary to any action taken with regards to the merger of Healthy Families into the Medi-Cal Program.*

11. Department of Health Care Services: State Support Requests

The May Revision proposes the following State Support requests for the DHCS:

A. State Option to provide Health Homes to Enrollees with Chronic Conditions (DOF 440)

Governor's May Revision. The May Revision proposes an increase of $700,000 ($350,000 in Reimbursements and $350,000 federal funds) for assessment activities related to a federal State Option to Provide Health Homes for Enrollees with Chronic Conditions" Program. Specifically, these funds would provide for the planning and assessment activities and do not commit the State to implementing the Health Homes program. This assessment phase will allow the State to evaluate whether the activity is warranted, particularly when the two-year enhanced federal funds are no longer available.

Background. Under this federal option, an enhanced federal match to provide for care coordination services for a two-year period. Health Home services include coordination of physical health and behavioral health care and linkages to social services that are related to the beneficiary's health.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. This is an important federal option which California should study and plan for in the future. No issues have been raised and there is no effect to the General Fund.

B. Health Care Reform

Governor's May Revision. The May Revision requests an increase of $1.2 million ($495,000 General Fund) to fund a total of 9 limited-term positions (to June 30, 2013) to implement additional health care reform mandates. The positions include some clinical staff as well as administrative positions.

These positions would be responsible for:

- Conducting Enhanced Provider Screenings;
- Developing the infrastructure for integrating dual eligible beneficiaries into a new health care delivery system;
- Expanding the Program All-Inclusive Care for the Elderly (PACE) health plans; and
- Addressing workload related to various Wavier analyses and system changes.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to approve the May Revision to ensure California can make all necessary changes to implement federal mandates as they pertain to the Medi-Cal Program and federal health care reform. No issues have been raised.

C. Federally Mandated HIPAA Updates and System Compliance

Governor's May Revision. The May Revision proposes an increase of $2 million ($462,000 GF) to extend 11.5 positions for an additional three-years, and establish four new three-year limited term positions. Federal funding is available for some of these activities at a 90 percent federal match for a limited time.

These positions would be used to implement new federal HIPPA (Health Insurance Portability and Accountability Act) requirements that were created as part of federal health care reform. The new requirements include more frequent HIPAA updates, new operating rules, new standards, and new health pan certification requirements

Subcommittee Staff Comment and Recommendation—Adopt May Revision. It is recommended to approve the May Revision to ensure California can make all necessary changes to implement federal mandates as they pertain to the Medi-Cal Program and federal health care reform. No issues have been raised.

D. Proposed Compromise on Positions for Development of Hospital DRGs

Background. Among other things, SB 853, Statutes of 2010, (Omnibus Health Trailer bill for the Budget Act of 2010) requires the DHCS to development a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). Initially a reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

Prior Action and Revised DHCS Proposal. In the SB 69 Budget Bill, the Legislature did not approve a January budget request by the DHCS for staff pertaining to the development and implementation of this new methodology. The Budget Bill reflects *a reduction* of $1.2 million ($480,000 General Fund) and 11 positions from this action.

The DHCS has subsequently identified a redirection of five audit positions to address some of their need for staff and are now requesting an increase of only $118,000 ($59,000 General Fund) to hire a Research Program Analyst I in order to conduct this work.

Subcommittee Staff Comment and Recommendation—Approve DHCS Compromise. It is recommended to approve the DHCS compromise to redirect five audit positions from within the DHCS to this function, and to approve an increase of $118,000 ($59,000 General Fund) for the Research Program Analyst I position.

12. Technical Adjustment to Managed Care Organization (MCO) Tax (DOF 463)

Background. AB 1422, Statutes of 2009, established an alternative funding mechanism for essential preventative and primary health care services provided through the Healthy Families Program by adding Medi-Cal Managed Care Plans to the list of insurers subject to California's gross premiums tax of 2.35 percent. It is required that the tax proceeds be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax.

Governor's May Revision. The May Revision proposes a technical adjustment to increase by $103.4 million (General Fund) to provide for a correction of a technical error in the Administration's MCO tax extension calculation. Capitated Rates to Medi-Cal Managed Care Plans are paid out of the General Fund. Revenues from the MCO tax are used to backfill those expenditures with no net effect in the DHCS Medi-Cal budget. Savings are realized in the Managed Risk Medical Insurance Board budget.

The General Fund expenditures associated with the MCO tax were inadvertently scored as special fund expenditures. This adjustment would correct the initial Medi-Cal estimate provided to the Legislature on May 16th.

Subcommittee Staff Comment and Recommendation—Approve Technical Correct. A technical adjustment is necessary. It is recommended to adopt this later change.

B. Department of Public Health (Items 1 through 9)

1. Every Woman Counts (EWC) Program (DOF Issues 220 and 221)

Legislative Actions Contained in SB 69 Budget Bill—Conformed to Governor. The Legislature adopted total expenditures of $64.9 million ($27.8 million General Fund) to serve 393,000 clients for 2011-12. This action conformed to the Governor's January budget.

Governor's May Revision. The May Revision proposes total expenditures of $71.5 million ($18.4 million General Fund, $10.7 million Breast Cancer Control Account, $22.1 million Cigarette and Tobacco Product Surtax Funds, and $4.4 million federal funds).

As shown in the *table below*, the May Revision reflects total expenditures of $57.8 million, or a total fund reduction of $7.1 million (reduction of $9.3 million General Fund), as compared to the SB 69 Budget Bill. Two adjustments are proposed as follows:

- **10 Percent Medi-Cal Rate Reduction**. Reduce by $7.1 million (General Fund) to reflect a conforming action in Medi-Cal Program to reduce provider reimbursement by 0 percent. The EWC Program reimburses providers using Medi-Cal Program rates.
- **Increased Revenues from Breast Cancer Control Account.** Increase by $2.2 million from the Breast Cancer Control Account, and reduce General Fund support, to reflect the availability of special funds available from interest revenues that had accrued in the Breast Cancer Fund and are proposed to be transferred to the Breast Cancer Control Account for expenditure.

Table: Fiscal Comparison (dollars rounded)

Fund Source	May Revision 2011-12	SB 69 Budget Bill	**Difference**
General Fund	$18.4 million	$27.8 million	-$9.3 million
Breast Cancer Control Account	$12.9 million	$10.6 million	+$2.2 million
Proposition 99 Funds	$22.1 million	$22.1 million	--
Federal Funds	$4.5 million	$4.5 million	--
Total Program	**$57.8 million**	**$64.9**	**-$7.1**

Background. The Every Woman Counts (EWC) Program provides breast and cervical cancer screening services to low-income individuals. Generally, to be eligible for services, a person must have no health care coverage, have a family income below 200 percent of the federal poverty level, and be 40 years of age or older. Under EWC, breast cancer screening includes clinical breast exams, mammograms, and diagnostic work ups. It also provides cervical cancer screening and diagnostic services to women aged 25 and over who meet similar eligibility criteria. Cancer treatment is not covered by this program. If a cancerous condition is found, treatment services are available through Medi-Cal, or other referrals are made.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision to reflect two technical adjustments as noted. No issues have been raised.

2. State Operations: Adjustment for Breast Cancer Research (DOF Issue 220)

Governor's May Revision. The May Revision proposes a one-time reduction of $86,000 (Breast Cancer Research Fund) in State Operations expenses in order to maintain fiscal solvency in the Breast Cancer Research Account.

Subcommittee Staff Recommendation—Approve May Revision. This is a technical adjustment and no issues have been raised.

3. Proposition 99 Funds: Research Account & Health Education (DOF Issues 225 & 226)

Governor's May Revision. The May Revision proposes three adjustments in the Department of Public Health that pertain to the expenditures of Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) in the Research Account and Health Education Account.

These adjustments are as follows:

- **Environmental Health Branch ($6,160 Research Account).** This increase will allow the Branch to expand its investigations into the analysis of dust samples collected at fire stations for the Firefighters Occupational Exposure study. The samples will be analyzed for the presence of carcinogenic chemicals in the firefighting environment.
- **Cancer Surveillance and Research Branch ($49,840 Research Account).** This increase will allow the Branch to design and conduct initial testing for the Integrating Medical Informatics Systems to Expand Cancer Surveillance and Research. The overall goal of this project is to ultimately implement a new approach to cancer data collection that will provide more detailed, high-quality data on persons diagnosed with cancer in a faster, more cost-effective manner.
- **CA Tobacco Control Program ($173,000 Health Education Account).** This increase will allow the California Tobacco Control Program to increase the purchase of media in rural and smaller markets.

Subcommittee Staff Recommendation—Approve May Revision. No issues have been raised regarding these adjustments.

4. Medical Marijuana Program Loan Repayment (DOF Issue 254)

Governor's May Revision. The May Revision proposes to extend the repayment date of the $1.5 million loan from the Health Statistics Fund to the Medical Marijuana Fund for two years--from June 2012 to June 2014. The extension is requested due to low fund balances in the Medical Marijuana Program Fund.

The Budget Act of 2004 provided a loan of $1.5 million from the Health Statistics Fund to begin implementation of the program. It was anticipated that the loan funds would be used for the first 18 months of program operation until fees collected from card program users began to flow into the State to offset program costs and repay the loan.

In 2010-11, $500,00 will be repaid to the Health Statistics Fund and the remaining $1 million is due to be repaid by June 30, 2012. However, due to less than anticipated fees, this loan repayment must be deferred until June 2014.

Background. Senate Bill 420 (Vasconcellos), Statutes of 2003, required the DPH to establish and maintain a voluntary medical marijuana identification card and registry program for qualified patients and their primary caregivers through County Health Departments or designee. It is supported by fee revenue and the loan from the Health Statistics Fund.

Subcommittee Staff Recommendation—Approve May Revision. No issues have been raised regarding these adjustments.

5. Reappropriation: Health Care Surge Capacity (DOF Issue 213)

Governor's May Revision. The May Revision proposes to reappropriate $1.272 million through June 30, 2013 from unspent funds originally appropriated in SB 162 (Ortiz), Statutes of 2006. The reappropriation is to support the storage, maintenance, and transportation costs associated with transitioning DPH's healthcare surge stockpile and the Emergency Medical Services Authority (EMSA) mobile field hospitals.

The Administration states that over the course of 2011-12, the DPH and EMSA will work together to secure alternatives to distribute the assets to public and private organizations. The following Budget Bill Language is proposed for the reappropriation:

"As of June 30, 2011, the appropriation provided in the following citation is reappropriated for the purposes of storing emergency preparedness assets, including pharmaceuticals, medical supplies, and state mobile field hospitals, to allow the DPH and EMSA to distribute the assets to alternate, permanent points of responsibility. These funds shall be available for encumbrance or expenditure until June 2013.

0001—General Fund
(1) $1,832,000 in Item 4260-111-0001, Budget Act of 2006 (Chs. 47 and 48, Stats. 2006).

Subcommittee Staff Recommendation—Approve May Revision. This conforms to the Governor's January comments to limit General Fund expenditures associated with the Health Surge Capacity Initiative implemented in 2006 in readiness for a potential influenza pandemic which did not occur. The May Revision will continue storage and maintenance for one-year while alternate, permanent points of responsibility can be ascertained. It is recommended to approve the May Revision.

6. Health Care Reform: National Background Check Program (DOF Issue 251)

Governor's May Revision. The May Revision proposes an increase of $1.721 million (federal grant funds) to enhance the State's criminal record clearance process for direct patient access employees of Long-Term Care Facilities. Federal funds were made available for this purpose under the federal Patient Protection and Affordable Care Act of 2010.

The DPH will be working with the Department of Social Services (DSS) to implement additional criminal record searches via the Federal Bureau of Investigation (FBI), the National Sex Offender Registry, the Health Care Integrity Protection Data Bank/National Practitioner Data Bank, the Federal Department of Health and Human Services, Office of Inspector General, Medi-Cal Ineligible and Suspended List, and other relevant State Registries based on residency.

Subcommittee Staff Recommendation—Approve May Revision. The May Revision is consistent with the purposes of the federal grant award. No issues have been raised.

7. General Fund Loan Repayment by Childhood Lead Prevention (DOF Issue 214)

Legislative Actions Contained in SB 69 Budget Bill. General Fund support was provided as a loan to the Childhood Lead Poisoning Prevention Fund for expenditure in the program in 1996-97 and was never repaid. The Legislature identified $6 million in reserve funds available in the Childhood Lead Poisoning Prevention Fund to transfer to the General Fund for a partial repayment of the original loan for 2011-12. This resulted in $6 million in General Fund savings.

Governor's May Revision. The May Revision has identified an additional $3.1 million available for repayment to the General Fund for this same purpose. This additional amount provides for a repayment of $9.1 million to the General Fund.

Subcommittee Staff Recommendation—Approve May Revision. The May Revision provides an additional $3.1 million in General Fund savings as noted. It is recommended to approve the May Revision.

8. Licensing and Certification: Technical Adjustment to Staffing Ratio (DOF Issue 255)

Governor's May Revision. The May Revision proposes a net increase of $252,000 ($234,000 Licensing and Certification Fees, and $18,000 in Reimbursements) and 12 positions due to a correction in applying the Health Facilities Evaluator Nurse staffing ratio.

Subcommittee Staff Recommendation—Approve May Revision. This is a technical adjustment to the baseline Licensing and Certification Program and has *no* General Fund or policy implications. In addition, this action has *no* Fee implications for the facilities. It is recommended to approve the May Revision.

9. Increase for Vaccine Purchases

Governor's May Revision. The May Revision proposes an increase of $7.3 million (General Fund) to provide influenza vaccine for distribution to Local Health Jurisdictions to immunize up to 700,000 "at-risk" populations, including the elderly and pregnant women.

The DPH notes that Section 104900 of Health and Safety Code directs that the State is to provide appropriate flu vaccine to local governmental or private, nonprofit agencies at no charge in order that agencies may provide the vaccine, at minimum cost, at accessible locations in the order of priority first, for all persons 60 years of age or older and then to other high-risk groups as identified.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to adopt the May Revision to provide increased funding for influenza vaccine.

10. State Operations: Women, Infants and Children (WIC) Nutrition Program

Governor's May Revision. The May Revision requests an increase of $7.642 million (federal funds) as compared to the SB 69 Budget Bill which for WIC conformed to the Governor's January budget.

This $7.642 million (federal fund) request consists of funds for **(1)** Interagency Agreements with various State agencies due to increases in vendor applications, increased WIC participation and changes in federal regulations; and **(2)** Consultant Contracts related to two automated management systems which generate reporting data to the USDA and WIC stakeholders. The table below provides a summary of this information.

WIC $7.6 million Federal Funds Augmentation

Entity	Description	Amount (Federal Funds)
A. Interagency Agreements		
UC Davis	Special Grant project for Toddler Behavior Research designed to assist WIC programs in evaluating innovative methods of service delivery.	$122,851
DPH—Maternal & Child Health Branch	Conducts epidemiology services to support caseload growth, identification of geographic areas of unmet need for WIC services, outreach and breastfeeding.	$1,855,750
State Treasurer's Office	Processes WIC checks and reimburses WIC vendors for purchases.	$600,000
State Controller's Office	Conducts vendor and local agency audits to ensure compliance.	$1,874,000
Department of Health Care Services	Conducts administrative hearings for appeals by WIC vendors.	$150,000
Office of State Publishing	Prints and distributes required nutrition education and breastfeeding materials to WIC families.	$1,900,000
B. Contracts For:		
Electronic Benefit Transfer	These are earmarked federal funds to conduct the planning process for transferring WIC food benefits from paper to an Electronic Benefits Transfer system.	$389,000
Automated Management System	This pertains to two contracts to maintain WIC's automated management system.	$750,000
TOTAL Federal Funds		**$7,642,000**

Subcommittee Staff Recommendation—Approve May Revision. The request is consistent with the federal grant funds and the purposes of the WIC Program. No issues have been raised.

C. Department of Mental Health (Items 1 and 2)

1. Technical Adjustment to Reimbursements for Local Assistance (DOF Issue 564)

Governor's May Revision. The May Revision proposes to reflect an increase of $914.2 million in Reimbursements in Item 4440-101-0001, and to eliminate two other Item numbers (i.e., 4440-103-3085 and 4440-105-3085.

The purpose of this action is to simplify the invoicing and payment processes of the Department of Mental Health and the Department of Health Care Services.

Subcommittee Staff Comment and Recommendation—Approve May Revision. The May Revision is a technical adjustment and is intended to streamline payment processes. It is simply consolidating budgetary items into one item. No issues have been raised.

2. State Staff: Legal Resources

Legislative Action as Contained in SB 69 Budget Bill. The Legislature *denied* a request from the Governor's January budget to increase by $2.1 million (General Fund) for legal services to be performed by the Attorney General's Office (AG's Office) for DMH regarding health education and welfare work and all new tors and condemnation work.

This budget proposal lacked fiscal detail and justification for the need of the $2.1 million (General Fund) request and was denied by the Legislature. This 2011-12 request simply reflected the amount which was denied by the Legislature last year regarding legal work at the DMH.

Governor's May Revision. The Department of Finance requested reconsideration of this proposal.

Background. Historically, the AG's Office has provided legal representation to the DMH for litigation and court appearances. In September 2009, the AG's Office informed the DMH of policy changes that would substantially reduce the amount of legal services provide by the AG's Office to the DMH as a result of reduced resources within the AG's Office.

In spring 2010, the DMH requested 6 new Legal positions for total expenditures of $3.1 million (General Fund). As recommended by the Legislative Analyst's Office (LAO), only $1.2 million (General Fund) was approved, along with Budget Bill Language requiring the AG's Office to provide certain legal representation for the DMH. DMH states that the funds are needed in 2011-12 since the AG's Office needs resources from the DMH to perform the work.

Legislative Analyst's Office Recommendation—Reject. Similarly to last year, the LAO has questions regarding this proposal and are still awaiting responses from the DMH. The LAO recommends denying this proposal.

Subcommittee Staff Recommendation—Deny. No new information has been provided by the DMH and it is recommended to continue the denial of this request for an augmentation.

D. Managed Risk Medical Insurance Board

1. Various Healthy Families Program Adjustments (DOF 401, 403, 404, and 407)

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 at least the age of 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.

Governor's May Revision. *First*, the Governor's May Revision proposes a series of estimate adjustments for the Healthy Families Program, including adjustments made due to the erosion of savings from delayed enactment of cost-containment actions, adjustments to caseload, adjustments which pertain to services provided by Federally Qualified Health Centers, and other related changes to the baseline Healthy Families estimate. These adjustments are listed below.

Second, the May Revision proposes to transition the Healthy Families Program into the Medi-Cal Program, as administered by the Department of Health Care Services. This issue will be discussed separately under the Department of Health Care Services.

- **Healthy Families Program Estimate—**It is requested that Schedule (2) of Item 4280-101-0001 be decreased by $9,885,000, Item 4280-101-0890 be decreased by $6,425,000, Item 4280-101-3156 be increased by $8,844,000, Schedule (1) of Item 4280-102-0001 be increased by $1,160,000, Item 4280-102-0890 be increased by $827,000, Item 4280-102-3156 be increased by $422,000, and Reimbursements be increased by $235,000.

  The net impact of these changes is an $12,628,000 decrease in the General Fund. These adjustments are primarily the result of a projected caseload decrease of 10,600 enrollees, as well as a $9,266,000 million increase in Managed Care Organization (MCO) tax revenue resulting from carryover of revenue from fiscal year 2010-11.

- **Healthy Families Program—Erosions of Savings to Vision Cost Containment, Emergency Room Co-Payment, and Hospitalization Copayment Budget Solutions--**It is requested that Schedule (2) of Item 4280-101-0001 be increased by $2,557,000, Item 4280-101-0890 be increased by $1,662,000, Item 4280-101-3156 be increased by $12,000, and Item 4280-102-3156 be decreased by $12,000.

The net impact of these changes is an $895,000 increase in the General Fund. These adjustments reflect a one month erosion of savings previously adopted by the Legislature for the vision benefit costs containment proposal and increased copayments for emergency room visits and inpatient hospital stays.

- **Healthy Families Program—Implementation of Children's Health Insurance Program Reauthorization Act** (**CHIPRA) Requirements—Local Assistance** It is requested that Schedule (1) of Item 4280-102-0001 be increased by $89,226,000 and Item4280-102-0890 be increased by $57,997,000. The net impact of these changes is a $31,229,000 increase in the General Fund.

  These adjustments primarily reflect the costs of prospective payments for services provided through Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) as required by the federal CHIPRA. These costs include federally required retroactive payments to FQHCs/RHCs for the period of October 2009 through June 30, 2011. Compliance with this requirement is necessary to maintain California's allocation of federal funds.

- **Healthy Families Program—Erosions of Savings to Vision Cost Containment, Emergency Room Co-Payment, and Hospitalization Copayment Budget Solutions—**It is requested that Schedule (2) of Item 4280-101-0001 be increased by $2,557,000, Item 4280-101-0890 be increased by $1,662,000, Item 4280-101-3156 be increased by $12,000, and Item 4280-102-3156 be decreased by $12,000. The net impact of these changes is an $895,000 increase in the General Fund. These adjustments reflect a one month erosion of savings previously adopted by the Legislature for the vision benefit costs containment proposal and increased copayments for emergency room visits and inpatient hospital stays.

- **Healthy Families Program—Increase in Managed Care Organization (MCO) Tax Revenue—**It is requested that Item 4280-101-0001 be decreased by $5,823,000, Item 4280-101-3156 be increased by $5,823,000, Item 4280-102-0001 be decreased by $241,000, and Item 4280-102-3156 be increased by $241,000.

  These adjustments reflect a $6,064,000 increase in the projected $97,226,000 budget year MCO tax revenue anticipated from the extension of the statutory authority through December 31, 2013. The resulting reduction of $6,064,000 in General Fund costs is necessary to address the remaining budget shortfall.

2. Access for Infants and Mothers (AIM) (DOF issue 501)

Background. The Access for Infants and Mothers (AIM) provides low cost insurance coverage to uninsured, low-income pregnant women with family incomes up to 300 percent of the federal poverty level, as well as to women who must pay an insurance deductible over $500. 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.

Governor's May Revision. The May Revision proposes total expenditures of $120.3 million ($53.9 million Perinatal Insurance Fund and $66.4 million federal funds) and trailer bill language.

These adjustments and proposed trailer bill language reflect the proposal to use the Medi-Cal Fee for Service system on a reimbursement funding basis to deliver AIM benefits beginning October 1, 2011. Use of Medi-Cal Fee-For-Service will assists to control program costs as well as ensure adequate statewide program coverage. The funding increase includes costs for AIM administrative vendor operational changes.

It is requested that the following technical adjustments be made to reflect this proposal: Schedule (1) of Item 4280-101-0001 be increased by $2,993,000, Item 4280-101-0890 be increased by $2,993,000, and Item 4280-602-0309 be increased by $3,908,000.

It also is requested that transfer authority in Item 4280-111-0232 be increased by $718,000, transfer authority in Item 4280-111-0233 be increased by $1,985,000, and transfer authority in Item 4280-111-0236 be decreased by $325,000.

Subcommittee Staff Recommendation—Adopt May Revision and Placeholder Trailer Bill. The Administration states that the use of Medi-Cal Fee-For-Service is necessary in order to provide adequate access to AIM Services. It is recommended to adopt the May Revision and placeholder trailer bill.

3. The Major Risk Medical Insurance Program (MRMIP) (DOF issues 701 and 702)

Background. 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.

Governor's May Revision. It is requested that transfer authority in Item 4280-112-0233 be decreased by $1,780,000 from the Physicians' Services Account and transfer authority in Item 4280-112-3133 be decreased by $1,186,000 from the Managed Care Administrative Fines and Penalties Fund.

The first decrease reflects a transfer of Proposition 99 revenue to the Perinatal Insurance Fund to meet 2011-12 funding needs of the Access for Infants and Mothers Program (as noted under item 2, above). The second decrease reflects an adjustment to projected Managed Care Administrative Fines and Penalties Fund revenue as reported by the Department of Managed Health Care. This special funded program provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered coverage at rates they could not afford. Caseload for this program varies as funding is available.

Subcommittee Staff Recommendation—Adopt May Revision. No issues have been raised regarding these technical changes.

4. County Health Initiative Matching Fund Program Estimate (DOF 601)

Background. 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.

Governor's May Revision. It is requested that Schedule (1) of Item 4280-103-3055 be increased by $43,000 and Item 4280-103-0890 be increased by $28,000.

These increases reflect a slight increase in program enrollment projected for the budget year. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 300 percent of the federal poverty level and who otherwise meet federal eligibility qualifications. Overall caseload has increased by 103 individuals among the three Phase I pilot counties of Santa Clara, San Mateo, and San Francisco.

Subcommittee Staff Recommendation—Adopt May Revision. No issues have been raised regarding these technical changes.

DISCUSSION ISSUES: Listed by Department

A. Department of Health Care Services & Managed Risk Medical Insurance Board:

Governor's May Revision: Overview and Perspective. The Governor proposes to shift *all* Healthy Families Program (HFP) children into Medi-Cal over a six-month period beginning in January 2012. Approximately 892,000 eligible beneficiaries would move to Medi-Cal in phases between January and June, 2012. A *net reduction* to the State, across the MRMIB and DHCS, of $91.7 million ($31.2 million General Fund) is reflected.

The Administration recognizes that many details need to be worked out once this proposal is enacted. They state that key benefits of this consolidation would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of poverty;
- Families would be able to apply for coverage at a County, by mail, or on-line and will not have to have their application bounced between programs;
- Children at or below 150 percent of poverty would no longer pay premiums, as is presently done in the Healthy Families Program;
- Children would receive retroactive coverage for three-months *prior* to their application;
- Children would be eligible for the free federal Vaccines for Children (0 to 18 years);
- Makes available to low-income children comprehensive Medi-Cal services including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;
- Many children would be able to remain with their existing provider during the transition as Health Plans contract with providers for both Medi-Cal and Healthy Families. Updated information notes that 73 percent of Children in Healthy Families match to a Health Plan that currently participates in both Medi-Cal and Healthy Families;
- There has been a considerable decline in the Commercial Health Plans participating in Healthy Families in many counties. By consolidating Healthy Families and Medi-Cal, Children will have more stable plan choices;
- Consolidates health care entitlement programs under one department so that duplicative systems and processes can be eliminated to gain administrative efficiencies;
- Simplifies contracting requirements, rates and other core components of delivering services in the public sector for Health Plans and providers;
- Increases the ability of the State to monitor encounter data and payment data to better ensure the State is receiving its best value for the dollars it invests in Children's coverage;
- Serves as an early building block for successful implementation of federal health care reform. California must implement many changes before 2014, including new online enrollment processes, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Waiting to implement the transfer of Healthy Families to Medi-Cal until 2014 will impede the success of implementing these other major reforms.

Governor's May Revision: Transition and Budget Details. Currently enrolled HFP children would transition to Medi-Cal *over a six month period* and would receive coverage as targeted-low income Medicaid children as allowed under Medicaid. DHCS would obtain enhanced federal funds for this population at the 65 percent federal to 35 percent State sharing ratio.

To the extent possible, HFP children enrolled in Managed Health Care Plans or Dental Managed Care Plans that are *also contracted* plans under Medi-Cal would *remain* with the plan; *otherwise*, they will be provided the option of choosing from available Medi-Cal Managed Care Health Plans or Dental Plans in their respective county.

If a child resides in a county with a County Organized Health System (COHS), they would receive their care from the COHS. Children residing in counties *without* a Medi-Cal Managed Care Health Plan would receive their health care services under Medi-Cal Fee-For-Service delivery system.

For purpose of Medi-Cal Dental Managed Care, the county of residence and the dental delivery service model would determine if the child would receive services through *mandatory* enrollment in a plan, *voluntary* enrollment in a plan, or under a Medi-Cal Fee-For-Service arrangement.

The *two Tables* below display a phase-in approach that was used for "budgetary" purposes. *However,* the Administration has publically stated that if more time is needed to ensure a smooth transition, this phase-in would be pushed-back.

Table 1: Medi-Cal Program Budget Assumptions Used for Phase-In (begins January, 2012)

Children's Health Plan	**Eligibles**	**Percent of Eligibles**	**Phase-In Period**
Able to Enroll in Same Plan	387,366	43 percent	January to February
Enroll in Different Plan	454,734	51 percent	March to April
In Fee-For-Service County	49,600	6 percent	January to April
TOTAL Children	891,700	100 percent	January to June

Table 2: Medi-Cal Program Budget Assumptions: Detail of Member Months Assumed

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012			
					15,849			
				15,100	15,100			
			12,400	12,400	12,400			
		12,400	12,400	12,400	12,400			
			230,058	230,058	230,058			
		230,050	230,050	230,050	230,050			
	196,358	196,358	196,358	196,358	196,358			
193,683	193,683	193,683	193,683	193,683	193,683			
193,683	**390,041**	**632,491**	**874,949**	**890,049**	**905,898**	Member Months		
					3,887,111	Total Member Months FY 2011-12		

The Table below provides more technical fiscal detail of the split between departments.

Table 3: State Budgetary Detail Across Departments (dollars in thousands)

Program Area and Category	**General Fund**	**Total Funds**
Medi-Cal Program		
Benefit Cost (non-CCS Program)	$101,191	$289,116
Premiums (150% to 250%)	-$26147	$74,704
Net Medi-Cal Benefit Cost	$75,044	$214,412
Benefit Cost of CA Children's Services Program	$9,314	$44,350
Bridge to Healthy Families Savings (not necessary)	-$363	-$1,036
Total Benefits Impact	$83,995	$258,762
County Administrative Cost (100% to 150%)	$2,967	$5,934
Total Medi-Cal Impact	$86,962	$263,660
Family Health Programs Impact	-$9,314	-$44,350
TOTAL DHCS Programs	$77,648	$219,310
Managed Risk Medical Insurance: Healthy Families		
Benefit Savings	-$104,903	-$298,969
Administrative Savings	-$3,945	-$12,022
TOTAL MRMIB	-$108,848$	-$310,991
State TOTAL	**-$31,200**	**-$91,681**

Governor's May Revision: New Applicants and Eligibility Processing. *New applicants* seeking services as of January 1, 2012 will *go straight* into Medi-Cal and continue to be able to apply for health care services through County Human Services Offices or through the existing "Single Point of Entry" (SPE) and "Public Access" (PA) website.

Counties would make eligibility determinations as they do today for Children applying at the local County office.

Children *with incomes up to 150 percent* of poverty would enroll into *no-cost* Medi-Cal, receive services through the Medi-Cal delivery system (i.e., Managed Care or Fee-For-Service) and receive ongoing case management through the County.

Children *with incomes above 150* percent of poverty and up to 250[1] percent of poverty would enroll in Medi-Cal and be *subject to premiums*. DHCS will use the same premium amounts as Healthy Families. The existing contractor that handles Healthy Families eligibility determinations *or* the Counties would handle the *ongoing management* of the cases for individuals with incomes above 150 percent of the poverty and up to 250 percent of poverty. To the extent the current eligibility processing vendor handles the ongoing case management for these children, DHCS *may* contract with select Counties (i.e., a "regional" approach rather than all Counties) to make the annual redetermination.

The "Single Point of Entry" vendor would continue to do the *initial screening* of applications it receives and would grant presumptive eligibility[2] for those who appear to meet established income guidelines. The SPE would forward the case to the County for a *final eligibility* determination. Once the County establishes eligibility, the income level of the Child would determine how the case would be managed as described above.

It should be noted that the DHCS is also proposing to proceed with a new "budgeting" methodology for County eligibility processing which is discussed later in this Agenda under the Medi-Cal Program.

Technical Finance Letter Schedules for Item 4280 (DOF Issue 402). It is requested that Schedule (2) of Item 4280-101-0001 be decreased by $298,969,000, Item 4280-101-0890 be decreased by $194,330,000, Item 4280-101-3156 be increased by $264,000, Schedule (1) of Item 4280-102-0001 be decreased by $12,022,000, Item 4280-102-0890 be decreased by $7,814,000, and Item 4280-102-3156 be decreased by $263,000.

The net impact of these changes is a $108,848,000 decrease in the General Fund. This reduction is necessary to address the remaining budget shortfall. These adjustments reflect the proposal to shift all Healthy Families children to the Medi-Cal program based on a phased in transition beginning January 1, 2012.

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[1] As noted in the accompanying TBL, income eligibility for targeted low-income children is technically 200 percent of the FPL pursuant to federal Medicaid law. Thus for individuals with incomes above 200 percent and up to 250 percent the FPL, an income deduction is provided in an amount that will result in an effective income of 200 percent of the FPL.

[2] DHCS is working out the details for how presumptive eligibility will be handled since elimination of this would be considered an ACA maintenance of effort violation.

This proposal would implement the Medicaid expansion for children to 133 percent of the federal poverty level required under health care reform early and take the additional step of transitioning all Healthy Families children to Medi-Cal. The net statewide impact of this proposal is a savings of $31.2 million General Fund in 2011-12.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision in Concept. The Governor's restructuring has merit and is visionary. Federal Patient Protection and Affordable Care Act (ACA), coupled with the State's newly implemented 1115 Medicaid Waiver, and the Mental Health Parity Act of 2008, offer *very* constructive opportunities for a more inclusive and comprehensive delivery model.

Discussions need to be ongoing with various consumer advocacy groups, Health and Dental Plans, Vision Plans, various provider organizations and representatives, as well as the Policy and Fiscal Committees of the Legislature to ensure a constructive and seamless transition for all involved parties, particularly the child and families who receive vital health care services.

It is recommended to adopt the May Revision fiscal calculations and "placeholder" Budget Bill Language, as well as "placeholder" trailer bill language (an intent framework) to enable complex discussions to continue and for a comprehensive framework to be developed over the course of 2011-12.

A key component of the placeholder language needs to be identifying markers that demonstrate readiness to implement this proposal in an effective fashion. Before Children are transitioned to Medi-Cal, fulfillment of these identified "trigger" conditions must be demonstrated

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

1. Please provide an overview of the key concepts of the proposal.
2. How may all of the various constituency interests be actively engaged in these discussions?
3. What are the key short-term aspects that need to occur for this to be an effective transition?
4. What are the longer-term components that need to be addressed?
5. How may the State track progress during a phase-in to ensure that Children are being transitioned appropriately? How can access be assured?
6. What key issues have been express from Health Plan providers (provider networks, rates)?
7. What key issues have been express by County Mental Health Plans?
8. What key issues may there be regarding dental services?
9. May there be opportunities for improving the reimbursement paid to Medi-Cal providers by drawing increased revenues from the Managed Care Tax or by reinvesting savings from efficiencies in the out-years?

A. Department of Health Care Services: The Medi-Cal Program

BACKGROUND SUMMARY

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).

Governor's May Revision—Substantially Lower than Current-Year. The May Revision proposes total expenditures of $46.3 billion ($14.7 billion General Fund) for 2011-12 which represents *a reduction* of $8.3 billion (total funds), or 15.3 percent less than the current-year.

At the same time, Medi-Cal caseload is hitting an all-time caseload high of 8 million eligibles. This reflects an increase of 6.5 percent, which does include the Administration's proposal to shift Healthy Families to Medi-Cal.

Medi-Cal Funding Summary *(Dollars in Thousands)*	**2010-11 May Revision**	**2011-12 May Revision**	**Difference**	**Percent**
Benefits	$51,745.8	$42,910.8	-$8,835.0	-17.1
County Administration (Eligibility)	$2,610.7	$3,022.2	-$373.5	15.8
Fiscal Intermediaries (Claims Processing)	$263.7	$3.53.1	$89.4	33.9
Total-Local Assistance	**$54,620.2**	**$46,286.1**	**-$8,334.1**	**-15.3**
General Fund	$12,437.1	$14,728.4	$2,291.3	18.4
Federal Funds	$36,553.0	$29,047.7	-$7,505.2	-20.5
Other Funds	$5,630.2	$2,510.0	-$3,120.2	-55.4

The May Revision continues all cost-containment enacted in the SB 69 Budget Bill, including the following key changes: (1) Placing limits on health care services; (2) Elimination of certain benefits; (3) Cost-sharing through Medi-Cal enrollee copayment requirements; (4) Provider payment reductions; and (5) Mandatory enrollment of seniors and persons with disabilities in Medi-Cal Managed Care.

Medi-Cal Program Discussion Issues

1. 1115 Medicaid Waiver: Trailer Bill Fund Shift for Federal Dollars

Background. California's 1115 Medicaid Waiver, approved in November 2010, is to provide $10 billion in federal funds over the course of the next five years and will serve as a bridge to federal health care reform. These federal funds will be obtained through the use of "Certified Public Expenditures" (CPE), both from the State and local public entities (i.e., Designated Public Hospitals and Counties).

No General Fund is expended for the Waiver. In fact the Waiver is to provide $400 million in annual General Fund savings by enabling the State to offset certain health care expenditures with federal funds available from the Waiver.

The Waiver has several key components including the following:

- Heath Care Expansion. Increases and expands health care coverage by phasing-in coverage for "newly eligible" adults (aged 19 to 64 years) with incomes up to 133 percent of poverty as offered under the federal Patient Protection and Affordable Care Act. This is to be accomplished through the new "Low Income Health Program".

  The Low Income Health Program consists of two components: **(1)** the existing "Health Care Coverage Initiative"; and **(2)** the new "Medicaid Coverage Expansion". Both are elective programs at the local government level (mainly Counties). Federal funds for the Health Care Coverage Initiative are capped at $180 million (federal funds) per federal year. The Medical Expansion Coverage initiative

  The new Medicaid Coverage Expansion within the Low Income Program will cover people with family incomes at or below 133 percent of poverty. The existing Health Care Initiative will cover people with family incomes above 133 percent through 200 percent of poverty.

- Safety Net Care Pool for Uncompensated Care. Provides for a federal "Safety Net Care Pool" to provide additional resources to support uncompensated care costs in both safety net care hospitals and critical State Programs;

- New Mandatory Enrollment in Medi-Cal Managed Care. Authorizes mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care which implementation beginning June, 2011 ;

- Federal Funds for Delivery System Reforms. Establishes a Delivery System Reform Incentive Pool for Designated Public Hospitals to promote hospital delivery system transformation

Governor's May Revision. The May Revision proposes trailer bill to authorize the DHCS to obtain federal approval through an amendment to the 1115 Waiver to *annually transfer* federal funds from within the Health Care Coverage Initiative portion of the Waiver that will not be fully utilized in the federal demonstration-year, to the Safety Net Care Pool to be expended for uncompensated care provided by the State, and by the Designated Public Hospitals.

This would result in a shifting of federal funds to enable the State to *voluntarily* utilize "Certified Public Expenditures" (CPEs) from Designated Public Hospitals to draw federal funds from the Safety Net Care Pool to offset State General Fund expenditures up to $400 million.

Presently the DHCS contends the State does not have adequate State CPEs on its own to draw its share of the federal Waiver funds ($400 million annually), but believes the Designated Public Hospitals have "excess"/unused CPEs for which they will not be able to obtain federal matching funds unless the State obtains approval to transfer funds to the Safety Net Care Pool where the hospitals can also access federal funds.

Specifically, the Waiver annually provides up to $180 million in federal funds for "Health Care Coverage Initiative" counties, which are voluntary county programs that provide health care services for eligible individuals (incomes above 133 percent and up to 200 percent of poverty). The Health Care Coverage Initiative (HCCI) counties use "Certified Public Expenditures" (CPEs) to obtain federal matching funds for health care services provided to their eligible populations. According to the DHCS, it is estimated that a significant amount of the federal funds allocated for these HCCI counties *will not be* expended.

For the State to achieve its share of the federal funds and General Fund relief, it needs additional CPEs. The Designated Public Hospitals have CPEs but cannot draw the federal funds unless the State receives federal approval of the Waiver amendment to transfer more federal funds into the Safety Net Care Pool.

Based on recent estimates by the DHCS, the State estimates that from possibly as low as $40 million to as high as possibly $90 million or more in voluntary, excess CPEs are needed from the Designated Public Hospitals in order for the State to achieve its $400 million in annual General Fund savings from the Waiver.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" trailer bill language to craft a compromise that is workable for the State to achieve its General Fund savings target and to maintain the voluntary nature of the CPEs and Designated Public Hospital financing.

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

1. DHCS, Please provide a brief description of the May Revision request.

2. Managed Care: General Fund Reimbursement from Designated Public Hospitals

Background and Governor's May Revision. Effective June 1, 2011, Seniors and Persons with Disabilities enrolled in Medi-Cal Fee-for-Service are to be phased-in to mandatory enrollment in Medi-Cal Managed Care. Payments made to Designated Public Hospitals for health care services provided to people in Medi-Cal Fee-for-Service are comprised of "Certified Public Expenditures (CPE)" matched with federal funds. This payment mechanism was established under the original Hospital Financing Wavier.

However, payments made to these hospitals for Medi-Cal Managed Care inpatient days had historically been composed of General Fund and federal fund support, no use of these hospitals CPEs. Therefore, as Seniors and Persons with Disabilities are transitioned into mandatory Medi-Cal Managed Care, General Fund expenditures would increase for Inpatient days obtained at Designated Public Hospitals.

Under the 1115 Medicaid Waiver payment structures were modified. As a result, Designated Public Hospitals will reimburse the General Fund for the costs that are built into the Medi-Cal Managed Care capitation rates that would not have been incurred had the Seniors and Persons with Disabilities remained in Medi-Cal Fee-for-Service.

The May Revision assumes that annual reimbursement from the Designated Public Hospitals is $150.3 million (total funds). Because the mandatory Managed Care enrollment transition will be phased-in (starting June 1, 2011), the initial reimbursement from the Designated Public Hospitals to the State for *General Fund offset will be $94 million*.

Subcommittee Staff Comment and Recommendation—Adopt May Revision. The proposal conforms to the 1115 Medicaid Waiver payment structure. No issues have been raised

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

1. DHCS, Please provide a brief description of the May Revision and fiscal calculation.

3. Managed Care: New Processing Fee for Inter-Governmental Transfers (DOF 425)

Governor's May Revision. The May Revision proposes trailer bill to institute a new 20 percent fee on *each* voluntary Inter-Governmental Transfer (IGT) that is used to match federal funds to provide Medi-Cal Managed Care rate increases, beginning July 1, 2011. Revenues generated from this 20 percent fee will be used to offset General Fund expenditures for medical services within the Medi-Cal Program. Federal approval is required for implementation.

The May Revision assumes savings of $34.2 million (General Fund) from the collection of this 20 percent fee. Presently about $173 million in voluntary IGTs is anticipated for 2011-12.

IGTs are used to provide additional funds for the "non-federal" portion of risk-based payments to Medi-Cal Managed Care Plans in order to provide increased compensation to certain Providers who provide health care services to Medi-Cal enrollees. The IGTs are matched with federal funds and serve as an additional funding source for Medi-Cal services. Funds for IGTs come from "transferring entities" which include any public entity, such as County, City, governmental unit or special district.

DHCS develops Medi-Cal Managed Care rates by establishing a rate range that consists of a lower to upper bound that has about a 7.5 percent range. DHCS reimburses at the lower end of this range.

Since the 2005-06 rate year Counties and Designated Pubic Hospitals have been voluntarily participating in this rate range IGT Program which they use to enhance health care services provided to Medi-Cal enrollees.

DHCS administers the IGT Program. They note that this is a voluntary program and could possibly be phased-out in the future.

The DHCS contends this new fee will benefit all involved. Medi-Cal Managed Care Plans are able to compensate Designated Public Hospitals and other providers for health care services provided to Medi-Cal enrollees, and the State can be reimbursed for the costs incurred for operating the IGT Program and the new fee benefits the Medi-Cal Program overall.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" trailer bill language and the May Revision savings of $34.2 million (General Fund).

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

1. DHCS, Please provide a brief explanation of the use of IGTs and the May Revision proposal.

4. Managed Care: Trailer Bill to Extend Managed Care Organization Tax

Governor's May Revision. The May Revision proposes to extend the exiting Managed Care Organization (MCO) Tax for almost three years, from July 1, 2011 to January 1, 2014.

Revenues from this tax are matched with federal funds and are used for the following:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and
- Fund health care coverage for children in the Healthy Families Program (serves as a backfill to the General Fund).

Extending this statute will provide funding of about $334.1 million for the Healthy Families Program and $206.8 million to supplement Medi-Cal Managed Care Plan capitation rates, including the federal fund match.

Background. AB 1422, Statutes of 2009, established an alternative funding mechanism for essential preventative and primary health care services provided through the Healthy Families Program by adding Medi-Cal Managed Care Plans to the list of insurers subject to California's gross premiums tax of 2.35 percent. It is required that the tax proceeds be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt placeholder trailer bill to extend the existing statute to January 1, 2014. Without this extension, the provision of health care services could be jeopardized and there would be added pressure on General Fund resources.

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

1. DHCS, Please provide a brief description of the May Revision.

5. Managed Care: Proposed Trailer Bill Language for a One-Year Lock In (DOF 427)

Background. Mandatory enrollment into Medi-Cal Managed Care for Seniors and Special Populations is to commence as of June 1, 2011. This will be an entirely new approach for hundreds of thousands of these individuals over the course of 2011-12. This is a vulnerable population, many of whom have unpredictable and changing needs which may require them to change plans more than once per year.

Currently, people in the Two-Plan Model and Geographic Managed Care forms of Medi-Cal Managed Care can change Health Plans when they choose. This is a critical option for Medi-Cal enrollees if they are not getting their needs met by a Health Plan, or if their doctor (such as specialty care) no longer contracts with the plan they are in.

Governor's May Revision. The May Revision proposes trailer bill to change this existing Managed Care enrollment policy to only allow Medi-Cal enrollees in Two-Plan and Geographic Managed Care counties to change plans *once a year*, effective as of October 1, 2011.

The effect of this proposal is that an open enrollment period would be set for September 1, 2011 of each year (after enactment). A notification would be mailed to each Health Plan member to allow the individual the opportunity to change Health Plans during a specified open enrollment period.

New Medi-Cal enrollees would only have a 60-day period from their initial enrollment date to switch plans after which they would be locked-in for the balance of the one-year period.

It should be noted that this DHCS proposal requires an amendment to California's 1115 Medicaid Waiver, and is a change in policy as it pertains to SB 203, Statutes of 2010, which provided the framework for the mandatory enrollment of Seniors and Special Populations into Medi-Cal Managed Care.

The May Revision reflects a *net* reduction of almost $3.3 million ($1.6 million General Fund) by implementing the proposed statutory change. This *ne*t reduction consists of the following two components:

- Reduction in Health Screens. Reduction of $5.3 million ($2.6 million General Fund) in health care services from a projected decrease in the need to perform initial health assessments that are done when a new Medi-Cal Managed Care enrollee starts with a health plan. This is because people would not be changing health plans due to the "lock-in".
- Increased Mailing Costs. Increase of $2 million ($1 million General Fund) to provide initial informing materials that must be mailed out to Medi-Cal enrollees explaining the "lock-in" proposal and process.

DHCS states that out-year expenditures related to this proposal would evolve and they expect additional savings on an annualized basis.

DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies cine enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using Health Plan; and
- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution).

The DHCS notes that several States, including Maryland, Michigan, Hawaii, Colorado, Minnesota, New Jersey and New York have one-year lock-in requirements in their Medicaid programs.

Subcommittee Staff Comment and Recommendation—Deny Proposal. It is recommended to deny the trailer bill and to adjust the Medi-Cal budget (benefits and health care options) accordingly.

First, according to advocates, the proposal violates federal regulations that require Medicaid enrollees to be given *90 days* from the date of initial enrollment or the date the State sends notice of enrollment, whichever is later.

Second, mandatory enrollment is just commencing June 1, 2011. It is imperative for this year to be a transition year with a focus on having Medi-Cal enrollees comfortable with their plans, this is particularly important for Seniors and Special Populations. Imposing a “lock-in” immediately after this new program starts is unworkable.

Third, the proposal is not in concert with the intent of the enabling legislation and 1115 Medicaid Waiver which were just approved late last year.

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

1. DHCS, Please provide a summary of the May Revision request.

6. Medi-Cal Eligibility: Trailer Bill for New Budgeting Methodology

Governor's May Revision. Federal Medicaid law requires a governmental entity to finalize *all* eligibility applications. In California, County Human Services Departments serve as surrogate for the State to perform this important function.

The May Revision proposes trailer bill to develop a new methodology for reimbursing Counties for Medi-Cal eligibility determinations for applicants and enrollees. This new methodology would be developed in consultation with County representatives and is to include the following components:

- Establishment of eligibility category groups;
- Establishment of case rates for distinct eligibility categories;
- Recognition of time and resource costs incurred when making eligibility determinations; and
- Recognition of time and resource costs for ongoing case maintenance activities, including annual redeterminations.

Based on discussion and analysis, the DHCS states that the new budget methodology for determining expenditures for Medi-Cal eligibility processing conducted by Counties would be presented in the Governor's May Revision of 2012 and utilized thereafter.

DHCS states that a new methodology needs to be developed for several reasons. *First*, the federal Patient Protection and Affordable Care Act (federal ACA) requires Medicaid (Medi-Cal) eligibility to transition to using "modified adjusted gross income" (MAGI) standard for making eligibility determinations for most of the population. The use of MAGI is designed to simplify eligibility determinations and to eliminate the use of asset tests for families, children, and newly eligibility populations.

Second, the federal ACA also requires implementation of streamlined eligibility processing procedures t help facilitate the enrollment of individuals into coverage.

Third, the existing process for determining county administrative baselines, adding in caseload increases and making other special and technical adjustments has not been an effective method for the State or for the Counties.

DHCS states that a new budgeting methodology would result in a simpler and more accurate budgeting of Medi-Cal eligibility processing and would provide flexibility in the future when the State adds new eligible groups pursuant to the ACA. Further it would help inform budget decisions, allow for ongoing monitoring, improve fiscal accountability and support better management and evaluation of program administration.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt "placeholder" language that, at a minimum, would require the DHCS to provide an overview of any recommended methodology change to the Legislature for its review *prior* to its inclusion as a budget calculation as of May 2012 as presently stated in the Administration's trailer bill.

It is expected that a compromise can be ascertained by working with the DHCS and interested stakeholders. Therefore it is recommended to adopt "placeholder" trailer bill.

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

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

7. Trailer Bill: Average Acquisition Price as New Pricing Benchmark

Legislative Actions Contained in SB 69 Budget Bill. The Legislature conformed to the Governor's budget by reducing Pharmacy reimbursement by up to 10 percent for a reduction of $271.9 million ($143 million General Fund). This reduction is contingent upon federal CMS approval.

In addition, AB 97, Statutes of 2011 (Omnibus Health Trailer Bill), contained Legislative intent language which states expresses the desire to have new legislation by August 1, 2011 that provides for a new Pharmacy reimbursement methodology based on the actual acquisition cost of drug ingredients.

Background on Pharmacy Reimbursement and Average Wholesale Price (AWP). The Medi-Cal Pharmacy reimbursement consists of two components—a professional dispensing fee *and* payment for drug ingredient costs.

For the drug ingredient cost of this equation, DHCS relies primarily on the Average Wholesale Price benchmark (AWP minus 17 percent). This is because Average Wholesale Price has been the only price readily available for all drugs but its calculated value is based on information supplied solely by drug manufacturers. Over time, the Average Wholesale Price has been subject to differing and variable interpretations, as evidenced by legal actions relating to its calculation and use.

The primary sources of Average Wholesale Price are private drug data compendia, with most Pharmacies and Third-Party payers using First Data Bank or Med-Span. The DHCS currently uses First Data Bank as its primary pricing reference.

However in 2009, First Data Bank and the McKesson Corporation (drug wholesaler)) were found to have wrongfully inflated the mark-up factor used to determine the Average Wholesale Price for certain prescription drugs. Subsequent to the settlement of that lawsuit, First Data Bank announced that it would cease the publication of Average Wholesale Price for drugs within two-years (as of September 2011).

In addition, DHCS notes that federal regulation requires that any new drug ingredient cost benchmark must be one that has a genuine relationship to what Pharmacies are actually paying for drug acquisition costs.

Governor's May Revision. The May Revision proposes trailer bill which provides for the DHCS to establish an Average Acquisition Price which is to represent the purchase price paid for a drug product by retail Pharmacies in California. The Average Acquisition Price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act.

The trailer bill provides the DHCS with broad authority to establish the Average Acquisition Price for single source, innovator multiple source drugs and non-innovator multi-source drugs.

The language articulates that, *at the discretion of the DHCS*, the Average Acquisition Price may be established in one of the following ways:

- Based on volume weighted Average Acquisition Price (AAP) adjusted by the DHCS to ensure that it is representative of retail Pharmacies in California;
- Based on a national pricing benchmark, established by the federal CMS, or a on a similar benchmark listed in the DHCS's primary price reference (such as First Data Bank), and adjusted for California; or
- Pursuant to a contract with a Vendor for the purpose of data analysis and calculating a proposed Average Acquisition Price.

The trailer bill requires providers to submit drug pricing information and if this information is not provided, the DHCS may suspend the provider from the Medi-Cal Program.

In addition the language states that a *one-time* adjustment to the Pharmacy professional dispensing fee *may* occur if the new Average Acquisition Price results in lower drug ingredient costs on the aggregate to providers. Any one-time adjustment to the Pharmacy professional dispensing fee would not exceed the aggregate savings associated with the implementation of the Average Acquisition Price (i.e., cost neutral to the State).

DHCS contends trailer bill language is necessary in order to ensure that a process is in place *prior* to the elimination of the Average Wholesale Price which is to occur in October 2011.

DHCS states that while it's possible that Medi-Span or other companies *may* continue to publish the Average Wholesale Price past September 2011, it is widely accepted and validated through federal audits that the Average Wholesale Price based Pharmacy reimbursement is *not* a true reflection of the actual acquisition costs Pharmacy providers are paying for pharmaceuticals in the marketplace.

DHCS notes that current statute does not provide them with a viable mechanism to reimburse Pharmacy providers if the State does not have an alternative to replace the current Average Wholesale Price pricing methodology.

The DHCS states that no fiscal adjustment is reflected in the May Revision for this proposed trailer bill language since a method needs to be established and costs analyzed. This information would be updated in the Governor's January budget release for 2012.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder. It is recommended to adopt placeholder trailer bill to develop a transition methodology. Details need to be addressed and conversations are progressing.

This issue needs to be included as trailer bill in order to address the timing of the anticipated elimination of the Average Wholesale Price and to address how Medi-Cal is to appropriately reimbursement Pharmacy providers.

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

1. DHCS, Please provide a summary of the proposed trailer bill *and* why the Administration believes trailer bill is necessary.

8. Trailer Bill: Extension of Sunset Date for AB 1629 Quality Assurance Fees & Expansion of Fee to Pediatric Subacute Care Facilities

Legislative Actions Contained in SB 69 Budget Bill. Both the SB 69 Budget Bill and AB 97, Statutes of 2011 (Health Trailer Bill) conformed to the Governor's January budget to reduce payments by 10 percent to AB 1629 Nursing Facilities effective June 1, 2011.

In addition, this conforming action reduces Pediatric Subacute Care Facilities to 2008-09 levels then further reduces payments by 10 percent effective June 1, 2011.

Governor's May Revision. The May Revision proposes a series of changes to the Administration's January budget with was approved by the Legislature. Specifically, the May Revision makes the following changes.

First, it extends the sunset on the Quality Assurance Fee and makes adjustments to the rates paid to Nursing Homes. These adjustments are contained below:

- Extends Sunset on Fee. Extends the sunset date by one year to July 31, 2013 for the AB 1629 Quality Assurance fee (QAF) and the rate-setting methodology.
- Terminates Rate Reduction. Terminates the 10 percent payment reductions on August 1, 2012 for AB 1629 Nursing Homes as specified.
- One-Time Supplemental Payment. Provides a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction that was applied from June 1, 2011 to July 31, 2012 for Medi-Cal fee-for-service Nursing Homes.

  DHCS will provide the supplemental payment to Med-Cal fee-for-service Nursing Homes by December 31, 2012 (for claims adjudicated by October 31, 2012). Medi-Cal Managed Care Nursing Homes will receive an actuarially equivalent amount of the supplemental payment.
- Apportion the Reduction. Applies the 10 percent payment reduction effective June 1, 2011 equally to each Nursing Facilities' 2010-11 rates.

  For the 2011-12 rate year beginning August 1, 2011, DHCS will *offset* the 10 percent payment reduction by the weighted average rate increase applicable to the rate year and will apply the net percent decrease equally to each Nursing Home's 2010-11 rates.

  For Rate Year 2011-12, the *net percent decrease* will be approximately 7.6 percent.

Second, it expands the Quality Assurance Fee to Pediatric Subacute Care Facilities and makes changes to their reimbursement rates as follows:

- Expand the Fee. Applies the Quality Assurance Fee to Pediatric Subacute Care Facilities (both Distinct Part and Freestanding) beginning August 1, 2011. The proposal provides certain flexibilities to the DHCS in the collection of the new Quality Assurance Fee to assist the facilities with the financial transition.

- Adjustment to Payments. Reduces the payment reductions on the Pediatric Subacute Care Facilities 2008-09 rates based on the QAF revenue received and the increased federal matching funds.

  Beginning June 1, 2011, the payment reduction on the 2008-09 rates for Freestanding Subacute Facilities will be a 5.75 percent decrease.

  Beginning June 1, 2011, the payment adjustment on the 2008-09 rates for Distinct-Part Pediatric Subacute Care Facilities will be a 1.5 percent increase.

- Quality and Accountability Supplemental Payment System. Delays implementation of the Quality and Accountability Supplemental Payment System for one year; and

- Set-Aside for the Quality and Accountability Supplemental Payment System. Delays until Rate Year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System of one percent of the AB1629 facilities reimbursement rate.

DHCS states that in the absence of an extension of the Quality Assurance Fee, there would be a loss of about $500 million in revenue (in July 2012). They state they would need to either implement a future rate reduction or seek increased General Fund support. The one year extension of the QAF provides continued revenue and federal matching funds for AB 1629 Nursing Facility rates.

Further, DHCS notes the Long-Term Care Industry is unlikely to support an extension of the Quality Assurance Fee without assurance that the funds would benefit the industry. This proposal will roll back the June 1, 2011 reductions after 14 months, but it is balanced with an extension of the Quality Assurance Fee.

The Administration notes that by assessing a Quality Assurance Fee on Pediatric Subacute Care Facilities, the State will receive additional revenue and obtain additional federal funds which would enable DHCS to lower the reductions applied to these facilities.

Finally the DHCS contends that delaying the Quality and Accountability Supplemental Payment System for one year enables DHCS to delay the set-aside of 1 percent of the weighted average Medi-Cal reimbursement rate that it would have used for the supplemental rate pool. This limits further erosion of funding for the SNFs in addition to the payment reduction.

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, Statues 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 $500 million in General Fund support is at risk.

Background--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 and Recommendation—Adopt Placeholder. The May Revision completely revisits actions taken in the Budget Act of 2010 regarding the beginnings of implementing a quality assurance system, but also considerable changes what the Administration had proposed in its January budget.

Due to the sweeping nature of the May Revision, further discussions are warranted and it is recommended to adopt “placeholder” trailer to extend and expand the fee and work with all constituency groups on a resolution. Discussions need to continue.

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

1. DHCS, Please walk-through each component of the May Revision proposal.

9. Settlement in California v. Quest Laboratories—Recognize Settlement (DOF 460)

Background and May Revision. State Attorney General Kamala Harris just announced a $241 million settlement—the largest recovery in the history of California's False Claims Act—with Quest Diagnostics Incorporated, the largest provider of medical laboratory testing in California.

The settlement is the result of a 2005 whistleblower lawsuit alleging that Quest overcharged the Medi-Cal Program for more than 15 years and gave illegal kickbacks in the form of discounted or free testing to doctors, hospitals and clinics that referred Medi-Cal patients and other business to the labs.

The settlement provides for Quest to pay California $241 million in settlement claims that Quest overcharged Medi-Cal for testing services and gave kickbacks. Of this amount, $50.056 million will go to Medi-Cal.

Of the remaining amount, (1) $96.4 million is for the federal government for their portion of the Medicaid Program; (2) $69.9 million is for the whistleblower; and (3) $24.6 million is for the Department of Justice (AG's Office).

It should be noted that similar cases are still pending against four other defendants, including Laboratory Corporation of America (LabCorp), the second largest medical laboratory services provider in California. Trial is scheduled for early next year.

Subcommittee Staff Comment and Recommendation—Reflect Settlement. Since the settlement was just determined, the $50.056 million in recoupment for Medi-Cal is not reflected in the Governor's May Revision.

Therefore it is recommended to *reflect a General Fund savings of $50.056 million* in Medi-Cal by decreasing the General Fund appropriation and increasing Reimbursements by an equal amount.

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

1. Administration, Is there any comment regarding this settlement with Quest?

10. Gradual Transition of Community Mental Health to DHCS

Governor's May Revision. The May Revision proposes *a two-step process* for transitioning the State-Level responsibilities associated with Medi-Cal, including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and Mental Health Managed Care, to the DHCS. This transfer is intended to become effective as of July 1, 2012 (next budget-year).

First, the Administration is proposing trailer bill language which expresses the intent of the Legislature to transfer to the DHCS, by no later than July 1, 2012, Medi-Cal mental health functions currently administered through the State Department of Mental Health, without regard to whether or not that Medi-Cal mental health function has been formally created by statute.

Second, for 2011-12, the May Revision proposes cursory Budget Bill Language that would provide for broad authority for the Department of Finance to transfer both staff and funds from the Department of Mental Health to the DHCS after 10 days after giving the Legislature notification. The three pieces of proposed Budget Bill Language are as follows:

Add Provision 7 to Item 4260-001-0001

Provision 7. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of staff and related expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-001-0001, and 4260-001-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer. The 10-day notification shall include the reasons for the transfer, the assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which resources are being transferred.

Add Provision 14 to Item 4260-101-0001

Provision 14. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized under departments 4200, 4280, 4440, 4260-101-0001, and 4260-101-0890 as a result of the shift of responsibilities from the Department of Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the Department of Mental Health to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

Add Provision 2 to Item 4260-113-0001

Provision 2. *Notwithstanding any other provision of law*, the Department of Finance may authorize the transfer of expenditure authority between the various appropriations itemized under department 4280 to 4260-113-0001 and 4260-113-0890 for activities necessary to transition and maintain programs and populations administered by the Managed Risk Medical Insurance Board to the Department of Health Care Services' Medi-Cal Program. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

No other structural programmatic or fiscal detail has as yet been provided by the Administration.

Legislative Analyst's Comment and Recommendation. The LAO states the Governor's proposal has merit because it has the potential to streamline administrative functions and improve service delivery. They note that it could result in the elimination of administrative redundancies and could facilitate better coordination and integration of the behavioral services provided through EPSDT, and Mental Health Managed Care, as well as Drug Medical (proposed for transfer from the Department of Drug and Alcohol).

However, the LAO notes few details have been provided on how the transition would be implemented.

The LAO expresses concerns with the Administration's sweeping Budget Bill Language, and its lack of Legislative oversight, and also recommends for the Legislature's Policy Committees to be engaged in decision making regarding these critical issues.

Subcommittee Staff Comment and Recommendation—Adopt in Concept with Placeholder Trailer Bill *and* Placeholder Budget Bill Language. This transition is an integral component of the Governor's Realignment and is consistent with the Legislature's approval to transition the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) and Mental Health Managed Care to the Counties, as discussed through the March budget deliberations. While the State will continue to have important oversight functions and federal responsibilities, it is no longer essential to have separate State departments with overlapping responsibilities and potentially unclear accountabilities.

This proposed consolidation not only offers administrative efficiencies, but it can also offer fuller integration of health and behavior health care services to consumers in need of these critical services. The State's newly implemented 1115 Medicaid Waiver, coupled with federal health care reform, and the Mental Health Parity Act of 2008, offer very constructive opportunities for a more inclusive and comprehensive delivery model.

Considerable discourse needs to occur with mental health advocates, mental health system providers, County Mental Health Plans, various interest groups and with the Legislature. It is anticipated that these discussions will be ongoing through the course of 2011-12.

With respect to the Administration's proposed Budget Bill Language, it is recommended to adopt placeholder Budget Bill Language to conceptually require a comprehensive description of funding and positions to be transferred from DMH to the DHCS, as well as other aspects of a transition plan. In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

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

1. Administration, Please provide a conceptual summary of the intent of this State administrative consolidation.

11. Transfer of Drug Medical Program to DHCS

Prior Subcommittee Hearing. In the Subcommittee's May 25th hearing, the Governor's May Revision proposal to transfer the Drug Medical Program to the DHCS was discussed and adopted in concept.

Governor's May Revision—Budget Bill Language. The May Revision for the DHCS proposes the following broad Budge Bill Language to provide for the fiscal

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Budget Bill Language. It is recommended to adopt placeholder Budget Bill Language to conceptually require a comprehensive description of funding and positions to be transferred from the Department of Alcohol and Drug (DADP) to the DHCS, as well as other aspects of a transition plan. In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

This language would be crafted in the same manner as that for the transfer of Community Mental Health programs as noted above.

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

1. Administration, Please provide a conceptual summary of the intent of this State administrative consolidation.

B. Managed Risk Medical Insurance Board-- Transition

Governor's May Revision. The May Revision proposes to eliminate the Managed Risk Medical Insurance Board (MRMIB and have MRMIB's Executive Director report to the Secretary of the California Health and Human Services (CCHHS) Agency by July 1, 2012.

During 2011-12, the Healthy Families Program and the Access for Infants and Mothers (AIM) Program would be transferred to the Department of Health Care Services (DHCS).

In 2012-13, the remaining MRMIB programs—the Pre-Existing Condition Insurance Plan (PCIP), Major Risk Medical Insurance Program (MRMIP) and the County Children's Health Initiative Program would be transferred to the DHCS.

Background. The Managed Risk Medical Insurance Board provides health coverage through commercial health plans, local initiatives and County Organized Health Systems to certain persons who do not have health insurance. The Board also develops policy and recommendations on providing health insurance to uninsured Californians. It 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).

MRMIB has a total of 110 positions budgeted for 2011-12.

Background--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.

Background--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.

Background--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.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision in Concept. It is recommended to adopt the May Revision in concept. With respect to the Administration's proposed Budget Bill Language, it is recommended to adopt placeholder Budget Bill Language in the same manner as proposed under the transfer of State-level functions as discussed under the Medi-Cal Program. (See items 10 and 11 above, in Medi-Cal). In addition, this information should be provided to the relevant fiscal and policy committees of the Legislature at least 45-days prior to any fiscal or position transfers.

Question. The Subcommittee has requested the Administration to respond to the following question:

1. Administration, Please provide a brief summary of the May Revision.

C. CA Medical Assistance Commission (CMAC)

1. Dissolve the California Medical Assistance Commission

Governor's May Revision. The May Revision proposes trailer bill language and a reduction of $129,000 (General Fund) and 3.5 personnel years by dissolving the CMAC.

Specifically, the Commission would be dissolved as of January 1, 2012, and all staff would then be transferred to the CA Health and Human Services Agency (CHHS Agency). All the duties and responsibilities of CMAC related to hospital contracting would still continue until the new hospital in patient payment methodology using Diagnosis Related Groupings (DGRs) is implemented.

With the implementation of a new hospital inpatient payment system for general acute care services based upon DRGs, the services CMAC provides will no longer be needed.

Background. Established in 1983, the California Medical Assistance Commission (CMAC) negotiates with hospitals through the Selective Provider Contracting Program on a per diem rate for the health care services they provide to Medi-Cal enrollees. The goal of the Commission is to promote efficient and cost-effective Medi-Cal programs through a system of negotiated contracts fostering competition and maintaining access to quality health care for Medi-Cal enrollees.

Among other things, SB 853, Statutes of 2010, requires the DHCS to development a new hospital inpatient payment methodology for general acute care services based upon diagnosis related groups (DRGs). Initially a reconciliation process is to commence as of July 1, 2012, with full implementation of the DGR payment method by July 1, 2014. The Medicare Program has utilized a DRG methodology for over 15 years.

Subcommittee Staff Comment and Recommendation—Adopt the May Revision. It is recommended to adopt the May Revision

Question. The Subcommittee has requested the Administration to respond to the following question:

2. Administration, Please provide a brief summary of the May Revision.

D. Department of Public Health

1. AIDS Drug Assistance Program (ADAP)

Legislative Actions Contained in SB 69 Budget Bill. In *prior action*, the Legislature modified the Governor's January proposal for the AIDS Drug Assistance Program by **(1)** shifting a total of $73 million in General Fund expenditures to Reimbursements and federal funds; and **(2)** identified savings of $4 million (General Fund) from revised transaction processing to be conducted under the new Pharmacy Benefit Manager contract. The specific actions were as follows:

- Reduced by $70 million (General Fund) and increased by $70 million (Reimbursements which are federal funds from Department of Health Care Services) to reflect ADAP's share of the Safety Net Care Pool Funds made available under California's 1115 Medicaid Waiver.
- Reduced by $3 million (General Fund) and increased by $3 million (federal funds) in anticipation of receipt of additional federal Ryan White CARE Act funds.
- Reduced by $4 million (General Fund) to reflect anticipated transaction processing savings from a new Pharmacy Benefit Manager contract to be effective as of July 1, 2011.
- Rejected the Governor's proposal to institute monthly premiums in ADAP estimated to generate $19.7 million in revenue from ADAP Clients which would have been offset by $2.9 million in administrative costs for a net reduction of $16.8 million (General Fund).
- Directed the Office of AIDS *to work immediately* with Stakeholders and other departments to **(1)** recast and expand the Health Insurance Premium Payment Program under the federal Ryan White Comprehensive AIDS Resources Emergency Act (CARE/HIPP); and **(2)** utilize the federal Pre-Existing Condition Insurance Program (PCIP) to provide health care coverage for eligible people with HIV/AIDS.

  Both the CARE/HIPP and PCIP can be utilized to reduce expenditures in ADAP while providing more comprehensive health care to people living with HIV/AIDS.

Governor's May Revision for 2011-12. The May Revision proposes total expenditures of $511.1 million for ADAP. The chart below displays the proposed fund sources.

AIDS Drug Assistance Program Fund Sources: Governor's May Revision

General Fund	$ 86.7 million
Drug Rebate Fund	$253.8 million
Reimbursement—1115 Medicaid Waiver	$ 70.0 million
Federal Funds	$100.6 million
Total Funds	$511.1 million

First, the Governor's May Revision reflects the Legislature's direction and actions in SB 69 by:

- Identifying General Fund savings by enrolling people with HIV and AIDS into the Pre-Existing Condition Insurance Plan (PCIP);
- Identifying General Fund savings by expanding the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP);
- Rescinding the Governor's January proposal to institute monthly premiums in ADAP; and
- Reflecting increased in Reimbursements from the Department of Health Care Services (DHCS) from the receipt of federal funds from the 1115 Medicaid Waiver (Safety Net Care Pool).

Second, the Governor's May Revision makes a series of technical updates regarding **(1)** savings attributable to the Pharmacy Benefit Manager Contract; **(2)** updated revenues in the Drug Rebate Fund; and **(3)** caseload adjustments.

Background: ADAP Eligibility. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM) (Ramsell Holding Company is the State's PBM for ADAP)

Individuals are eligible for ADAP if they:

- Reside in California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that *does not exceed* $50,000;
- Have a valid prescription from a licensed CA physician; and
- Lack private insurance to cover medications or do not qualify for no-cost Medi-Cal.

The ADAP is the *payer of last resort*. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services *first*, before the ADAP will provide services. The following chart provides a summary of estimated ADAP client enrollment.

ADAP Clients by Coverage Group (2011-12)

Coverage Group	Clients	Percent
ADAP-Only	22,910	53.8
Medi-Cal Program	524	1.2
Private Insurance	9,509	22.4
Medicare coverage (Part D)	9,631	22.6
TOTAL	42,574	100.0

ADAP clients with incomes between $43,560 (401 percent of poverty as of April 1, 2011) and $50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

The cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the Pharmacy at the time the client picks up their medication

The client's payment is then credited and the amount the Pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

Background: ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including *both* mandatory (required by federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with 14 drug manufacturers through ADAP Taskforce).

Generally, for every dollar of ADAP drug expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

Background—ADAP is Cost-Beneficial to the State. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the State, whereas only 30 percent of ADAP costs are borne by the state. Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person's health and productivity.

Background--Availability of Other Programs. The availability of the following two programs, as discussed in the Subcommittee's hearing of February 1, 2011, will enable the Office of AIDS to reduce expenditures in the ADAP:

CARE/HIPP. Federal law authorizes this Health Insurance Premium Payment (HIPP) program under the Ryan White Comprehensive AIDS Resources Emergency Act. This program provides premium payment assistance for eligible people for various insurance policies including: private insurance; COBRA; Cal-COBRA; and others. Eligible individuals are low-income California residents unable to work full time due to HIV-AIDS related health problems that are either receiving or in the process of applying for disability benefits. The income and asset limits are 400 percent of poverty and assets of $6,000. The monthly health insurance premium must be less than $700 per month. The private insurance plan must have prescription coverage as well. Current caseload is about 174 cases.

Pre-Existing Condition Insurance Program (PCIP). As discussed in Subcommittee on January 26th, California received federal approval and an allocation of $761 million (federal funds) to operate a high risk health insurance pool. 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. PCIP is to provide health care coverage for eligible individuals through December 31, 2013,

Subcommittee Staff Comment and Recommendation—Adopt the May Revision. It is recommended to adopt the May Revision

Question. The Subcommittee has requested the Administration to respond to the following question:

1. Administration, Please provide a brief summary of the May Revision.

E. Department of Mental Health: Community-Based Programs & State Support

Background Summary

Summary of Legislative Actions Contained in SB 69 Budget Bill. *First,* the Legislature adopted the Governor's proposal to realign certain community-based mental health programs, including the Early Periodic Screening, Diagnosis, & Treatment (EPSDT) Program, Medi-Cal Specialty Mental, and mental health services provided to special education pupils. *Second*, the Legislature modified the Governor's Finance Letter regarding adjustments to the State Administrative component of the Mental Health Services Act (Proposition 63 Funds).

Specifically, these actions by the Legislature are detailed below:

- o One-Time Redirection of $861.2 million (Mental Health Services Act Funds). Redirected a total of $861.2 million (MHSA) from Counties to backfill for General Fund support, as contained in AB 100, Statutes of 2011, for three programs as follows: **(1)** EPSDT = $579 million; **(2)** Medi-Cal Specialty Mental Health Managed Care = $183.6 million; and **(3)** Mental Health Services to Special Education Pupils = $98.6 million.

  This *one-time* redirection is necessary to adequately fund essential mental health services that would otherwise be significantly reduced absent this temporary funding support. This funding serves as a bridge to the 2011 Realignment.

- o 2011 Realignment. Beginning in 2011-12, upon passage of the Constitutional Amendment and a vote of the people, these three programs will be managed by the Counties, with oversight and direction by the State as necessary due to federal requirements. The Legislature's intent is to more equitably align program responsibilities and to provide a stable funding source.

- o State Administration Changes. Modified the 5 percent of total annual revenues for State administrative expenditures to support the DMH, the MHSA Oversight and Accountability Commission and other State entities to be a total of 3.5 percent. Appropriated a total of $21.975 million (MHSA Funds) for State administration.

  Of this amount, $1.9 million (MHSA Funds) is for State staff at the DMH. This provides for a total of 19 positions, including seven positions for housing, three positions for suicide prevention, four positions for stigma mitigation, and five positions for focused data analysis. The DMH will no longer be reviewing and approving County MHSA Plans. A total of five positions were also provided to the Mental Health Planning Council to continue their involvement with the MHSA.

Governor's May Revision. The May Revision *continues* the Governor's Realignment proposal for community mental health and State support as adopted in AB 100, Statutes of 2011 and as contained in SB 69 Budget Bill, ***except*** *for the following proposed modifications:*

- Mental Health Services to Special Education Students (AB 3632). The May Revision continues to provide $98.6 million (MHSA Funds) on a one-time basis for mental health services to special education students; however, ongoing responsibility for these services is proposed for realignment to school districts instead of County Mental Health beginning in 2012-13. The 2011-12 MHSA Funding is *not* affected by this proposal. *(Senate Budget Subcommittee #1 on Education will discuss this proposal. There is no action required of Senate Budget Subcommittee #3.)*

- Mental Health Managed Care Technical Adjustment. The May Revision proposes an increase of $294,000 ($148,000 General Fund and $146,000 federal funds) to reflect an increase in programs costs related principally to the number of Medi-Cal eligibles. This issue is discussed below.

- Increase in Proposition 63 Mental Health Services Fund Revenue. The May Revision reports a *decrease* of $20 million (MHSA Funds) for 2010-11, an *increase* of $123 million (MHSA Funds) for 2011-12 is assumed, as compared to the Governor's January budget revenue projections. Therefore a net increase of $103 million is projected across the two-years, as compared to the Governor's January budget. *(No additional budgetary changes are necessary for these revenues to be recognized.)*

- State Support for Mental Health Services Act (Proposition 63). The May Revision proposes to augment by $2.277 million (MHSA Funds) and 51 positions (25.5 personnel years) for transition planning purposes. This issue is discussed below.

Discussion Issues

1. Mental Health Managed Care—Technical Adjustments (DOF issue 520)

Governor's May Revision. The May Revision proposes an increase of $294,000 ($148,000 General Fund and $146,000 Reimbursements which are federal funds) for 2011-12 to reflect an increase in program costs related principally to the number of Medi-Cal eligibles.

This technical adjustment is in augmentation of the appropriation contained in the SB 69 Budget Bill.

SB 69 Budget Bill conformed to the Governor's January Budget for 2011-12 and appropriates $367.1 million ($183.6 million one-time MHSA/Proposition 63 Funds and $183.5 million federal funds) for this program. County Realignment Funds, which do not flow through the State's budget, are also used by Counties for these services.

Background: Mental Health Managed Care (Adults) and Existing Waiver. California provides "specialty" mental health services under a comprehensive federal Waiver that includes outpatient specialty mental health services, such as clinic outpatient services, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. County Mental Health Plans contract with local providers to provide services.

California's Waiver for this program and for EPSDT (one Waiver) is set to expire as of June 30, 2011. This Waiver provides about $2 billion in funding. The DHCS is presently working for a renewal of this Waiver.

This program is funded using a combination of predominately County Realignment Funds, some General Fund support, and federal matching funds (50 percent and is drawn from the Counties and the State's contribution). State General Fund support for Mental Health Managed Care has been reduced considerably over the past years from about $226 million (General Fund) in 2008 to only $131 million in 2010.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision as noted. No issues have been raised.

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

1. DMH, Please provide a brief summary of the May Revision technical adjustment.

2. State Support for Mental Health Services Act (Proposition 63) (DOF issue 509)

Governor's January Budget & March Finance Letter. Through a Finance Letter in March, the Governor proposed to provide a total appropriation of *only* $19.1 million (Mental Health Services Act Funds) and 62 positions for State Administrative expenditures to support the Department of Mental Health, as well as all other State entities engaged in various Proposition 63 activities.

The Governor's Finance Letter reflected a *reduction* of $30.5 million (MHSA Funds) and 143 positions in State Administrative expenditures as compared to his January budget. This reduction eliminated the Mental Health Planning Council, cut by 50 percent the Mental Health Services Act Oversight and Accountability Commission, and eliminated all positions within education related to the Mental Health Services Act.

The Finance Letter reduced the Department of Mental Health's positions from a total of 146.5 positions to 34.3 positions, for a reduction of 112.2 positions.

In addition, trailer bill language was proposed to reduce the role of the Department of Mental Health's administrative functions relating to Proposition 63, and to make other related changes, including capping at 3.5 percent the amount of MHSA Funds that could be expended for State Administrative functions.

These State Administrative reductions were proposed in an effort to recognize the need to streamline State Government, to improve program efficiency and to direct more MHSA funding to county mental health programs.

Legislative Actions Contained in SB 69 Budget Bill. The Legislature modified the March Finance Letter by appropriating a total of $26.7 million (MHSA Funds) for State Administrative expenditures, or $7.6 million (MHSA Funds) more than the Finance Letter. A total of total of 67 positions were provided to various departments.

The Legislature *restored* funding and positions to the Mental Health Services Act Oversight and Accountability Commission (OAC), the Mental Health Planning Council, key contracts such as those that fund consumer advocacy and trainings, as well as key positions for education.

A total of 24 positions were provided to the DMH for their remaining functions, including 5 for the Mental Health Planning Council.

Governor's May Revision. The May Revision proposes to augment State Administration within the Department of Mental Health on a *one-time only basis* by $2.277 million (MHSA Funds) and 51 positions (25.5 personnel years) for transition planning purposes and to effectuate a State Staff reduction plan as a result of the MHSA realignment.

The 51 positions (25.5 personnel years) are positions that pertain to business functions, such as Accounting, Business Management, Data Processing, Personnel, and Legal. The DMH arrived at this request by already taking into account 27 vacant positions (as of April 15, 2011). This temporary funding and position authority is intended to provide the DMH with appropriate planning time to develop and implement a State Staff reduction plan that must conform to Department of Personnel Administration (DPA) and bargaining unit contract obligations. For this to occur, the DMH must identify the number of positions and classifications affected, confirm all affected staff's accurate State service credits and provide timely and complete notice to State Staff of their rights and obligations under the reduction plan.

The DMH projects that a State Staff reduction plan of this magnitude will take six to nine months to develop *and* implement.

Further, these requested positions and funding are intended to provide assistance in monitoring financial aspects of the funding, conducting certain accounting and data reporting, and facilitating a transition to the counties.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision as requested. The DMH needs to develop and implement a State Staff reduction plan as noted, and the requested positions will be used to complete certain data and fiscal requirements.

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

1. DMH, Please provide a brief summary of the May Revision request.

F. Emergency Medical Services Authority (EMSA)

1. Eliminate the Commission on Emergency Medical Services

Governor's May Revision. The May Revision proposes trailer bill language to eliminate the Commission on Emergency Medical Services as established by Chapter 8 of Division 2.5 of the Health and Safety Code (Section 1799, et al). This results in a decrease of $38,000 ($9,000 General Fund) in 2011-12.

The statutory duties of the Commission on Emergency Medical Services are as follows:

- Shall advise the Emergency Medical Services Authority (EMSA) on the development of an emergency medical data collection system;
- Shall advise the Director of the EMSA concerning the assessment of emergency facilities and services;
- Shall advise the Director of the EMSA with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system;
- Shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed by the EMSA; and
- Make recommendations for further development and future directions of the emergency medical services in the State.

The Administration states that the EMSA can obtain input from various other groups without the Commission on Emergency Medical Services structure in place.

Constituency Group Concerns. The Subcommittee is in receipt of several letters expressing concerns regarding the Administration's proposed elimination of this Commission. They state that the duties include the approval of regulations and guidelines developed by the EMSA to provide advice on a number of components of the emergency system, including appeals by local emergency medical service agencies which are critical to maintaining the system.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision by adopting placeholder trailer bill language as proposed to eliminate the Commission on Emergency Medical Services.

The EMSA is well established and does seek consultation and information from various professional groups and interested parties as necessary.

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

1. Administration, Please provide a brief description of the current functions of the Commission on Emergency Medical Services and the May Revision proposal.