

APPENDIX A

**MEDI-CAL
MAY 2008
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2007-08 and 2008-09**

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**MEDI-CAL
MAY 2008
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2007-08 and 2008-09**

ARNOLD SCHWARZENEGGER
Governor
State of California

S. Kimberly Belshé
Secretary
California Health and Human Services Agency

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DEPARTMENT OF HEALTH CARE SERVICES
BUDGET BALANCING REDUCTIONS
ASSUMES STATUTORY CHANGES ENACTED BY July 1, 2008
(Dollars in Millions)

Issue #	Reduction	2008-09		
		TF	GF	FFP
Medical Care Services				
1	Reduction to Provider Payments by 10%	-\$639.385	-\$326.285	-\$313.100
2	Reduction to Hospital Financing--DPH SNCP by 10%	-\$6.048	-\$6.048	\$0.000
3	Reduction to Non-Contract Hospitals by 10%	-\$54.188	-\$27.094	-\$27.094
4	Reduction to LTC Provider Payments by 10%	-\$98.470	-\$49.235	-\$49.235
5	Reduction to Private and NDH DSH Payment by 10%	-\$44.500	-\$22.600	-\$21.900
6	Discontinue Adult Chiropractic Services	-\$0.392	-\$0.196	-\$0.196
7	Discontinue Adult Incontinence Creams and Washes	-\$5.894	-\$2.947	-\$2.947
8	Discontinue Adult Acupuncture Services	-\$2.799	-\$1.400	-\$1.399
9	Discontinue Adult Optional Dental Services	-\$147.645	-\$73.823	-\$73.822
10 ^{1/}	Discontinue Adult Audiology Services	-\$3.458	-\$1.729	-\$1.729
11	Discontinue Adult Optometry/Optometrists Services	-\$1.017	-\$0.509	-\$0.508
12	Discontinue Adult Optician/ Optical Lab Services	-\$7.598	-\$3.799	-\$3.799
13	Discontinue Adult Podiatry Services	-\$1.710	-\$0.855	-\$0.855
14	Discontinue Adult Psychology Services	-\$0.189	-\$0.095	-\$0.094
15 ^{1/}	Discontinue Adult Speech Therapy Services	-\$0.220	-\$0.110	-\$0.110
16	Discontinue Part B Premium for Unmet SOC Benes	-\$53.767	-\$53.767	\$0.000
17	Reinstate Quarterly Status Reports for Parents	-\$7.595	-\$3.798	-\$3.797
18	Reduce CEC and Restore Quarterly Status Reports	-\$78.954	-\$39.477	-\$39.477
19	Reduction to FFACT Provider Payments by 10%	-\$18.221	-\$5.476	-\$12.745
20	Reduction to BCCTP (federal program) Provider Payments by 10%	-\$3.792	-\$1.327	-\$2.465
21	Reduction to Freestanding Pediatric Subacute Facilities Payments by 10%	-\$3.535	-\$1.768	-\$1.767
	Medical Care Services Subtotal	-\$1,179.377	-\$622.338	-\$557.039

**DEPARTMENT OF HEALTH CARE SERVICES
BUDGET BALANCING REDUCTIONS
ASSUMES STATUTORY CHANGES ENACTED BY July 1, 2008**

(Dollars in Millions)

Issue #	Reduction	2008-09		
		TF	GF	FFP
County Admin/Other Admin				
22	Reduction to CCS Case Management by 10%	-\$5.337	-\$2.188	-\$3.149
23	Reduction to EPSDT Case Management by 10%	-\$1.686	-\$0.590	-\$1.096
24	Reduction to MIS/DSS Contract by 25%	-\$2.100	-\$0.525	-\$1.575
25	Reduction to CNI-Based COLA to Counties	-\$64.598	-\$32.299	-\$32.299
26	Reduction to County Admin. Caseload Growth	-\$41.270	-\$20.635	-\$20.635
27	Reduction to County Admin. Base by 3.67%	-\$46.608	-\$23.304	-\$23.304
	County/Other Admin Subtotal	-\$161.599	-\$79.541	-\$82.058
Fiscal Intermediaries				
28	Reduction to FI Systems Group	-\$12.600	-\$2.100	-\$10.500
29	Reduction to CA-MMIS Modification	-\$1.700	-\$0.425	-\$1.275
30	Transition to EMT	-\$2.000	-\$1.000	-\$1.000
31	Reduction to Dental FI SURS	-\$2.800	-\$0.700	-\$2.100
32	Discontinue Vector Messages on TSC Provider Phone Lines	-\$0.600	-\$0.100	-\$0.500
	FI Subtotal	-\$19.700	-\$4.325	-\$15.375
Managed Care				
33	Reduction to Managed Care Provider Payments by 10%	-\$393.728	-\$196.864	-\$196.864
	Managed Care Subtotal	-\$393.728	-\$196.864	-\$196.864
	Total - All Reductions	-\$1,754.404	-\$903.068	-\$851.336

1/ Issue 10 and Issue 15 write-ups are combined.

Note: Totals may not add due to rounding.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits, Waivers Analysis, and Rates Division
Title: Reduce Provider Payments by 10%**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$326,285	\$313,100		\$639,385	
Governor's Budget					

Program Description

The Medi-Cal program was established by the Legislature to provide health care to uninsured Californians on March 1, 1966. Medi-Cal provides health care services for millions of low-income families with children, seniors, visually impaired, and disabled Californians. For approximately one half of the program, Medi-Cal pays providers directly through the traditional fee-for-service (FFS) method. In addition, the program contracts with managed care plans that develop their own provider networks to serve managed care beneficiaries. Approximately, 150,000 providers currently participate in the Medi-Cal FFS program.

Program Reduction

This budget reduction proposal reduces payments for FFS for Medi-Cal provider types/programs by ten percent. Except for the exemptions listed below, the payment reductions will apply to services rendered by any provider authorized to bill Medi-Cal for services.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

The following are exempt from the payment reductions for this proposal but in some cases are affected by other reduction proposals: contracted acute hospital inpatient services, Hospice, Federal Qualified Health Centers and rural health clinics; Breast and Cervical Cancer Treatment Program services (Federal Program), Family PACT services, and payments to long term care facilities, including but not limited to freestanding level B nursing facilities, intermediate care facilities for developmentally disabled individuals, freestanding sub-acute care units of skilled nursing facilities, and special treatment program services. All other Medi-Cal providers are subject to this proposal.

Non-Medi-Cal programs affected by the payment reductions include the following: California Children's Services, Every Woman Counts, Genetically Handicapped Persons Program, and the Child Health and Disability Prevention Program.

Reduction Impacts

As a result of this proposal, certain providers may choose not to continue their participation in the program. This may cause some beneficiaries to seek replacement services from higher cost facilities, such as federally qualified health centers and emergency rooms. To the extent this proposal causes beneficiaries to seek services from higher cost facilities, the savings expected from the proposed payment reduction will be reduced.

Timing of Implementation

The reduction will be effective July 1, 2008.

Statutory and/or Regulatory Change

This payment reduction will require a change in State statute and authority to implement the changes with regulations. Public notice is required prior to this change being effective and State Plan Amendments would also be required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Safety Net Financing Division

**Title: Increasing the Federal Reimbursement of the State-Funded Programs
through the Safety Net Care Pool**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$6,048			\$6,048	
Governor's Budget					

Program Description

The Safety Net Care Pool (SNCP) was established on July 1, 2005, to reimburse hospitals for uncompensated care they provide to the uninsured, as part of the *Medi-Cal Hospital/Uninsured Care Demonstration* (hospital financing waiver). There are 15 positions in the department that are authorized for implementing the program. The SNCP makes \$586 million available to be claimed using the certified public expenditures of designated public hospitals (DPHs) for uncompensated care to the uninsured, and by claiming State expenditures for four State-funded health care programs (called "federalizing"). Those State-funded programs include: the California Children's Services program; the Genetically Handicapped Persons Program; the Medically Indigent Adult – Long Term Care Program; and the Breast and Cervical Cancer Treatment Program. The federalizing of the four State-funded programs allows federal funds to replace State General Fund (GF) for up to 50 percent of the health care costs for documented beneficiaries who receive services under these programs.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

The State GF freed up by the federalizing of the State-funded programs is used to provide stabilization funding for the DPHs, Non-designated Public Hospitals (NDPHs), private hospitals, and distressed hospitals, in addition to reimbursing the State for the \$32.7 million GF increase that resulted from changes to hospital reimbursement under the hospital financing waiver.

The distribution of the SNCP is based on formulas specified in section 14166 et seq. (SB 1100 (Chapter 560, Statutes of 2005)), and as amended by SB 474 (Chapter 518, Statutes of 2007). Additionally, SB 474 requires that \$100 million of the SNCP monies be allocated to the newly created South Los Angeles Medical Services Preservation Fund.

Program Reduction

The DPHs and the South Los Angeles Medical Services Preservation Fund would receive a ten percent reduction in SNCP payments. This ten percent would allow the Department to use more of the four State-funded program expenditures to claim additional Federal Financial Participation to replace GF in these four programs. The Department would not be required to use this additional GF savings for baseline or stabilization payments to the hospitals and instead would use these funds to reduce General Fund expenditures.

Reduction Impacts

In Demonstration Year 2008-09, the DPHs are estimated to receive \$542 million from the SNCP (including the South Los Angeles Medical Services Preservation Fund). The Department would reduce the amount of the SNCP payments to the DPHs and the Los Angeles County by 10 percent or \$54.2 million. The additional federal funds, based on the expenditures of the four federalized State-funded programs, will replace GF in both the Family Health and Medi-Cal budgets.

A reduction in funding to hospitals funded under the hospital financing waiver may impact the hospital safety net delivery system, which could impact Medi-Cal beneficiaries and uninsured individuals' access to services.

The amount of stabilization to the NDPHs, privates, or distressed hospitals would not change.

Timing of Implementation

The reduction will be effective July 1, 2008.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Statutory and/or Regulatory Change

Any change in the amount to be allocated to the hospitals or a change in the calculation of SNCP funds would require legislation including notice to the federal government of this funding change.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Safety Net Financing Division

Title: Reduction in Payments and Reimbursable Cost to Non-Contract Hospitals

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$27,094	\$27,094		\$54,188	
Governor's Budget					

Program Description

The Department of Health Care Services (DHCS) administers the Selective Provider Contracting Program (SPCP) which allows the State to selectively contract with hospitals to provide inpatient services to Medi-Cal beneficiaries. The California Medical Assistance Commission (CMAC) regulates hospital contracts and ensures Medi-Cal beneficiary health care access by maintaining the patient/hospital ratio throughout the state. CMAC negotiates per diem rates and supplemental payment amounts for contract hospitals on a competitive basis. Of the approximately 440 general acute care hospitals statewide, about 200 hospitals are participating in the SPCP.

Non-contract hospitals are hospitals that do not participate in the SPCP program. Non-contract hospitals tend to be located in rural areas of the State; however, a number now exist in urban areas. Non-contract hospitals can be limited in the number of beds they offer due to the size of the facility and may not offer certain specialty services.

Non-contract hospitals are paid an interim reimbursement rate for inpatient services provided to Medi-Cal beneficiaries that is expressed as a percentage of cost/charges.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

The interim rate paid to these hospitals approximates their reimbursable costs, and is subject to settlement based on a financial audit performed by Audits and Investigations (A&I) to determine allowable cost for reimbursement. A&I is responsible for establishing the interim rates which are routinely reviewed on an annual basis as part of the required Medi-Cal cost report filing with the Department. The estimated aggregate Fee-For-Service payment to these hospitals in Fiscal Year 2007-08 is \$716 million.

Program Reduction

Under this proposal non-contract hospital inpatient payments would be reduced by ten percent. The reduction in payments and reimbursable cost is applicable to all non-contract hospitals except (1) Hospitals that participate in the SPCP; (2) Hospitals that provide 100 percent psychiatric services; (3) and designated public hospitals that participate in the Medi-Cal Hospital/Uninsured Care Demonstration waiver.

This proposal would reduce the hospital's existing interim rate by ten percent. The ten percent reduction would be effective for dates of service on the effective date of the change and would be permanent.

A correlating provision is needed to prevent the refunding of the ten percent monies when A&I does the final settlement and when interim rates are adjusted. Without a provision, non-contract hospitals would be fully cost reimbursed for Medi-Cal inpatient services. Also, a provision would be needed to temporarily "freeze" accommodation rates to avoid hospitals from requesting higher approved rates to offset any perceived decrease due to the ten percent interim rate reduction.

Medi-Cal managed care plan would receive the 10% reduction, reflected in their rates.

Reduction Impacts

This proposal would limit non-contract hospital payments to 90 percent of their allowable rate of payment or cost. A&I also would be required to perform additional reduction-related activities, including the preparation of rate adjustment notices for submittal to EDS and the calculation of final cost settlements for each non-contract hospital.

To the extent that the Department is able to maintain high participation in the SPCP, this rate reduction should not impact access to hospital services for Medi-Cal beneficiaries in urban areas. However, the reduction could impact some rural hospitals operating under less stable financial conditions. Other programs that rely upon the Medi-Cal inpatient interim rate percentage for payments related to their programs would need to be notified.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective three months after adoption of State legislation authorizing this change.

Statutory and/or Regulatory Change

The reduction will require a change in State statute and emergency regulation authority.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Benefits, Waiver Analysis and Rates Division (BWRD)
Title: Reduce Selected Long Term Care Payments by 10 Percent**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$49,235	\$49,235		\$98,470	
Governor's Budget					

Program Description

The Medi-Cal program was established on March 1, 1966 and began reimbursing for long term care (LTC) services shortly thereafter. LTC providers include freestanding (FS) and distinct part (DP) nursing facilities (NF), intermediate care facilities for the developmentally disabled (ICF/DD), Adult Day Health Care (ADHC) agencies, hospice, and other facility types. These facilities provide care to Medi-Cal beneficiaries in need of LTC services. Reimbursement rates for LTC services are based on two-year-old cost data that are projected forward to determine a prospective reimbursement rate.

Program Reduction

The budget reduction proposes a ten percent payment reduction to the proposed 2008-09 rates for DP NFs, NFs Level A, ADHC agencies, and other facility types. Nursing facility level Bs and intermediate care facilities for the developmentally disabled are excluded from the rate reductions because they pay a fee that helps pay for the cost of services. The state achieves budget savings from the fee; these fees are paid in lieu of the rate reductions.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

The ten percent reduction in the payment of LTC services will impact the following facility types: Nursing Facility level A; Distinct Part Nursing Facilities level B; Distinct Part Subacute facilities; Rural Swing Bed facilities; and Adult Day Health Care.

As a result of this proposal, certain providers of LTC services to Medi-Cal beneficiaries may choose not to continue their participation in the program. To the extent providers stop accepting Medi-Cal patients, it may result in some patients having to stay longer in acute hospitals before they can be placed in nursing facilities or at home.

Timing of Implementation

The reduction will be effective July 1, 2008. Advance notification to all Medi-Cal LTC facilities of a reduction in reimbursement payments is required.

Statutory and/or Regulatory Change

A reduction in payment of LTC rates will require a change in State statute and authority to implement without regulations. In addition, a State Plan Amendment and reimbursement regulations modifications are required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits, Waivers Analysis and Rates Division
Title: Reduce Medi-Cal Benefits of Chiropractor Services**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$196	\$196		\$392	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Chiropractic services were established in 1982 and are currently covered as an optional benefit under the Medi-Cal program as a Medi-Service (restricted to two/month). California is one of 27 states that offers this benefit. Chiropractic services include bone and joint manipulation for the relief of pain.

Program Reduction

This proposal will reduce the number of Medi-Cal optional benefits by no longer offering chiropractic services for adults 21 years of age or older who are not in a nursing facility.

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to chiropractic services. The total annualized reduction for this change has been reduced by twenty-five percent due to increased costs for physician services. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in State statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits, Waivers Analysis and Rates Division
Title: Reduce Medi-Cal Benefits of Chiropractor Services**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$196	\$196		\$392	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Chiropractic services were established in 1982 and are currently covered as an optional benefit under the Medi-Cal program as a Medi-Service (restricted to two/month). California is one of 27 states that offers this benefit. Chiropractic services include bone and joint manipulation for the relief of pain.

Program Reduction

This proposal will reduce the number of Medi-Cal optional benefits by no longer offering chiropractic services for adults 21 years of age or older who are not in a nursing facility.

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to chiropractic services. The total annualized reduction for this change has been reduced by twenty-five percent due to increased costs for physician services. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in State statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Pharmacy Benefits Division

Title: Eliminate Incontinence Creams and Washes as an Optional Benefit

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$2,947	\$2,947		\$5,894	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Coverage of incontinence medical supplies was established in 1976 with the adoption of regulations for the coverage of medical supplies (CCR Title 22 section 51320). Federal Medicaid law recognizes medical supplies, in general, as an optional benefit. From its inception, Medi-Cal has experienced increasing program costs for incontinence medication supplies and fraud in this program area. Welfare and Institutions (W&I) Code, Section 14125.4 in 1993, limited expenditures for incontinence medical supplies per beneficiary to no more than \$165 per month including sales tax. Incontinence creams and washes are exempt from this law. Medi-Cal currently contracts with a variety of manufacturers and re-labelers to provide reasonably priced incontinence supplies to Medi-Cal providers. Contracts for incontinence creams and washes were signed in November 2007 and are estimated to reduce expenditures by \$1.3 million TF (\$650,000 GF) annually.

To obtain products, beneficiaries must have a doctor certify the medical condition that is causing their incontinence and obtain a prescription. Beneficiaries may fill prescriptions through any authorized Medi-Cal provider (usually a pharmacy or durable medical equipment dealer).

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Currently, there are more than 7,000 Medi-Cal providers (pharmacies and medical supply companies) in California authorized to sell incontinence supplies to Medi-Cal beneficiaries. Medi-Cal does not reimburse for incontinence supplies for patients under age five.

Program Reduction

This proposal will reduce the services provided by Medi-Cal by no longer providing coverage for incontinence creams and washes. These products can be replaced through the use of commercially available soap and skin creams.

Reduction Impacts

Beneficiaries will have to purchase these incontinence creams and washes which are readily available at drug stores and don't require a prescription.

Reimbursement rates that include incontinence medical supplies (e.g. nursing facility daily rate) would need to be recalculated. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

This reduction will require a change in State statute and emergency regulations:

CCR Title 22 Section 51526(c), W&I 14125.4(a)

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits Waivers and Rates Division
Title: Eliminate Acupuncture Services as an Optional Benefit**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$1,400	\$1,399		\$2,799	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Acupuncture services were established in 1981 and are currently covered as an optional benefit under the Medi-Cal program (restricted to two sessions per month). Acupuncture services include treatment for pain syndromes and other medical conditions. These services are used widely for the relief of the symptoms of AIDS.

Program Reduction

This proposal will reduce the number of Medi-Cal optional benefits by no longer offering acupuncture services for adults 21 years of age or older who are not in a nursing facility.

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to acupuncture services. It is not anticipated that the program will experience increased cost to other services if acupuncture is no longer offered as an optional benefit. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in State statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary Contracts Oversight Division
Title: Eliminate Adult Dental as an Optional Benefit**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$73,823	\$73,822		\$147,645	
Governor's Budget					

Program Description

Medi-Cal has been providing health and dental care services to Californians since 1965. Medi-Cal beneficiaries access services through Medi-Cal's fee-for-service (FFS) and managed care programs. Medi-Cal is the funding source for health care services for low-income children, their parents, pregnant women, and seniors and people with disabilities. In addition to providing those benefits that are required by federal law, California is one of six states that offer this benefit. The Denti-Cal program provides comprehensive primary and specialty dental care for adults and children. The categories of service (including periodicity of services and clinical criteria for covered services) parallel those found in commercially available dental benefits plans. In 2003 and 2004 the state implemented a number of program changes that resulted in cost savings: pre-treatment x-rays to justify medical necessity for restorations; reduced payment rate for subgingival curettage and root planning; restricted use for posterior laboratory processed crowns for adults; and, increased provider enrollment requirements. Additionally, in 2006 an annual cap of \$1,800 was imposed on adult dental services (per beneficiary), excluding certain services.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

The Medi-Cal budget includes \$613 million (\$306.5 million GF) in FY 2008-09 to offer dental services to Medi-Cal beneficiaries (approximately 6.6 million), of whom approximately 2 million utilize services.

Program Reduction

This proposal will reduce Medi-Cal benefits of adult dental services by reducing coverage for all non federally required adult dental services for persons 21 years of age and older. However, the program will continue to pay a dentist for a service that could be provided by a physician and services for people in nursing facilities, as required by federal law. Under this proposal, this population would no longer receive care such as cleanings, examinations, periodontics, endodontics (root canals), restorative care such as crowns, and fillings, oral surgery/extractions, x-rays, related drugs/anesthesia, certain emergency dental-specific services, dentures (full and partial), and Maxillofacial services. AB X3 5 (Chapter 3, Statutes of 2008) requires payments to many providers to be reduced by 10% beginning July 1, 2008. Therefore, a 10% reduction of the total estimated savings has been applied to this policy change.

Reduction Impacts

Approximately half of the 6.6 million Medi-Cal beneficiaries are adults 21 years of age or older (roughly 3 million). These are the persons who will no longer have comprehensive dental care available if optional adult dental services are eliminated (federally required adult dental services would remain a benefit). When these beneficiaries need dental care, they will have to pay for the services. Lack of treatment often results in emergency room visits. This results in a shift and increase to medical and hospitals costs; that has been adjusted into the savings amount.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Reduction of this benefit would require statutory and/or regulatory changes and appropriate State Plan Amendments.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits, Waivers Analysis, and Rates Division
Title: Eliminate Speech and Audiology Services as an Optional Benefit

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$1,839	\$1,839		\$3,678	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Speech and audiology services were established in 1976 and are currently covered as an optional benefit under the Medi-Cal program. California is one of 40 states that offer this benefit. Speech services include language evaluation, speech evaluation, therapy, and speech generating device assessment. Audiology services include screening, diagnostic evaluations, hearing aid evaluations, and hearing therapy. Many of these patients may also receive long-term care. The bulk of services are for audiological evaluations for hearing aids.

Program Reduction

This proposal will reduce the number of Medi-Cal optional benefits by no longer offering speech and audiology services for adults 21 years of age or older who are not in a nursing facility.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to speech or hearing therapy or screenings and diagnosis for hearing aids. This change will also reduce the number of hearing aids and hearing aid devices provided by Medi-Cal.

The total annualized reduction for this change has been reduced by fifty percent due to increased costs for nursing facilities. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in state statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Pharmacy Benefits Division
Title: Eliminate Optometry Services as an Optional Benefit**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$509	\$508		\$1,017	
Governor's Budget					

Program Description

The Medi-Cal Vision Services Branch (VSB) of the Medi-Cal Pharmacy Benefits Division (MPBD) in the Department of Health Care Services (DHCS) is responsible for administering, establishing, and maintaining the policy governing vision care benefits for the Medi-Cal Program. In addition, VSB adjudicates Treatment Authorization Requests (TARs) for medically necessary eye appliances; provides professional consultation to Medi-Cal providers and field office consultants; serves in a staff capacity in the formulation, implementation, interpretation, and evaluation of laws, regulations, policies and procedures relating to vision care benefits under the provisions of the Medi-Cal program; works with other elements of the Department and Prison Industries Authority in their activities in vision care aspects of the Medi-Cal program; and prepares oral and written responses to communications relating to vision care.

Adult optometry services are currently covered as optional benefits under Medi-Cal. California is one of 40 states that offer this benefit. This coverage was established in 1971 and includes routine eye examinations and eyeglasses, as well as diagnostic and ancillary eye procedures to protect the health of the eye. In addition, this coverage also

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

includes medically necessary contact lenses and low vision aids by TAREquest and prosthetic eye services for the visually impaired.

There are approximately 1,200 ophthalmologists and 2,600 optometrists that accept Medi-Cal in California (CA).

Program Reduction

This proposal will reduce the number of optional Medi-Cal benefits by no longer offering optometry services to Medi-Cal beneficiaries, except those under 21 years of age and persons in nursing facilities.

Reduction Impacts

Adult Medi-Cal beneficiaries will be required to obtain eye examinations and other vision services from ophthalmologists rather than optometrists. This reduction has been reduced to account for a cost shift to ophthalmologist services. The annualized reduction has been adjusted to account for increased emergency room and community clinic visits since many ophthalmologists will not provide routine eye examination services. In addition, since very few ophthalmologists practice in rural areas of CA, this reduction may impact access to vision services for many adult Medi-Cal beneficiaries.

Beneficiaries who are legally blind or visually impaired (most of whom are over 21 years of age) depend on the Medi-Cal program for low-vision services and devices for activities of daily living and independent living. These beneficiaries will no longer have such benefits. Costs for some of these services may shift to the CA Department of Rehabilitation.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Will require a change in State statute or emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Pharmacy Benefits Division**

Title: Reduce Medi-Cal Benefits of Optician/Optical Laboratory Services

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$3,799	\$3,799		\$7,598	
Governor's Budget					

Program Description

The Medi-Cal Vision Services Branch (VSB) of the Medi-Cal Pharmacy Benefits Division (MPBD) in the Department of Health Care Services (DHCS) is responsible for administering, establishing, and maintaining the policy governing vision care benefits for the Medi-Cal Program. In addition, VSB adjudicates Treatment Authorization Requests for medically necessary eye appliances; provides professional consultation to Medi-Cal providers and field office consultants; serves in a staff capacity in the formulation, implementation, interpretation, and evaluation of laws, regulations, policies and procedures relating to vision care benefits under the provisions of the Medi-Cal program; works with other elements of the Department and Prison Industries Authority in their activities in vision care aspects of the Medi-Cal program; and prepares oral and written responses to communications relating to vision care.

Opticians/optical labs are currently covered as an optional benefit under Medi-Cal. Optician providers dispense prescription eyeglasses and contact lenses prescribed by optometrists and ophthalmologists to Medi-Cal beneficiaries. All 50 states offer optician benefits to Medicaid recipients.

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Unlike optician providers, fabricating optical laboratories produce eyeglasses for Medi-Cal beneficiaries. In 1988, the Governor, by Executive Order, established an Interagency Agreement (IA) between the Department of Health Services (DHS) and Prison Industry Authority (PIA) to fabricate eyewear for Medi-Cal beneficiaries. In December of that year, the first PIA fabricating optical laboratory at R.J. Donovan Correctional Facility (RJD) in San Diego began manufacturing eyewear for the Medi-Cal population. Today, in addition to RJD, PIA also has fabricating optical laboratories at California State Prison-Solano, Pelican Bay State Prison and Valley State Prison for Women. In 2006, the four PIA optical laboratories produced approximately 830,000 pairs of eyeglasses for Medi-Cal beneficiaries in 56 of 58 California Counties. California is one of 13 States that use the prison system to fabricate eyewear for Medicaid beneficiaries.

Program Reduction

This proposal will reduce the number of optional Medi-Cal benefits by no longer offering Optician/Optical Lab coverage for adults 21 years of age or older who are not in a nursing facility.

Reduction Impacts

Adult Medi-Cal beneficiaries would no longer receive eyeglasses under the program. Without such services, adults in need of them will have difficulty with driving, reading, and other activities of daily living. This proposal will also reduce the costs of the interagency agreement between the Department and PIA, because the Department reimburses PIA for one-half of the costs of the courier service that delivers orders between the optical providers and PIA. For more information, see policy change Other Admin, Reduction to PIA Eyewear Courier Service.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

This reduction will require a change in State statute or emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits, Waivers Analysis, and Rates Division
Title: Reduce Medi-Cal Benefits Provided by a Podiatrist**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$855	\$855		\$1,710	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Coverage of services provided by a podiatrist was established in 1974 and is currently covered as an optional benefit under the Medi-Cal program (restricted to two sessions per month). California is one of 44 states that offer this benefit. Podiatry services include medical and surgical services necessary to treat disorders of the feet, ankles, or tendons of the foot rendered by a podiatrist. Most podiatry services are provided to treat conditions that complicate chronic medical diseases, or disorders that significantly impair the ability to walk.

Program Reduction

This proposal will eliminate, as a Medi-Cal optional benefit, podiatry services rendered by a podiatrist for adults 21 years of age or older who are not in a nursing facility. Podiatry services that are performed by physicians would not be affected by this reduction.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to podiatry services. The total annualized reduction for this change has been reduced by forty percent due to increased costs for other services, primarily physician services. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in State statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Benefits Waivers and Rates Division
Title: Eliminate Psychology Services as an Optional Benefit**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$95	\$94		\$189	
Governor's Budget					

Program Description

Medi-Cal covers virtually every optional benefit in the Medicaid program providing a wide range of benefits. Psychology services were established in 1976 and are currently covered as an optional benefit under the fee-for-service Medi-Cal program (restricted to two sessions per month unless provided by a county mental health department through a consolidation agreement with the Department of Mental Health). California is one of 34 states that offer this benefit. Psychology services include those services provided by or under the supervision of a licensed psychologist. The vast majority of psychology services are provided by a county mental health department through a consolidation agreement with the Department of Mental Health. Psychology services that are provided by a county mental health department would not be affected by this reduction as they are certified as rehabilitative optional services.

Program Reduction

The reduction will be effective three months after adoption of state legislation authorizing this change.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

Beneficiaries who are 21 years or older and not in a nursing facility will not have access to psychology services. The total annualized reduction for this change has been reduced by fifty percent due to increased costs for other services, primarily psychiatric services. Future Managed Care capitation rates will be adjusted to reflect the elimination of this benefit.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Requires a change in state statute and authority to implement the change by provider bulletin.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Third Party Liability and Recovery Division
Title: Cessation of Payment of Part B Premiums for Share of Cost (SOC)
Beneficiaries**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$53,767			\$53,767	
Governor's Budget					

Program Description

The Third Party and Liability Division, Medicare Operations Unit is responsible for the Medicare Premium Payment Program. Medicare premium payment allows Medi-Cal to pay Medicare Part A (inpatient) and/or Part B (outpatient) premiums for Medi-Cal beneficiaries and others who qualify for Medi-Cal under special programs, allowing Medi-Cal to defer costs for medical care to Medicare.

Under the authority of Section 1843 of the Social Security Act (1966), the State of California participates in a buy-in agreement with the Centers for Medicare and Medicaid Services, whereby Medi-Cal automatically pays Medicare Part B premiums for all Medi-Cal beneficiaries who have Medicare Part B entitlement in the following groups:

- Medicare Savings Program individuals, who are not on Medi-Cal, but who qualify for Medicare premium payments under Federal income and asset rules;
- Full Scope Medi-Cal recipients, who are currently both Medicare Part B entitled and Medi-Cal eligible with no Share of Cost (SOC).

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Thirty-one (31) states participate in similar Buy-In agreements.

In addition to these two groups the state pays Part B premiums for a third group; Medi-Cal Share of Cost individuals who are Medicare entitled but whose adjusted income exceeds the Federal income limit of 129% of the Federal Poverty Level (FPL). In the twelve months preceding March 2008, there was a monthly average of 72,226 individuals in the SOC group. Medi-Cal pays the part B premium for this entire group eventually these individuals who are not certified are Medi-Cal eligible by meeting their share of cost spend down. This is a state only program and is not eligible for federal funding. There is no federal requirement for the payment of Medicare premiums for these groups of individuals who do not meet their share of cost.

Program Reduction

Cease payment of Medicare Part B premiums for the Medi-Cal SOC groups who do not meet their share of cost spend down.

Reduction Impacts

Approximately 60,712 dual eligible individuals, primarily aged, blind and disabled with income above 129 percent of the FPC, will be required to pay \$96.40 per month through December 2008 and \$99.40 per month from January 2009 to June 2009, to receive Medicare Part B benefits. Some will choose not to pay the optional Part B premiums for financial reasons and will have to pay for outpatient medical services out of pocket until they meet their Medi-Cal SOC. The inability or refusal to pay out of pocket costs could result in the beneficiary abstaining from preventative outpatient care, resulting in expensive emergency treatment.

Timing of Implementation

The reduction will be effective three months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

This proposal requires legislative authority to reduce the Part B premium payments without regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Eligibility Division
Title: Reinstate the Quarterly Status Reports for Parents**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$3,798	\$3,797		\$7,595	
Governor's Budget					

Program Description

In January 2001, the quarterly status report was eliminated for parents eligible for Medi-Cal only. For over 20 years, the Medi-Cal program had a stringent quarterly status report (QSR) requirement. The QSR form was complex and required submission of documentation on income and assets, even if there was no change to report. The QSR applied to parents and most children, but did not apply to aged, blind, disabled, pregnant women, and infants up to one year of age. In order to contain Medi-Cal costs and to ensure that people receiving Medi-Cal benefits were eligible, on October 2003, a simplified midyear status report (MSR) was implemented for parents. The simplified MSR only requires that the beneficiary check a box if there are no changes, and sign the form. If the person has changes that could affect their eligibility, they are required to describe those changes. Counties send these forms out without a review of the case file and the SB 87 ex-parte re-determination process is used to resolve any problems that occur with submitted forms. Most counties implemented this form on a phase-in basis between October 2004 and March 2005.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

Program Reduction

Reinstate the QSR for parents, effective July 2008. Beneficiaries would complete three quarterly reports each year utilizing a simplified form modeled after the current MSR form. Additionally, an annual redetermination form would continue to be required. The current process of sending out the forms and the use of SB 87 procedures for returned forms would be used.

Reduction Impacts

Parents who are no longer eligible for Medi-Cal will lose their Medi-Cal coverage up to 3 months earlier than they do now, producing program savings. People who move or have an income or employment change often do not inform Medi-Cal of this change requiring Medi-Cal to pay for coverage that is no longer necessary nor often wanted. Since Medi-Cal does not require a premium payment, this reporting is the only way that Medi-Cal can ensure contact with beneficiaries and ensure that they are still eligible. As Medi-Cal makes monthly payments to health plans and for dental coverage, it is important that these payments only be made for people who are eligible.

Also, beneficiaries may fail to complete the QSR status report even if they are still eligible for the program, making them ineligible for Medi-Cal services resulting in Medi-Cal savings. However, beneficiaries who forget to submit their forms and still need coverage can have their Medi-Cal coverage reinstated if they submit their forms within 30 days of losing coverage.

Reinstatement of the QSR would require systems changes for the automated county eligibility systems and increased county administrative workload to process the QSR forms.

Medi-Cal reporting has an impact on food stamp reporting and food stamp error rates. To the extent that a county receives any report from a beneficiary on income or assets, counties and the SDSS send a report to DHCS that the county must do a redetermination of food stamp eligibility.

Timing of Implementation

The reduction will be effective four months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

Will require a change in state statute and emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Medi-Cal Eligibility Division

Title: Reduce Continuous Eligibility for Children and Restore
Quarterly Status Reports

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$39,477	\$39,477		\$78,954	
Governor's Budget					

Program Description

Continuous Eligibility for Children (CEC) was implemented January 1, 2001, and was authorized by Assembly Bill (AB) 2900, Chapter 945, Statutes of 2000. Currently, children found eligible for no cost Medi-Cal receive continuous coverage until their annual re-determination, even if family income and/or assets have increased. Families are required to report changes in income, assets, etc., within ten days of the change, in mid-year status reports, and at annual re-determination. If they report any increase in income or assets prior to the annual determination that affect the family's eligibility, the children retain coverage as they have continuous coverage. Children are currently exempt from the Mid-Year Status reporting requirement that is applicable to parents. Children ineligible for no share of cost Medi-Cal because of income are bridged to the Healthy Families Program.

Program Reduction

This proposal would eliminate CEC and would restore the Quarterly Status Report (QSR) process to children.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

Reduction Impacts

Eliminating CEC could result in children whose families are no longer income eligible for Medi-Cal transitioning earlier to the Healthy Families Program to receive coverage. Implementation of QSR for children will require these families to report changes in income and assets quarterly in addition to the ten-day and annual reporting requirement. Any reported increase may result in ineligibility because of assets or a share of cost due to income. Children found ineligible for no share of cost Medi-Cal because of income or resources would be bridged to the Healthy Families Program earlier. Medi-Cal would reduce program expenditures by no longer covering children who were income ineligible for the program.

State systems changes are minimal, but counties would have to change their automated eligibility systems. There also would be increased county administrative workload to process the QSR forms.

Timing of Implementation

The reduction will be effective four months after adoption of state legislation authorizing this change.

Statutory and/or Regulatory Change

This change would require State statute changes and emergency regulations for both reduction of CEC and reinstating Quarterly Status Reports. A State Plan Amendment for eliminating CEC also would be required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Benefits, Waiver Analysis and Rates Division (BWRD)
Title: Reduce F-PACT Payments by 10 Percent**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$5,476	\$12,745		\$18,221	
Governor's Budget					

Program Description

The Medi-Cal program was established on March 1, 1966 and began reimbursing for family planning services shortly thereafter. The Family Planning, Access, Care and Treatment Program (FPACT) was created in 1997.

Program Reduction

The budget reduction proposes a ten percent payment reduction to the payments for specified services and provider groups. FPACT services are currently exempted from the ten percent payment reduction.

Reduction Impacts

This proposal would eliminate the exemption for FPACT services provided to Medi-Cal beneficiaries. As a result of this proposal, some providers of FPACT services may choose not to continue their participation in the program. To the extent providers stop accepting Medi-Cal patients, it may result in some patients accessing these services through higher cost providers, such as hospital outpatient departments.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective July 1, 2008. Advance notification to all FFACT providers of a reduction in payments is required.

Statutory and/or Regulatory Change

A reduction in payment for FFACT services will require a change in State statute and authority to implement without regulations. In addition, a State Plan Amendment and reimbursement regulations modifications are required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Benefits, Waiver Analysis and Rates Division (BWRD)
Title: Reduce BCCTP Payments by 10 Percent**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$1,327	\$2,465		\$3,792	
Governor's Budget					

Program Description

The Medi-Cal program was established on March 1, 1966. The Breast and Cervical Cancer Treatment Program (BCCTP) has been in existence since 2002, and is administered by the California Department of Public Health. Reimbursement rates for BCCTP services are based on Medi-Cal fee-for-service rates for similar services.

Program Reduction

The budget reduction proposes a ten percent payment reduction to the payments for specified services and provider groups. BCCTP services are currently exempted from the ten percent payment reduction.

Reduction Impacts

This proposal would eliminate the exemption for BCCTP services provided to Medi-Cal beneficiaries. As a result of this proposal, some providers of BCCTP services may choose not to continue their participation in the program. To the extent providers stop accepting Medi-Cal patients, it may result in some patients accessing these services through higher cost providers, such as hospital outpatient departments.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction will be effective July 1, 2008. Advance notification to all BCCTP providers of a reduction in payments is required.

Statutory and/or Regulatory Change

A reduction in payment for BCCTP services will require a change in State statute and authority to implement without regulations. In addition, a State Plan Amendment and reimbursement regulations modifications are required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Benefits, Waiver Analysis and Rates Division (BWRD)
Title: Freestanding Pediatric Subacute Payments**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$1,768	\$1,767		\$3,535	
Governor's Budget					

Program Description

The Medi-Cal program was established on March 1, 1966. Freestanding pediatric subacute (FPS) facilities provide care to Medi-Cal beneficiaries in need of a specialized level of long term care service. Reimbursement rates for FPS services are based on two-year-old cost data that are projected forward to determine a prospective reimbursement rate.

Program Reduction

The budget reduction language does not propose a ten percent payment reduction to the 2008-09 rates for FPS facilities in either fee-for-service Medi-Cal or Managed Care Medi-Cal.

Reduction Impacts

As a result of the proposal to not reduce payments to FPS facilities, pediatric subacute services provided in a Distinct Part pediatric subacute (DP/PS) facility, may shift to the FPS facilities. To the extent providers stop accepting Medi-Cal patients, it may result in some patients having to stay longer in acute hospitals before they can be placed in nursing facilities or at home.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Timing of Implementation

The reduction of other long-term care facility payment reductions will be effective July 1, 2008. Advance notification to all Medi-Cal FPS facilities of a reduction in reimbursement payments is required.

Statutory and/or Regulatory Change

No statutory or regulatory change is required.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Systems of Care Division

Title: 10% Reduction in Medi-Cal funding for CCS Case Management

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$2,188	\$3,149		\$5,337	
Governor's Budget					

Program Description

The California Children's Services (CCS) program, established in 1927, provides case management and authorization of services for 170,000 individuals with complex and/or chronic medical conditions. County CCS programs receive Medi-Cal administrative funding in support of administrative case management activities for Medi-Cal eligible CCS children in their caseloads. This funding is allocated to individual counties in conjunction with CCS-only state Funding and Title XXI State Children's Health Insurance federal funds. There have been no recent program expansions.

The funding, for approximately 1,700 county FTEs (statewide), is provided based on county administrative budgets approved by the State CCS program. The budgets are based on uniform staffing standards and current caseload projections for the budget period.

Program Reduction

The proposal would reduce 10% of funding to support the county programs' administrative case management of CCS clients who are Medi-Cal beneficiaries.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

This reduction will likely impact CCS programs processing times for eligibility determinations, determining medically necessary services, and authorizing services. There would be no direct impact on other health care programs, or to state revenues or fees. If counties reduce staffing levels they could face challenges depending on the requirements of labor bargaining agreements.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

This proposal will require a change in state statute and emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Systems of Care Division**

**Title: 10% Reduction in Early and Periodic Screening Diagnosis and Treatment Case
Management funds for Local Child Health and Disability Prevention Programs**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$590	\$1,096		\$1,686	
Governor's Budget					

Program Description

The Child Health and Disability Prevention Program (CHDP), established in 1975, implements the federal Medicaid requirements of the Early and Periodic Screening requirements of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit of the Medi-Cal program. The local (county or city) CHDP programs are required to perform EPSDT care coordination; approval, enrollment and oversight of providers; and outreach and education. The program was expanded in 2003 with the implementation of the CHDP Gateway.

Medi-Cal provides \$37.5 million (\$13.2 million General Fund) in funding for support of staff in the local CHDP Programs which serve Medi-Cal eligible children who receive CHDP screening and immunization services.

Program Reduction

Reduce funding for county case management activities by 10%.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Reduction Impacts

CHDP programs would have reduced ability to do follow-up work to ensure that children get the treatment necessary to address conditions detected in their health care screenings. In addition, local CHDP programs may be delayed in visiting the offices of new providers who wish to participate in the CHDP program. There could be a potential impact on Medi-Cal beneficiaries' access to CHDP health assessments and immunizations, although access to services has traditionally not been a problem in the CHDP program.

There would be no direct impact on other programs, or on state revenues or fees. If counties reduce staffing levels they could face challenges depending on the requirements of labor bargaining agreements

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

This proposal will not require a change in state statute or emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division
Title: Reduce Management Information System/Decision Support System
Contract by 25%**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$525	\$1,575		\$2,100	
Governor's Budget					

Program Description

The Management Information System/Decision Support System (MIS/DSS) project was initiated in June of 1996, to procure and oversee the development of a Medi-Cal data warehouse. The purpose of this project was to establish a comprehensive information system to support the day-to-day and contract management needs of the Medi-Cal program, and to significantly enhance the availability of Medi-Cal information for staff that monitor and oversee Medi-Cal services including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance and Audits and Investigations in its anti-fraud efforts. The Department of General Services (DGS) conducted a competitive procurement and executed the first MIS/DSS contract on April 17, 1997 (through various extensions, this contract was in force until January 17, 2007). The Department of Finance (DOF) required an Independent Assessment of the MIS/DSS system. It was conducted in August 2004 and documented that the MIS/DSS had a positive return on investment (ROI) of over \$156 Million in State fiscal year (FY) 2003-04, and estimated a higher return in future years. One of the systems' most valuable assets is the consolidation of data from many disparate Medi-Cal operational systems.

2008-09 Governor's Budget Budget-Balancing Reduction Proposal (Dollars in Thousands)

The Management Information System/Decision Support System (MIS/DSS) gathers data from provider, financial, eligibility and managed care/fee-for-service encounters and claims data and organizes it into an integrated, knowledge-based system used by staff in DHCS, Department of Public Health (CDPH), and the Office of the Legislative Analyst (LAO).

On September 1, 2005, DHCS received approval from DOF for a new project (the Next Generation MIS/DSS), to procure and implement a new/replacement MIS/DSS solution. The current contract builds on the success of the original project and enhances it by adding new business components and updating the system to reflect technological advances. On behalf of DHCS, DGS released the MIS/DSS Request for Proposal (RFP) on September 2, 2005 to solicit bids for a new MIS/DSS IT contract. The new contract requires the functionality of the original MIS/DSS, as well as enhancements to replace proprietary software, add new functionality, new data sources, and more stringent security controls.

The new contract resulting from this procurement was executed on February 14, 2007 and is a combination of fixed price and fixed rate tasks with enforceable standards and remedies/penalties related to contractor performance. In addition to system operation and maintenance, the contractor is required to provide training, analytical consultation and Help Desk support to assist users to maximize the results achieved from system use, and to encourage knowledge transfer to State staff in order to build in-house expertise in system use, as well as, data analysis and operational application.

Program Reduction

This proposal is to reduce the MIS/DSS contract by \$525,000 GF to achieve an annualized 25% reduction in General Funds for this contract.

Reduction Impacts

This reduction will require re-negotiation of this contract and a sole source IT contract amendment for the reduced contract amount. If the contractor does not agree to the reduction, other options would need to be considered including a new procurement, State operation with new staffing, or elimination of the data warehouse. At a minimum, re-negotiation of the current contract will result in the elimination of analytical consultation hours included in the current contract, and will reduce the user training hours included in the current contract. This reduction will impact: (1) MIS/DSS User support; (2) transfer of knowledge to State staff regarding ways to maximize MIS/DSS capabilities; (3) the inability to perform critical analyses i.e., predictive modeling for new/changed policy, programs and initiatives; and (4) the need for longer lead times to complete projects and analyses in the many critical and high profile programs and initiatives that rely on data from the MIS/DSS including anti-fraud, managed care

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expansion, managed care rate setting, waiver program reporting and Coordination of Care and Disease Management program pilots.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

The reduction will not require a change in state statute or emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**Department of Health Care Services
Administration Division: County Administrative Expense Section
Title: Reduction of CNI-Based COLA to Counties**

	GF	FF	Other	Total Reductions	PY Reduction
2007-08					
Workload Budget					
Reductions					
Governor's Budget					
2008-09					
Workload Budget					
Reductions	\$32,299	\$32,299		\$64,598	
Governor's Budget					

Program Description

County Administration Expense Section provides funding for county staff and support items to perform all activities associated with the Medi-Cal eligibility process. Currently the Welfare and Institutions (W&I) Code states that counties shall receive reasonable cost-of-doing-business increases annually. It further links these increases to the performance standards expected for processing of eligibility documents and applications. Beginning with fiscal (FY) year 2005-06, salary increases for Eligibility Workers (EWs) and support staff in each of the counties would be tied to the California Necessities Index (CNI). An agreement reached between DHS and the counties set annual salary increases at a level equal to the published CNI or any increase given to state employees that year, whichever was higher.

Program Reduction

Counties will not receive Cost of Living (COLA) increases for EWs as well as, administrative and support staff.

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Reduction Impacts

County EWs perform intake and re-determination work with beneficiaries applying for services. The accuracy and timeliness of the decisions made by the EWs is crucial to maintaining an up-to-date listing of eligible and enrolled beneficiaries. Reducing COLAs may make it more difficult for counties to hire and keep capable staff in the EW functions. Staffing issues could have a negative impact on the timeliness and accuracy of eligibility determinations, and redeterminations which could negatively impact accuracy of Department payments.

Timing of Implementation

The reduction will be effective July 1, 2008

Statutory and/or Regulatory Change

This proposal will require a change in state statute and all county welfare director letter.

Impact on Clients/Consumers/Providers

Any reduction in the COLA granted to EWs could negatively impact existing agreements between County Welfare/Human Service Agencies and the unions representing their staff. A reduction could impact the ability of certain counties to retain or hire competent staff due to salary issues. In addition, reducing the COLA may contradict a previous agreement between the Department and the counties related to salary structure and productivity standards. The Department and the counties have an agreement in place to grant COLAs based upon CNI or state worker salary increases, and in exchange the counties have agreed to a set of productivity standards that establish statewide workload and staffing levels. Counties will argue that their budgets will be reduced at the same time that quarterly status reports are being proposed. Those status reports will increase county workload. Experience has shown that underfunding of M/C caseload in the counties has resulted in counties reducing their work on M/C. This will increase Medi-Cal caseload and result in an overall increase in Medi-Cal program costs.

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Budget-Balancing Reduction Proposal
(Numbers in Thousands)**

**Department of Health Care Services
Administrative Division: County Administrative Expense Section
Title: Reduction of Caseload Growth Funding**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$20,635	\$20,635		\$41,270	
Governor's Budget					

Program Description

The County Administration Expense Section provides funding for county staff and support items to perform all activities associated with the Medi-Cal eligibility process. An annual estimate of growth in the Medi-Cal population is published as part of the Medi-Cal Estimate, and is used to create a budget number to fund additional services in each of the counties to offset demands created by this growth. This item is funded as a policy change in the Medi-Cal Estimate and is calculated based upon caseload measurements from past years and projections for growth in future years. The funding is granted in two parts. The first part is granted in the beginning of the fiscal year as part of the initial allocation, based upon growth in the six months from October to March of the previous fiscal year. The second part is granted in January and is paid out as part of the third-quarter county payment. The January grant is based upon subsequent caseload growth from April to September of the previous year. The methodology for distributing growth funds was agreed to in a series of meetings mandated by trailer bill language in 2004.

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(Numbers in Thousands)**

Program Reduction

This proposal would reduce additional funding which is allocated to counties based upon projected Medi-Cal caseload levels.

Reduction Impacts

The funds allocated for caseload growth help counties to hire additional staff to handle increased workload due to increases in Medi-Cal eligible persons. Reducing this item could negatively impact a county's ability to handle increased workload, which may result in less accurate eligibility determinations and redeterminations as staff is forced to manage higher numbers of cases per worker. Additionally, the Medi-Cal caseload could be affected as heavier workload could mean redeterminations would not be done on a timely basis, which would mean individuals potentially could continue to be counted as eligible when they may no longer be eligible for services.

Timing of Implementation

This reduction will be effective July 1, 2008

Statutory and/or Regulatory Change

This proposal will require a change in state statute and the issuance of an All County Welfare Director Letter.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**Department of Health Care Services
Administrative Division: County Administration Expense Section
Title: Reduction of County Administration Base**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$23,304	\$23,304		\$46,608	
Governor's Budget					

Program Description

The County Administration Expense Section provides funding for county staff and support items to perform all activities associated with the Medi-Cal eligibility process. The Base Allocation is comprised of funding for Staff, Staff Development, and Support as managed by each of the 58 counties. County Eligibility Workers (EWs) perform all intake and re-determination work with beneficiaries applying for services. The accuracy and timeliness of the decisions made by the EWs is important for maintaining an up-to-date listing and roster of beneficiaries. The current fiscal year Base Allocation for County Administration is \$1.3 billion (\$650 million GF).

Program Reduction

Reduce 3.67% from the budget-year base allocation.

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(Dollars in Thousands)**

Reduction Impacts

Reducing the base will likely force counties to handle existing workload with less EW staff or less support and administrative staff. This would have a negative impact on the timeliness and accuracy of eligibility determinations, as each existing worker will be forced to handle higher caseload, which increases the opportunity for errors.

Redeterminations would not be done on a timely basis, which would mean individuals potentially could continue to be counted as eligible when they may no longer be eligible for services.

Timing of Implementation

The reduction will be effective July 1, 2008

Statutory and/or Regulatory Change

This proposal will require a change in state statute and release of an All County Welfare Director Letter.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division
Title: Fiscal Intermediary Systems Group Reduction**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$2,100	\$10,500		\$12,600	
Governor's Budget					

Program Description

The current FI contractor is Electronic Data Systems (EDS) which has been the Fiscal Intermediary (FI) since 1988. Reimbursement of health care providers under the Medi-Cal program is conducted under contract with the Department of Health Care Services. Its overall contract with the Department is approximately \$167 million (\$46.6 million GF) per year. The current California Medicaid Management Information System, which is managed by the FI contractor, has been in place for over 30 years.

The FI contract includes provision for a systems group of programmers and systems analysts to make necessary modifications to the claims processing system for Federal and State legislation, regulations, and policy changes. The systems group funding is currently \$16.7 million of which 75% is Federal Financial Participation (FFP) and 25 % is State General Fund (GF). The systems group has been expanded to 190 systems engineers to accommodate Health Insurance Portability and Accountability Act (HIPAA) mandated changes and there is a need for continuation of this level of staffing to complete HIPAA conversions scheduled until 2011. There is also a backlog of systems projects resulting from the dedication of FI resources to the HIPAA National Provider Identifier implementation.

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Program Reduction

The FI Systems Group is proposed to be reduced by 70 systems analysts and programmers from 190 to a level of 120. This reduction in the Systems Group (SG) staffing provides a level of continued support which will maintain support of critical DHCS systems projects. The level of staffing for the FI Systems Group is directly related to staffing in the Fiscal Intermediary and Contracts Oversight Division (FICOD) which manages the FI SG systems projects. A corresponding reduction in the FICOD staffing is being proposed as part of the overall reduction package. The reduced level of FICOD staffing can only support the Systems Group staffing level of 120. Any increase in the Systems Group requires an increase in FICOD staffing.

Reduction Impacts

The proposed reduction in the Fiscal Intermediary Systems Group would result in a delay in Health Insurance Portability and Accountability Act (HIPAA) projects required to convert many local billing codes to national codes. This conversion to national codes, which has been projected to be completed by 2011 would be further delayed. The reduction would result in delays to other Federally mandated projects and delay or reduce needed improvements that support program operations. The FI systems work would be prioritized to work primarily on the most critical systems changes. While this reduced level of Systems Group staffing will still support critical projects, the reduction of over one third of the budgeted staffing would have a definite impact on systems projects. Besides impacting the conversion of HIPAA billing codes, which will extend our period of non-compliance with federal mandate, the reduction is expected to impact projects also. Projects that may be impacted are changes required to obtain manufacturer rebates on nutritional and diabetic supplies, maintenance of Treatment Authorization purging process which would improve system response time, and projects to reduce information security risks related to the Treatment Authorization system, Drug rebate system, and data center connectivity. The proposed reduction would delay or reduce numerous projects which have been backlogged because of the resources dedicated to the implementation of the HIPAA required National Provider Identifier (NPI).

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

Will not require a change in statute or emergency regulations.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division
Title: Change Order Reduction for Electronic Data Systems Contract**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$425	\$1,275		\$1,700	
Governor's Budget					

Program Description

The current Fiscal Intermediary (FI) contractor is Electronic Data Systems (EDS) which has been the FI since 1988. Reimbursement of health care providers under the Medi-Cal program is conducted by a FI under contract with the Department of Health Care Services. Its overall contract with the Department is approximately \$167 million (\$46.6 million GF) per year. The current California Medicaid Management Information System, which is managed by the FI contractor, has been in place for over 30 years.

When the Department alters the work required or reallocates functions performed within the general scope of the contract, the FI contract allows change orders to be utilized. These changes to the contractor's responsibilities are the result of compliance with new legislation, court mandates, state policy, etc.

For example, the Department installed standardized transactions and code sets into the Medi-Cal claims processing system through a change order issued in May 2003 to comply with a federal mandate pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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(Dollars in Thousands)**

The development of standards and requirements enable the electronic exchange of health information to improve the efficiency and effectiveness of the Medicare and Medicaid health care system programs. The HIPAA changes were implemented, and as a result of stabilization of operations costs, have steadily decreased by about \$1.7 million.

Program Reduction

This proposal would reduce operations costs by \$1.7 million total funds. This reduction is from the \$6.2 million total funds budgeted.

Reduction Impacts

Should there be a change in requirements and this reduction is taken, the Department could be in a situation where it would have to negotiate a contract amendment to account for any increased operations costs that may come from new legislation or mandates.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

Will not require a change in state statute or emergency regulations.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division**

**Title: Reduction in cost reimbursement due to Fiscal Intermediary Transition to
Electronic Media Transfer in Print, Postage, & Parcel**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$1,000	\$1,000		\$2,000	
Governor's Budget					

Program Description

The current Fiscal Intermediary (FI) contractor is Electronic Data Systems (EDS) which has been the FI since 1988. Reimbursement of health care providers under the Medi-Cal program is conducted by a FI under contract with the Department of Health Care Services. Its overall contract with the Department is approximately \$167 million (\$46.6 million GF) per year. The current California Medicaid Management Information System, which is managed by the FI contractor, has been in place for over 30 years.

The FI contract requires the contractor to publish and disseminate Medi-Cal and other health program provider publications such as manuals, bulletins, and forms as directed by the Department. The publications serve as the primary source of information for program policy, billing, and statutes and regulations, and are sent to approximately 55,000 providers. The Medi-Cal FI's Publication expenses are cost reimbursed by the State and were not a part of the bid price of the contract because the quantities and types of printed materials were unknown. There have been no expansions in these services going back many years.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Program Reduction

Reduction in cost reimbursement is due to Fiscal Intermediary transition from hardcopy provider bulletins, manuals, and information notifications to an Electronic Media Transfer in Print, Postage, & Parcel for availability and utilization via the Internet.

Reduction Impacts

All paper provider manuals will be eliminated and providers will need to use provider manuals via the Internet at www.Medi-Cal.ca.gov. Paper provider bulletins will be eliminated to the extent allowed legally to meet the requirements for provider notice.

Printing and mailing were negotiated based on high volumes. Therefore, the reduction in paper orders could result in future price per page increase. There may also be a future cost increase for updating the electronic subscription service.

It is estimated that this action will result in a partial reduction in paper bulletins and that some providers will continue to need to receive paper bulletins.

Providers will have to adjust their internal processes to begin accessing the publications via the Internet.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

Will not require a change in state statute or emergency regulations.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division

Title: Reduction to Dental Fiscal Intermediary Surveillance and Utilization Review
Subsystem

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$700	\$2,100		\$2,800	
Governor's Budget					

Program Description

The Medi-Cal Dental program was created in 1974. The Medi-Cal program contracts with a Fiscal Intermediary, currently Delta Dental, to serve as the contractor for the Medi-Cal Dental program. Under this contract, the FI operates and maintains the Surveillance and Utilization Review Subsystem (S/URS), which is one part of the management information reporting capability of the California Dental Medicaid Management Information System. S/URS is a post payment system designed to provide a means to identify provider and beneficiary fraud and abuse; and provide a means to identify services provided which are below the community standard of care. The current funding level of the Delta Dental S/URS Unit is approximately \$7.5 million (\$1.8 million GF). S/URS currently issues annual audits for recoveries of \$7.4 million. In addition, S/URS saves \$24.0 million annually due to cost avoidance. There has not been a recent expansion of the program.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

Program Reduction

The Dental S/URS Program currently has 44.0 FI contract positions. There has not been a recent change in the number of positions. The proposed reductions would remove 20.0 positions, leaving 24.0 positions.

Reduction Impacts

Although Dental remains a high fraud area in the Medi-Cal program, the reduction of S/URS staff by approximately 45% is in line with the reduction in dental claims and potential reduction in providers resulting from the proposed elimination of optional dental benefits for adults.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

Will not require a change in state statute or emergency regulations.

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Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Fiscal Intermediary and Contracts Oversight Division
Title: Elimination of Vector Messages on Telephone Service Center Provider
Phone Lines**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$100	\$500		\$600	
Governor's Budget					

Program Description

The current Fiscal Intermediary (FI) contractor is Electronic Data Systems (EDS) which has been the FI since 1988. Reimbursement of health care providers under the Medi-Cal program is conducted by a FI under contract with the Department of Health Care Services (DHCS). Its overall contract with the Department is approximately \$167 million (\$46.6 million GF) per year. The current California Medicaid Management Information System, which is managed by the FI contractor, has been in place for over 30 years.

The EDS Telephone Service Center (TSC) serves Medi-Cal/Other state program providers as a resource to answer questions about Medi-Cal/Other program billing issues. Currently, the TSC receives approximately 1 million calls a year. DHCS regularly requests that the TSC provide recorded messages, known as "Vector" messages, at the entry of each call into the prompt menu,. These messages have, in the past, contained reminders/information on subject areas such as the Health Insurance Portability and Accountability Act (HIPAA), National Provider Identifier (NPI) number, Medicare Part D drug benefit, late budget information, etc.

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There is a per minute cost incurred each time a provider listens to the vector message. The TSC has placed vector messages on the provider call lines for approximately five years. This function saves the Department both staff and contract costs.

There has been no recent expansion of the program and there is no "funding level" or authorized positions attached to adding a vector message to the TSC.

Program Reduction

Eliminate all DHCS requested "vector" messages on the TSC Provider phone lines.

Reduction Impacts

DHCS will not offer important informative information to approximately 157,000 active providers, when they call to receive information about HIPAA requirements and form changes, registering their National Provider Identification (NPI), late budget issues and other information (about 1 million calls per year). Providers will not be given the extra information that the Department wishes to impart which currently assists providers with their billing, enrollment, training, eligibility and a myriad of other questions. Reduced provider access to information and problem issue solutions would necessarily create a reduction in provider satisfaction in the program and a resulting reduction in beneficiaries' access to care. It may increase the need for the telephone agents to explain updates verbally in real time on live calls. It may also increase the number of claim issues requiring extended research and correction due to the lack of updated information available through the Vector message. This may result in provider billing errors and more provider calls to the TSC.

Timing of Implementation

The reduction will be effective three months after adoption of this change.

Statutory and/or Regulatory Change

Will require a change in state statute or emergency regulations.

**2008-09 Governor's Budget
Budget-Balancing Reduction Proposal
(Dollars in Thousands)**

**4260 Department of Health Care Services (DHCS)
Medi-Cal Managed Care Division
Title: Reduce Managed Care Provider Payments**

	GF	FF	Other	Total Reductions	PY Reduction
<u>2007-08</u>					
Workload Budget					
Reductions					
Governor's Budget					
<u>2008-09</u>					
Workload Budget					
Reductions	\$196,864	\$196,864		\$393,728	
Governor's Budget					

Program Description

The Medi-Cal program was established by the Legislature to provide health care to uninsured Californians on March 1, 1966. Medi-Cal provides health care services for millions of low-income families with children, seniors, visually impaired, and disabled Californians. For approximately one half of the program, Medi-Cal pays providers directly through the traditional fee-for-service (FFS) method. In addition, the program contracts with managed care plans that develop their own provider networks to serve managed care beneficiaries. Approximately, 150,000 providers currently participate in the Medi-Cal FFS program. Approximately 30 contracted commercial and County entities currently participate in the Medi-Cal Managed Care program.

Program Reduction

This budget reduction proposal reduces payments for FFS for Medi-Cal provider types/programs by ten percent. Except for the exemptions listed below, the payment reductions will apply to services rendered by any provider authorized to bill Medi-Cal for services. This proposal also reduces Medi-Cal managed care capitation payments by the actuarial equivalent amount of the 10% FFS reductions.

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It is assumed that Medi-Cal managed care contracted health plans will pass on some or all of these reductions to their providers.

The following are exempt from the payment reductions for this proposal but in some cases are affected by other reduction proposals: contracted acute hospital inpatient services, Hospice, Federal Qualified Health Centers and rural health clinics; Breast and Cervical Cancer Treatment Program services (Federal Program), Family PACT services, and payments to long term care facilities, including but not limited to freestanding level B nursing facilities, intermediate care facilities for developmentally disabled individuals, freestanding sub-acute care units of skilled nursing facilities, and special treatment program services. All other Medi-Cal providers are subject to this proposal.

Non-Medi-Cal programs affected by the payment reductions include the following: California Children's Services, Every Woman Counts, Genetically Handicapped Persons Program, and the Child Health and Disability Prevention Program.

Reduction Impacts

Managed care plans are already concerned about their ability to reopen provider contracts and obtain reduced rates and savings from those providers. In response to any plan-initiated reduction efforts, some hospital and physician providers may terminate their contracts with our plans, reducing access for our beneficiaries. Alternately, to avoid this, plans may decide to absorb their capitation reductions to the degree their financial health allows. Our implementation of these reductions and any resulting budget savings will vary by model. We have the ability to implement the rate reductions through change orders for the Two Plan model. But reductions to the GMC and COHS plans require negotiated contract amendments. CMAC would negotiate the amendments for the GMC model, and DHCS would negotiate the amendments for the COHS model contractors.

Timing of Implementation

The reduction will be effective July 1, 2008.

Statutory and/or Regulatory Change

The special session budget bills contained statutory authority and an effective date for the managed care reductions. Federal waiver and State Plan amendments will be required.