2012-2013 Governor's Budget

Highlights

Department of Health Care Services

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES PROGRAM OVERVIEW

The California Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals.

DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner. The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 8.3 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low income people with specific diseases. Children's Medical Services coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening Program. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations, and it includes the Indian Health Program, the Rural Health Services Development Program, the Seasonal Agricultural and Migratory Workers Program, the State Office of Rural Health (CalSORH), the Medicare Rural Hospital Flexibility Program (FLEX)/Critical Access Hospital (CAH) Program, the Small Rural Hospital Improvement Program (SHIP), and the J-1 Visa Waiver Program. Due to recent program transitions, DHCS is also coordinating and directing the delivery of community mental health services, substance use disorder services, family planning services, cancer screening services to low income under-insured or uninsured women and prostate cancer treatment services to low-income, uninsured men. These services are provided through Mental Health and Substance Use Disorder Services programs, the Every Woman Counts Program, the Family Planning Access Care and Treatment Program and the Prostate Cancer Treatment Program.

GENERAL BUDGET OVERVIEW

The budget for DHCS supports activities and services that reinforce the State's commitment to protecting and improving the health of all Californians. Medi-Cal costs have grown about six-percent annually since 2006-07 due to a combination of health care cost inflation and caseload growth. For Fiscal Year (FY) 2012-13, the Governor's Budget presents a total of $61.0 billion for the support of DHCS programs and services. Of the amount proposed, $506.1 million is for state operations and $60.4 billion is for local assistance. The proposed budget contains proposals that attempt to balance the need to operate within a responsible budget yet affirm DHCS's commitment to address the health care needs of Californians.

Total DHCS Budget

Governor's Budget Fund Source	2011-12 Approved Budget	2011-12 Revised Budget	2012-13 Proposed Budget
General Fund (GF)	$14,939,154	$ 15,572,740	$15,398,789
Federal Funds (FF)	$27,570,562	$29,775,070	$33,770,967
Special Fund & Reimbursements	$5,784,784	$6,051,368	$11,783,356
Total Funds	**$48,294,500**	**$51,399,178**	**$ 60,953,112**

*Dollars in thousands

State Operations

State Operations by Fund Source *			
Governor's Budget Fund Source	**2011-12 Approved Budget**	**2011-12 Revised Budget**	**2012-13 Proposed Budget**
General Fund	$141,678	$140,489	$157,793
Federal Funds	$277,005	$271,812	$303,333
Special Funds & Reimbursements	$34,532	$35,406	$44,942
Total State Operations	**$ 453,215**	**$ 447,707**	**$506,068**

*Dollars in thousands

Local Assistance

Local Assistance by Fund Source *			
Governor's Budget Fund Source	**2011-12 Approved Budget**	**2011-12 Revised Budget**	**2012-13 Proposed Budget**
General Fund	$14,797,476	$15,432,251	$15,240,996
Federal Fund	$27,293,557	$29,503,258	$33,467,634
Special Funds & Reimbursements	$5,750,252	$6,015,962	$11,738,414
Total Local Assistance	**$47,841,285**	**$50,951,471**	**$ 60,447,044**

*Dollars in thousands

ESTIMATE ADJUSTMENTS

Medi-Cal Local Assistance

The FY 2011-12 Medi-Cal General Fund (GF) estimate is $595.8 million more than the 2011-12 Budget Appropriation.

The Medi-Cal General Fund costs in FY 2012-13, as compared to the 2011-12, are estimated to decrease by $497 million.

The major reasons for the change from the Appropriation include the following:

PC 182 - 2011-12 Trigger Cut: The Budget Act of 2011 (Chapter 41, Statutes of 2011) included Section 3.94 that established specific spending reductions or revenues that occur if certain revenue targets are not achieved. On December 13, 2011, the Department of Finance determined that revenues are lower than the revenue specified in Section 3.94, necessitating mandatory spending reductions. For Medi-Cal, the mandatory spending reductions apply rate cuts and copayments adopted in the Budget Act of 2011 to three managed care plans that were excluded from the reductions: Program of All-Inclusive Care for the Elderly (PACE), Senior Care Action Network (SCAN), and AIDS Healthcare Centers (AHF). Adjustments for the mandatory spending reductions are located in various Policy Changes (PC). The savings due to the mandatory spending reductions are estimated to be $4.7 million GF in FY 2011-12 and $9.1 million GF in 2012-13.

Various PCs—Cost Containment Strategies: AB 97 (Chapter 2, Statutes of 2011) requires DHCS to implement limits on specified Medi-Cal services, cost sharing through copayment requirements, elimination of certain benefits and provider payment reductions. The savings due to these reductions was estimated to be $1.755 billion GF in 2011-12 at the time of enactment. For the November 2011 Estimate, the Department updated data, refined exemptions and adjusted implementation dates for the reductions, resulting in a revised estimated savings of $1.045 billion GF in 2011-12 and $1.735 billion in 2012-13.

Various PCs—Additional Saving Proposals: The November Medi-Cal Estimate includes savings in 2012-13 to solve the budget problem. The additional saving proposals include Connected Care for Dual Eligible and Long-Term Care Rebalancing, Value-Based Purchasing, FQHC Payment Reform, Eliminating the Sunset Date for the Gross Premium Tax, Managed Care Expansion, Medical Therapy Program Means Test, Stabilization Funds, Annual Open Enrollment, and deferring payments. In 2012-13, savings are estimated to be $1,068.5 million GF.

Improved Care Coordination for Seniors and Disabled Beneficiaries. Within the Medi-Cal program, approximately 7 percent of beneficiaries account for 75 percent of program costs – mostly because of costly institutional services. These beneficiaries are typically seniors or persons with disabilities and they are frequently eligible for and

enrolled in both the federal Medicare program and the Medi-Cal program. Approximately one-third of these individuals are also enrolled in the In-Home Supportive Services (IHSS) program. Individuals eligible for both Medi-Cal and Medicare are known as dual eligible beneficiaries. California has 1.2 million dual eligible beneficiaries, which represents 14.1 percent of the total the Medi-Cal caseload. In addition, the majority of the 423,000 IHSS recipients (85 percent) are dual eligible beneficiaries. These dual eligible beneficiaries represent some of the most expensive and medically complicated health cases and the cost for their care is paid by public funds, including federal funds, state General Fund, and in some cases county funds.

Medicare is the primary insurance/payer for dual eligible beneficiaries and covers medically necessary acute health services such as physician services, hospital services, and skilled nursing. Medi-Cal is the secondary insurance/payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted. Most long-term care costs for these beneficiaries are paid for by Medi-Cal, including longer nursing home stays and home and community-based services designed to prevent institutionalization. In addition, many of these beneficiaries are also eligible for IHSS, which is locally administered and includes a county share of cost. Consequently, the current system attempts to address the health care needs of the most chronically ill and vulnerable beneficiaries through a variety of providers that receive funding from multiple government sources. The system is riddled with incentives that encourage payers to shift costs to one another.

The fractured funding streams and administrative responsibilities make it difficult for dual eligible beneficiaries to navigate program benefits associated with this uncoordinated fee-for-service environment. As a result, these individuals will benefit the most from a care model that provides benefits in a more coordinated manner. Coordinating care for these beneficiaries generally means having the same health plan responsible for the delivery of all benefits. This will achieve significant efficiencies and improve care for beneficiaries. This also will help beneficiaries remain in the community and reduce costs from unnecessary hospital and nursing home admissions. In addition to aligning program responsibility and financial incentives, this proposal increases the number of individuals in managed care and broadens the scope of managed care services. This proposal works to:

- Promote Coordinated Care — Managed care done properly results in high-quality care. This initiative provides managed care plans with a blended payment consisting of federal, state, and county funds and responsibility for delivering the full array of health and social services to dual eligible beneficiaries. The proposal combines strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives and improve care continuity across medical services, long-term services, and behavioral health services.

- Enhance the Quality of Home and Community-Based Services — Within an expanded system of coordinated care, it is critical to better coordinate medical

services with the full continuum of long-term services, including In-Home Supportive Services, Community-Based Adult Services, and nursing home services. Merging long-term services into managed care will increase access to home and community-based medical and social services. Improving access to these services should help beneficiaries remain in their homes and out of institutions, and should improve their health outcomes. When necessary, care will also be coordinated with behavioral health services, which generally will be provided by counties. The Home and Community-Based Services Waiver for Persons with Developmental Disabilities will continue to be administered by the Department of Developmental Services.

The proposal to improve care coordination for dual eligible beneficiaries will be phased in over a three-year period starting January 1, 2013. The transition to managed care for Medi-Cal benefits will occur in the first year, with the benefits becoming a more integrated plan responsibility over the subsequent two years. The transition of Medicare benefits to managed care will occur over a three-year period starting first with eight to ten counties that already have the capacity to coordinate care for these individuals. Beneficiaries in counties in which Medi-Cal managed care plans may not yet have the capacity to take on additional beneficiaries will begin to transition six or twelve months later. The Budget separately proposes to expand Medi-Cal managed care statewide starting in June 2013. Beneficiaries in these managed care expansion counties will transition in 2014-15.

In year one, IHSS, other home and community-based services, and nursing home care funded by Medi-Cal will become managed care benefits. The IHSS program will essentially operate as it does today, except all authorized IHSS benefits will be included in managed care plan rates. Beneficiaries in the eight to ten selected counties will also receive their Medicare benefits and long-term services and supports through their Medi-Cal plan. This represents about 800,000 of the 1.2 million dual eligible beneficiaries currently in California. These changes will be phased in over a 12-month period starting January 1, 2013. Over time, managed care plans will take on increasing responsibility for home and community-based services, including IHSS.

Delivering services through Medi-Cal managed care plans will make the state the single point of accountability for services to these beneficiaries. This will ensure access to the entire continuum of health care services for dual eligible beneficiaries through their Medi-Cal managed care plan. Delivering these services through Medi-Cal managed care plans, however, also raises important issues that will need to be considered in the program design including, but not limited to: (1) consumer protections for acute, long-term care, and home and community-based services within managed care; (2) development of a uniform assessment tool for home and community-based services; and (3) consumer choice and protection when selecting their IHSS provider. The Administration will consult consumers and other stakeholders in this effort.

This proposal also sets the foundation for the state to implement health care reform, which further impacts the health care delivery and financing structure by expanding Medi-Cal to include all adults below 138 percent of the federal poverty level. In addition,

it establishes the state as the level of government primarily responsible for delivering health care services. Additional issues to consider related to the state-county relationship in financing and delivering services include determining the collective bargaining structure for IHSS providers, and the long-term county financial responsibility for IHSS and other health care programs. The Administration will work with counties and stakeholders to address these overarching issues through the development of legislation that will be necessary to implement this Budget proposal.

As beneficiaries transition from fee-for-service to coordinated managed care, the state will generate savings due to a reduction in hospital and nursing home costs. However, because Medi-Cal is budgeted on a cash basis, there is a delay in realizing these savings. To accelerate these savings into 2012-13; the Budget also proposes a payment deferral (one payment for all providers), and alignment of payment policies for all managed care counties. Together, this proposal will achieve savings of approximately $678.8 million General Fund in 2012-13 and $1 billion General Fund in 2013-14.

Value-Based Purchasing. Medi-Cal is a major health care delivery system approaching an enrollment of 8.3 million Californians and is estimated to gain another 2 million beneficiaries when federal health care reform is implemented in January 2014. The Medi-Cal health care delivery system must have the capacity to respond to the rapidly changing field of health care and be able to change benefits, services, rate methodologies and payment policies faster than the current regulatory process allows. Examples of potential program changes include reducing laboratory rates, no longer funding avoidable hospital admissions, and no longer paying for services of limited value.

The Budget proposes a process that will incorporate stakeholder input and determine cost-effectiveness before implementing changes in benefit design, and includes a post-implementation assessment to ensure that changes achieve the intended results. Similarly, any changes in rate methodologies and payment policies driven by this process will comply with federal requirements to rigorously monitor the impact of rate changes on beneficiary access to services and to mitigate any problems as they arise. Under the proposed process, the Medi-Cal program will have the flexibility it needs to operate a health care delivery system that meets its obligations to use sound evidence, transparent processes, and monitoring mechanisms to ensure the program achieves its outcomes in the most efficient possible manner. This proposal will achieve General Fund savings of approximately $75 million in 2012-13 and ongoing.

Managed Care Expansion. Beginning in June 2013, the Budget proposes to expand managed care into rural counties that are now fee-for service only. This expansion will provide beneficiaries throughout the state with care through an organized delivery system. This proposal will result in a General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14.

Healthy Families Program Transition to Medi-Cal. The Budget proposes transferring approximately 875,000 Healthy Families Program beneficiaries to Medi-Cal over a nine-

month period beginning in October 2012. This transition will create benefits for children, families, health plans, and providers, by: (1) simplifying eligibility and coverage for children and families; (2) improving coverage through retroactive benefits, increased access to vaccines, and expanded mental health coverage; and (3) eliminating premiums for lower-income beneficiaries.

Federally Qualified Health Center Payment Reform. The Budget proposes to reform the payment methodology for federally qualified health centers (FQHCs) and rural health clinics (RHCs) funded under Medi-Cal to create a performance, risk-based payment model that will allow, and reward, these clinics to provide more efficient and better care. Under this proposal, payments made to FQHCs and RHCs participating in Medi-Cal managed care plan contracts will change from a cost and volume-based payment to a fixed payment to provide a broad range of services to its enrollees. A waiver of current operating restrictions will empower FQHCs to follow efficient best practices, such as group visits, telehealth, and telephonic disease management. The waiver will ensure that medical care is provided by the most appropriate and affordable medical professional and allow clinics to perform multiple services on the same day. The efficiencies will allow these community health centers to provide better and more efficient care, and to expand capacity. The proposal will achieve General Fund savings of $27.8 million in 2012-13 and $58.1 million in 2013-14.

Annual Open Enrollment. Current law authorizes Medi-Cal beneficiaries to change plans once per month or up to 12 times in a year. The Budget proposes an annual open enrollment period for beneficiaries to select their Medi-Cal health plan and receive care through that health plan for the entire year. This open enrollment process will align Medi-Cal with industry best practice of other third-party health benefit payers including CalPERS and Healthy Families. By establishing an annual election process, plans will be accountable for providing beneficiaries with a medical home, care coordination, and case management over the entire year leading to better care and health outcomes. This proposal will achieve General Fund savings of $3.6 million in 2012-13 and $6 million in 2013-14.

Managed Care Default Assignment. Under this proposal, the Department will require beneficiaries in the Family or SPD aid categories who do not choose a plan to be defaulted into a plan based on default ratios which consider health plan cost in addition to quality of care and safety net population factors. Savings would be recognized by rewarding plans with lower costs with additional default enrollment. This proposal will achieve General Fund savings of $2.4 million in 2012-13 and $5.8 million in 2013-14.

Gross Premium Tax. The Budget proposes to eliminate the sunset date of the Gross Premium Tax on Medi-Cal managed care plans. Continuing the tax, coupled with increased managed care utilization, will generate General Fund savings of $161.8 million in 2012-13 and $259.1 million in 2013-14.

Medical Therapy Program Eligibility. The Budget proposes to align income eligibility requirements for the Medical Therapy Program with the broader California Children's

Services (CCS) Program. Currently, there is no financial test for eligibility. Under the proposed eligibility standards, families with annual income less than $40,000 or with annual CCS-related medical expenses exceeding 20 percent of their annual income will continue to be eligible for the Medical Therapy Program. This is consistent with the eligibility requirements already in place for all other CCS benefits and will result in savings of $9.1 million General Fund in 2012-13 and $10.9 million in 2013-14. In addition to state savings, counties will also realize savings.

Stabilization Funds. The Budget proposes a one-time redirection of private and non-designated public hospital stabilization funding that has not yet been paid for fiscal years 2005-06 through 2009-10 to provide General Fund savings and avoid direct service reductions. This proposal will achieve one-time savings of $42.9 million General Fund.

Align Managed Care Benefit Policies. Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. Currently, the County Organized Health Systems (COHS) are responsible for covering the cost of the retroactive period and they receive an adjustment in their capitation rates for this cost. The Two-Plan and Geographic Managed Care health plans are not responsible to cover the costs of their enrollees during the retroactive period. Instead, these costs are paid in FFS. The Administration proposes to eliminate the COHS' responsibility for the retroactive period and shift this cost to FFS. This proposal will result in a one-time savings of $57.0 million General Fund.

The saving proposals are listed in the table below:

Savings Proposals	**GF Savings**
(Dollars in Thousands; Totals May Not Add Due to Rounding)	**2012-13**
Connected Care for Dual Eligibles and Long-Term Care Rebalancing	**-$621,793**
Value-Based Purchasing	**-$75,000**
Managed Care Expansion	**-$2,680**
Healthy Families Program Transition to Medi-Cal	**-$64,377**
Federally Qualified Health Center Payment Reform	**-$27,830**
Annual Open Enrollment	**-$3,568**
Managed Care Default Assignment	**-$2,409**
Eliminating the Sunset Date for the Gross Premium Tax	**-$161,843**
Medical Therapy Program Means Test	**-$9,123**
Hospital Stabilization Funds	**-$42,877**
Align Managed Care Policies	**-$56,984**
TOTAL	**-$1,068,484**

Other Significant Adjustments:

- Medi-Cal Base Benefit Costs — A decrease of $395.9 million General Fund in 2011-12 and an increase of $493.9 million General Fund in 2012 based on cost and utilization trends in the base program.

- Budget Savings Erosions — An increase of $778.2 million General Fund in 2011-12 and $235.3 million General Fund in 2012-13 because of delayed federal approval of budget savings proposals, litigation related to elimination of the Adult Day Health Care benefit, and a portion of the provider payment reductions not being approved by the federal government.

- Hospital Fee Extension — A savings of $255 million General Fund in 2011-12 and $472 million General Fund in 2012-13 as a result of extending the hospital fee. The fee provides funds for supplemental payments to hospitals and also makes some funding available to offset the costs of health care coverage for children.

- Managed Care Rate Adjustment -- An increase of $203.4 million General Fund in 2012-13 as a result of increasing managed care rates by 3.61 percent. Rate adjustments are based on the previous year's increase. The managed care rate adjustments for 2012-13 will be updated in May 2012.

- Nursing Home Fee Program — The Budget includes funding to restore the 10-percent provider rate reduction ($171.2 million General Fund) and also includes supplemental payments ($245.6 million General Fund). The Budget does not include the maximum 2.4-percent cumulative rate increase for 2011-12 and 2012-13 because preliminary fee revenues are insufficient to support such an increase. The Budget also proposes to permanently extend the rate methodology and nursing home fee initially established by Chapter 875, Statutes of 2004 (AB 1629). This extension is necessary to continue to fund the current payment methodology without a greater impact to the General Fund.

- Reserve for Litigation — The Budget includes a set-aside of $86.8 million General Fund in 2011-12 and $260.4 million General Fund in 2012-13 in the event litigation challenging recently approved provider rate reductions is successful.

- Potentially Preventable Admissions Managed Care Adjustment — Effective for Medi-Cal managed care plan rates starting July 1, 2012, DHCS will implement rate adjustments related to Potentially Preventable Admissions. DHCS will use a methodology developed by the Agency for Healthcare Research and Quality and applied by Mercer to the Medi-Cal managed care plan specific data. This proposal will achieve General Fund savings of $26.6 million in 2012-13 and $30.0 million in 2013-14.

Family Health Local Assistance

The November 2010 Family Health Estimate shows a 2011-12 General Fund surplus of $47.8 million compared to the FY 2011-12 Budget Appropriation. The Family Health Estimate shows a 2012-13 General Fund increase of $85.6 million compared to 2011-12.

In the May 2011 Estimate, the Department assumed it would receive approval from the Centers for Medicare and Medicaid Services (CMS) to claim additional federal funds using the Certified Public Expenditures (CPEs) of Designated State Health Programs in 2010-11. The Department did not receive CMS approval to claim Demonstration Year (DY) 6 in 2010-11. As a result, the Department will claim two years of CPE in FY 2011-12.

REORGANIZATIONS

The Budget continues efforts to streamline government operations to be more efficient and effective. As part of this effort, reorganizations impacting DHCS are:

- Reorganization of behavioral health programs. With the elimination of the Department of Mental Health (DMH) and the Department of Alcohol and Drug Programs (DADP), major community mental health programs and remaining non-Drug Medi-Cal programs and associated funding will be shifted to the Department of Health Care Services (DHCS). Co-locating these key mental health and substance use disorder services with physical health programs is the first step toward integrating services in preparation for an effective continuum of care, consistent with federal health care reform implementation in 2014.

- Transfer of the following medical services programs from the California Department of Public Health (CDPH) to DHCS effective July 1, 2012: (1) Every Woman Counts, (2) Prostate Cancer Treatment, and (3) Family Planning Access Care and Treatment. The transfer of these programs is consistent with the Administration's goal of placing direct health care service programs with the DHCS to improve service delivery.

- In preparation for California's implementation of federal health care reform, the Budget proposes to eliminate the Managed Risk Medical Insurance Board by July 1, 2013. Therefore, the remaining programs administered by the Board will transition to the DHCS by July 1, 2013. These programs include the Access for Infants and Mothers, the County Health Initiative Matching Fund Program, the Major Risk Medical Insurance Program (MRMIP), and the Pre-Existing Conditions Insurance Plan (PCIP) programs. The two programs that provide insurance to individuals with pre-existing conditions, MRMIP and PCIP, will be eliminated in January 2014 because these individuals will be able to purchase health insurance through the California Health Benefits Exchange as part of federal health care reform implementation.

BUDGET ADJUSTMENTS

Budget Change Proposals

Hospital Quality Assurance Fee Program

Positions: 9.5 Limited -Term
FF: $562,000
OF: $471,000
Total: $1,033,000

DHCS requests that 9.5 positions set to expire 6/30/2012 be extended through 12/31/2015; DHCS is also requesting contract funds. Senate Bill 335 extended the Quality Assurance Fee (QAF) program past June 30, 2011, and these resources are needed to continue the administration of the program. The original QAF program, which covered the period of April 1, 2009 – December 31, 2010, was extraordinarily successful, providing supplemental payments in the amount of $3 billion to California hospitals. The QAF provides much needed financial assistance for California's hospitals, especially those that provide critical services for Medi-Cal beneficiaries. In addition, an extension of the QAF will provide additional funding to pay for health coverage for children.

Money Follows the Person (MFP)

Positions: 8.0 Limited -Term
FF: $892,000
Total: $892,000

DHCS requests to extend 3.0 existing limited-term positions, and establish 5.0 new positions through 3/31/2016, to coincide with the renewal of the Money Follows the Person (MFP) grant. The positions will be 100 percent federally funded. These positions will maintain the current program, meet MFP benchmarks, expand MFP into additional counties, and adequately implement Minimum Data Set (MDS) 3.0 Section Q federal requirements. California first received this grant in 2007, and developed the MFP demonstration, called California Community Transitions. This grant addresses the Supreme Court Olmstead v. Zimring decision (119 S.CT.2176), which concluded that states are obliged by the Americans with Disabilities Act to provide community-based services for persons with disabilities of any age who would otherwise be entitled to services in a health care facility when: 1) the state's treatment professionals have determined that community placement is appropriate, 2) affected individuals do not oppose community placement, and 3) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of the individuals with disabilities.

Breast and Cervical Cancer Treatment Program

Positions: 6.0 Limited -Term
GF: $269,000
FF: $268,000
Total: $537,000

DHCS requests to extend 6.0 limited-term positions through December 31, 2013, to continue ongoing and increasing workload associated with the Breast and Cervical Cancer Treatment Program (BCCTP). The BCCTP is a special program that provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer who otherwise would not qualify for other Medi-Cal programs or commercial insurance coverage. The positions would address initial eligibility determinations, annual redeterminations that are required to receive federal funds for the program, and the processing of requests by applicants for retroactive coverage.

Privacy and Security of Medi-Cal Eligibility Data System (MEDS) Information

Positions: 10.0 Limited -Term
GF: $585,000
FF: $803,000
Total: $1,388,000

DHCS requests to extend 10.0 limited-term positions through June 30, 2015, to continue managing, protecting, and securing confidential Medi-Cal eligibility information, ensuring compliance with requirements of the federal Social Security Administration and monitoring access to the MEDS. The positions will allow DHCS to maintain crucial operations to Medi-Cal recipients, continue to meet the business needs of both internal and external department users who have a critical need for MEDS data and foster compliance with federal requirements related to the privacy and security of sensitive information maintained by DHCS.

Medi-Cal Ground Emergency Medical Transportation (GEMT) Services AB 678

Position: 1.5 Permanent
FF: $119,000
OF: $119,000
Total: $238,000

DHCS requests 1.5 positions and reimbursement authority to address the responsibilities associated with Assembly Bill 678 which allows GEMT service providers owned or operated by public entities to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment that these providers would otherwise receive, up to 100 percent of their actual allowable costs. The non-federal share of the supplemental reimbursement would be paid with funds from specified governmental entities through certified public expenditures.

Medi-Cal Coverage of Eligible Juvenile Inmate Inpatient Costs AB 396

Positions: 1.0 Permanent
FF: $50,000
OF: $49,000
Total: $99,000

DHCS requests 1.0 position to address the workload associated with Assembly Bill (AB) 396. AB 396 allows for the development of a process for counties and the California Department of Corrections and Rehabilitation (CDCR) to receive available federal funds for inpatient hospital services and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates off the grounds of a correctional facility. The position will also be responsible for processing adjudicated claims for federal reimbursement to counties or the CDCR, as applicable.

Health Care Financing: California Medical Assistance Commission Staff Transition and Diagnosis Related Group Payment System (CMAC/DRG)

Positions: 12.0 Permanent
GF: $658,000
Total: $658,000

Assembly Bill 102 enacted law to dissolve the California Medical Assistance Commission (CMAC) and transfer its staff and functions to DHCS effective July 1, 2012. It also directed DHCS to develop and implement the Diagnosis Related Group (DRG) payment system which would replace the current Selective Provider Contracting Program (SPCP). The new DRG system replaces payments based on per diem rates with payments based on the patient's assigned diagnosis/es. This proposal addresses these requirements by requesting the transfer of 12.0 CMAC "exempt" positions to continue working on the SPCP and related health care financing efforts until the new DRG payment system is implemented. It also requests the January 1, 2013, establishment of 12.0 permanent positions to administer and manage the new DRG payment system for fee-for-service hospital inpatient services and to continually evaluate improvements to the Medi-Cal financing system.

Maternal, Child and Adolescent Health (MCAH) Title V Reduction

Positions: -4.0 Permanent
OF: -$1,160,000
Total: -$1,160,000

DHCS, in conjunction with the California Department of Public Health, submits this proposal to bring budget and staffing resources in line with a reduction of the federal Title V grant. This grant provides a large amount of funding for the Maternal, Child and Adolescent Health (MCAH) program. The MCAH program partners with various state, federal, and local agencies to provide programs for reproductive health, family planning, pregnancy, human stem cell research, and birth defects. The program serves pregnant women, infants, children, and teens.

Local Educational Agency (LEA) Medi-Cal Billing Option Program Audit Staff

Positions: 14.0 Permanent
FF: $820,000
OF: $820,000
Total: $1,640,000

DHCS requests the conversion of 14.0 LEA positions from limited-term to permanent in order to continue performing financial oversight requirements mandated by the Centers for Medicaid and Medicare Services under State Plan Amendment 03-024. Audits and Investigations will reconcile and perform audits of LEA reported expenditures and services. The LEA program was established in DHCS in 2003. This program provides early and periodic screening, diagnosis and treatment services to children at local school sites.

Targeted Case Management (TCM) Audits

Positions: 8.0 Permanent
FF: $446,000
OF: $445,000
Total: $891,000

DHCS requests the conversion of 8.0 TCM positions from limited term to permanent in order to meet workload associated with the additional financial oversight requirements and corrective action for the TCM Program required by the Centers for Medicare and Medicaid Services. This program provides comprehensive case management services to Medi-Cal eligibles in six target populations including adult probation, outpatient clinics, and public guardianships. The case management services coordinate medical, social, and educational services.

Baseline HIPAA Staffing

Positions: 14.0 Permanent
GF: $723,000
FF: $1,228,000
Total: $1,951,000

DHCS requests the conversion of 14.0 limited-term positions to permanent in order to maintain the Health Insurance Portability and Accountability Act of 1996 (HIPAA) solutions established in recent years, address federally mandated changes in administrative health information exchange and management, maintain adherence to state and federal information privacy and security requirements, and prepare for the pending updates and changes in administrative standards and operating rules implemented as part of federal health care reform. As one of the largest health care entities, DHCS is highly impacted by the increased level of regulation associated with the protection of personal information, particularly for health care data.

Access Monitoring Program

Positions: 2.0 Permanent
GF: $282,000
FF: $282,000
Total: $564,000

DHCS requests 2.0 permanent positions and contract funds to comply with new federal requirements to establish a system for continuously monitoring Medi-Cal beneficiaries' access to healthcare services. California Assembly Bill 97 requires DHCS to implement a 10 percent provider payment reduction. Prior to implementation, DHCS must seek approval from the Centers for Medicare and Medicaid Services (CMS) to modify its Medicaid State Plan via a State Plan Amendment (SPA). New requirements set forth by CMS for approval of SPAs necessitate that California develop and implement a system for monitoring healthcare access for its Medi-Cal beneficiaries. CMS approval of California's SPA required DHCS to design and implement an adequate system for continuously monitoring healthcare access. The continuous monitoring of healthcare access across Medi-Cal's entire healthcare provider network will generate additional workload beyond what can be achieved with current staffing resources.

Other Care Services – Alcohol and Drug Programs

Positions: 161.5 Permanent
GF: $34,069,000
FF: $261,946,000
OF: $12,171,000
Total: $308,186,000

The Department of Alcohol and Drug Programs, in conjunction with DHCS, proposes to transfer 161.5 positions and funding authority for the majority of the DADP state-level programs to DHCS: the Substance Abuse Prevention and Treatment Block Grant administration, data collection and reporting, prevention activities, the statewide needs assessment efforts, the Parolee Services Network and other statewide oversight and coordination programs.

California Department of Public Health Transitions

Positions: 45.6 Permanent
GF: $17,413,000
FF: $7,184,000
OF: $33,282,000
Total: $57,879,000

The California Department of Public Health, in conjunction with DHCS, proposes to transfer.45.6 positions and funding authority for three direct service programs to DHCS: Every Woman Counts (EWC) Program, Prostate Cancer Treatment Program, and Family Planning Access Care and Treatment (FPACT) Program. The transfer of direct service programs to DHCS will allow both DHCS and CDPH to focus more closely on their core missions, goals, and objectives. These three programs are particularly well-

aligned with DHCS because they provide direct services to low-income individuals and have income eligibility requirements designed to serve low-income Californians, thus aligning more closely with the scope of services provided by DHCS.

As implementation of the Federal Affordable Care Act allows greater numbers of low-income individuals to enroll in Medi-Cal, placement of these programs in DHCS will facilitate a more seamless transition to Medi-Cal enrollment and maximize opportunities to leverage Federal Medicaid funds to cover costs currently supported with State funds.

By realigning these CDPH programs with DHCS, both departments expect more seamless service delivery between State-funded medical treatment programs, along with increased opportunities to leverage Federal Medicaid funds to cover costs currently supported with State funds.

Department of Mental Health Transition

Positions: 41.0 Positions
GF: $256,000
FF: $65,116,000
OF: $6,949,000
Total: $72,321,000

The Department of Mental Health, in conjunction with DHCS, proposes to transfer 41.0 positions and funding authority for the majority of the DMH state-level programs to DHCS. The programs and functions include: Financial Oversight, Certification Compliance/Quality Improvement, Mental Health Services Act (MHSA) State Level Issue Resolution, County Data Collection & Reporting, Suicide Prevention, Student Mental Health Initiative and Stigma & Discrimination, Co-occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Training Contracts, California Health Interview Survey , MHSA Housing, and the Mental Health Planning Council.