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# *California State Senate*

COMMITTEE
ON
BUDGET AND FISCAL REVIEW

ROOM 5019, STATE CAPITOL
SACRAMENTO, CA 95814

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## Agenda
## May 26, 2010
## Room 4203
## 9:30 a.m.

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## *JUDICIAL, CORRECTIONS, AND PUBLIC SAFETY*

## *HEALTH*

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

## 0250-111-0001 Judicial Branch

**Courts Budget Package.** The Governor's budget proposed budget solutions for the Judicial Branch that included (1) automated speed enforcement, (2) electronic court reporting, and (3) a $15 increase in the court security fee.

Senate Budget Subcommittee #4 approved an alternative package of budget solutions. Approved changes included the following:

- Court construction balance transfers ($98 mill.),
- Fund balance transfers ($32 million),
- $10 court security fee increase ($40 million),
- $250 summary judgment fee increase ($6 mill.),
- $15 telephonic fee increase ($5 million),
- $40 per citation fee on automated traffic enforcement ($28 million),
- First paper fee increase ($40 million),
- $250 pro hac vice fee increase ($1 million),
- $3 parking fee surcharge ($11 million),
- $50 million General Fund reduction.

$25,000

Trailer bill language

The package of changes approved by the Senate subcommittee was developed by a working group of court stakeholders and legislative staff. The package was designed to fund the courts at a level that would prevent court closures in 2010-11. As part of this package, the subcommittee rejected automated speed enforcement, did not hear electronic court reporting, and reduced the Governor's proposed court security fee.

Ongoing conversations have resulted in the following recommended changes to the package:

- Increase the telephonic fee increase to $20,
- Decrease GF reduction from $50 mill. to $25 mill.,
- Revise statute to add defense attorneys to membership on Judicial Council task force on court-ordered debt,
- Add a 2013 sunset on the court security fee increase with moratorium on further increases.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

## 0820-001-0001 Department of Justice

## 0820-001-0460

**Gun Show Program Augmentation.** The Governor proposes to augment the Attorney General's program for monitoring gun shows by one position, as well as transfer the entire program from the General Fund to the Dealers' Record of Sales (DROS) Account.

This proposal would result in General Fund savings of $616,000.

-$616 GF

$801 DROS Account

The DOJ reports that there are approximately 97 gun shows in California annually, ranging in size from 150 tables (vendors) to 5,300 tables per show. The DOJ has reduced its staffing for this program by 40 percent in recent years due to budget cuts.

The DROS Account is projected to have a healthy fund balance of $17.9 million at the end of the budget year.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 2100-001-3036 Department of Alcoholic Beverage Control

**Liquor License Fee Adjustment.** The Governor proposes to increase the original fee for a general liquor license from $12,000 to $13,800.

The proposed increase would generate an estimated $394,200 in the budget year and $788,400 in 2011-12. Revenues from this fee are deposited into the Alcohol Beverage Control Fund (3036).

$394.2 (revenues)

The administration's proposal reflects a 15 percent increase in this fee. The fee was last increased in 1995. While current law permits annual adjustments to license renewal fees based on the California Price Index (CPI), the law does not provide for the same adjustments for the original fee.

The department reports a structural budget shortfall of $3.3 million in 2010-11 without this fee increase.

The Assembly budget committee approved this request as well as trailer bill language to permit the increase of this fee based on CPI.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 5225-001-0001 California Department of Corrections and Rehabilitation

**Local Public Safety Block Grant Program.** The Governor's May Revision includes a proposal to require that all offenders sentenced to three years or less for a felony must serve that sentence in local jail rather than state prison. The Governor's proposal would exclude inmates who have a current or prior serious, violent, or sex offense.

The Governor proposes that a share of the state savings generated – $11,500 per additional offender housed in local jails – would be provided to county probation departments to be used by the county for correctional purposes, including supervision, housing, or treatment services.

-$243,840 GF

The CDCR estimates that the proposed change would reduce the average daily prison population by about 10,600 in 2010-11. Most affected offenders would be those convicted for drug and property crimes.

An estimated $122 million would be provided to county probation departments in 2011-12 as reimbursement for the offenders housed locally in 2010-11. Provision of funding to probation for evidence-based correctional programs could help reduce existing jail overcrowding pressures.

County jails currently house about 82,000 inmates on average, and counties supervise about 347,000 offenders on probation.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Felony Term Reform.** The Governor's January budget proposed to amend sentencing law by changing certain felonies that are currently eligible for incarceration in prison to an alternative felony term subject to no more than 366 days in local jail. The administration's proposed language would except individuals with prior serious or violent felony convictions who would be subject to state prison terms but not jail.<br><br>The May Revision proposes to withdraw this proposal in light of the Governor's Local Public Safety Block Grant proposal. | -$291,608 January<br><br>$291,608 May Revise | The CDCR estimated that the proposed January change would reduce the average daily prison population by about 12,700 in 2010-11.<br><br>This proposal affects many of the same offenders as under the Local Public Safety Block Grant proposal. Therefore, these policies are largely duplicative with each other. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Local Assistance Back Payments.** The administration requests $80.5 million one-time to pay backlogged claims from counties for the costs associated with housing parole violators. | $80,536 GF | The state is required to reimburse counties for the cost of housing parole violators awaiting their administrative revocation hearing. There were about 75,000 parolee revocations in 2008.<br><br>The LAO recommends spreading these payments over three years generating budget year savings of about $54 million. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Local Safety and Protection Account.** The Governor proposes trailer bill language that would provide $502 million General Fund, beginning in 2011-12, as a continuous appropriation to the Local Public Safety and Protection Account which provides funding for several local public safety programs.<br><br>This funding would replace revenue that will be lost when the Vehicle License Fee (VLF) is reduced per its sunset at the end of 2010-11. | $0<br><br>$502,900 (2011-12) GF | A share of the VLF (0.15) currently provides supplemental funding to local governments for several local public safety programs, including Citizens Options for Public Safety (COPS), Juvenile Justice Crime Prevention Act (JJCPA), and Juvenile Probation and Camps Programs.<br><br>Historically, the LAO has recommended that the Legislature examine more closely the specific public safety programs funded by the VLF. Some, like JJCPA, have defined objectives and reporting requirements on outcomes while others do not.<br><br>Prior to 2009, these programs were funded by the General Fund. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Juvenile Offender Population Reform.** The Governor's May Revise modified its January budget proposal regarding juvenile justice population reforms. The revised proposal would include (1) realignment of juvenile parole to county probation, and (2) transfer of some wards sentenced as adults to state prison when they reach age 18.<br><br>Under the juvenile realignment proposal, the state would provide a share of the state savings – $15,000 per parolee – to counties. The Governor also proposes to provide $115,000 for each parole violator housed in local facilities.<br><br>The Governor withdraws his proposals to reduce the age of jurisdiction to 21, as well as the proposal to eliminate "time-adds" – additional commitment time that can be given by department staff based on disciplinary problems. | -$10,180 GF<br><br>-$420 Prop 98 | There are currently about 1,800 parolees under DJJ supervision statewide. By comparison there were about 89,000 juveniles on community supervision by county probation in 2006. In the past, the LAO has recommended realigning juvenile parole to probation, in part, finding it could result in better supervision because the state's current staff resources are spread thinly across the state for a diminishing number of offenders.<br><br>According to the LAO, in 2009, wards have their parole consideration postponed by an average of 14 months over the course of their stay at DJJ facilities due to time-adds. The LAO estimates that elimination of time-adds would result in annual state savings in the low tens of millions of dollars annually. Department staff and national experts testified in Senate hearings earlier this year that time-adds are not effective at reducing disciplinary infractions. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 5225-801-0660 California Department of Corrections and Rehabilitation

**Local Youthful Offender Rehabilitative Facilities.** The Governor requests that existing law be amended to provide an additional $300 million lease revenue authority for local youthful offender rehabilitative facilities.

SB 81 (Chapter 175, Statutes of 2007) provided $100 million for construction and renovation of local juvenile justice rehabilitative facilities.

$300,000 Lease-revenue

This program provides funding on a competitive basis. The administering agency, the Corrections Standards Authority, used a weighting system for this program that prioritized demonstration of capacity need and project focus on rehabilitation programming.

The $100 million already authorized has been awarded to six counties. The state received a total of 14 funding requests totaling $232 million.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Design-Build Authority for Local Correctional Facilities.** The Governor proposes to amend existing law to allow counties to use design-build project delivery method in the construction of county jails authorized by AB 900 (Chapter 7, Statutes of 2007), as well as local youthful offender rehabilitative facilities authorized by SB 81 (Chapter 175, Statutes of 2007).<br><br>The proposed language will also amend current statutes that permit local governments to use design-build authority for construction projects by extending the sunset from 2011 to 2016. | Trailer bill language | Allowance for counties to use the design-build project delivery method for construction of correctional facilities would allow some projects to be completed more quickly. This may be particularly valuable should the Legislature choose to approve proposals that would result in more adult and juvenile offenders being housed in local instead of state facilities.<br><br>SB 879 (Cox) proposes to extend the sunset date for local construction design-build authority and is currently under legislative consideration. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 5225-002-0001 California Department of Corrections and Rehabilitation

**Receiver Solution.** The Governor proposes a reduction of $811 million to the budget for inmate medical care.

This reduction level was estimated based on the difference in per capita spending for inmate medical care in California ($10,482) versus in New York State ($5,757).

-$811,000

The state spent about $800 million on inmate health care (also including mental and dental health services) in 2001. Spending on these programs grew to $2.2 billion this year. Cost increases have been driven by the implementation of three major class action lawsuits designed to bring inmate health care up to constitutionally adequate levels of care.

Cost increases have been associated with increased staffing levels, salary increases, pharmaceuticals and medical supplies, and increased custody staffing for medical guarding, access, and transportation.

The DOF's Office of State Audits and Evaluation has been evaluating how California's inmate medical program costs differ from those of other large states.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Receiver Augmentations.** The Receiver requests budget year augmentations totaling $532 million for six purposes:<br>• Information technology projects ($235 mill.);<br>• Contract medical costs ($209 million);<br>• Pharmaceutical supplies ($46 million);<br>• Nursing relief ($24 million);<br>• Medication distribution ($10 million);<br>• Health information management ($8 million);<br><br>These proposals are designed to allow the Receiver to implement his Turnaround Plan of Action, his plan submitted to the Federal court specifying the steps necessary to return inmate medical care to a constitutionally adequate level of care. If successfully implemented, the Receiver reports that it should allow for the conclusion of the federal receivership. | $532,159 | Out-year costs are projected to be lower as one-time costs, particularly for IT projects, expire. In total, these proposals would add 531 PYs in the BY.<br><br>Combined with the Receiver Solution proposal, the Governor reduces the Receiver's budget by $279 million net. In addition, several of these proposals are designed to reduce inefficiencies and costs, including reliance on expensive nursing registries and overtime. These projected cost reductions ($308 mill.) are built into the Receiver's estimated need for contract medical.<br><br>The LAO recommends reducing funding by $153 million from the IT projects by prioritizing IT projects providing basic infrastructure or greater efficiencies, as well as recognizing $45.6 million already provided by the Legislature for IT projects. In addition, staff finds that funding for medication distribution is over-budgeted by $5 million on a workload basis. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 4300 Department of Developmental Services: Community Services *(Vote Only)*

**Governor's Reduction of $48.2 million ($25.3 million GF)**

-$48,200 total

-$25,300 GF

Governor's May Revision updates his January proposal to reduce by an additional $48.2 million ($25.3 million General Fund) the local assistance appropriation used to fund Purchase of Services expenditures managed by Regional Centers, and Regional Center Operations.

The proposal would increase the existing three percent reduction for Purchase of Services and Regional Center Operations by *an additional 1.25 percent* for a total of 4.25 percent each. The proposed total of 4.25 percent reduction would be effective from July 1, 2010 to June 30, 2011, inclusive, as contained in proposed trailer bill language.

Of the proposed reduction **(1)** $41.5 million ($20.7 million General Fund) would be from the Purchase of Services; and **(2)** $6.6 million ($4.6 million General Fund) would be from Regional Center Operations.

DDS has proposed trailer bill language to provide Regional Centers with temporary authority (one-year) to modify personnel requirements, functions or qualifications or training requirements for provides, except for licensed or certified residential providers, whose payments are reduced by this action.

Subcommittee #3 has previously discussed this issue twice—on April 29th and May 21st. Considerable testimony was received and some suggestions were incorporated by the DDS into trailer bill language as described.

DDS' proposed language is similar to temporary exemptions enacted in the early 1990s. This language tries to minimize impacts to consumers.

It should be noted that the Developmental Services system has absorbed substantial reductions over the course of the past 18-months. Due to the cohesive, community-based fabric of this system, it has collectively pulled together to creatively identify methods for obtaining more federal funds, to share resources and services across systems and to generally, make it all work together as a system of services and supports for people. This has taken tremendous effort.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 4440 Department of Mental Health: Community Mental Health Services

**Governor's Proposal to Eliminate Funds for Community Mental Health and Shift to Other Programs.**

-$602,000 GF

-602,000 County Funds

Governor proposes to reduce Mental Health Subaccount Funds by $602 million (County Realignment), and redirect these monies to pay for County social services costs that would be shifted from the State to Counties. Specifically, it would increase County shares-of-cost in Food Stamp Administration and Child Welfare Services for total General Fund savings of $602 million in 2010-11.

Local mental health services would lose 60 percent of their existing funding and be decimated. Under this concept, California would support only federally required mental health services to Medi-Cal enrollees. The Administration includes this to mean only Early and Periodic Screening, Diagnosis and Treatment Program services to children, in-patient treatment, and medications for adults.

This would be a radical departure from the existing provision of services. All other mental health services, such as Clinic Outpatient services, Crisis Management services, psychiatric therapies, and related *medically necessary* services would not be funded under this proposal.

County Mental Health Plans, for whom the State contracts for the provision of Medi-Cal Managed Care services, would likely return the program back to the State for operation. This would have significant unforeseen consequences.

Governor's proposal reneges on the fundamental foundations of AB 1288 (Bronzan and McCorquodale), Statutes of 1991, which realigned the fiscal and administrative responsibility for community-based mental health services. The core intent of this partnership was to provide a more stable funding source for community-based mental health services and to make services more client centered and family focused.

This proposal is severely flawed for numerous reasons from a public policy perspective, legal perspective, fiscal perspective and most importantly, from a human consequence on individuals and our respective society. Specifically, it does the following:

- Violates maintenance of effort language under the Mental Health Services Act (Proposition 63) which requires continued financial support for mental health programs as provided in 2003-04 (Section 5891 (a) of W&I Code).
- Likely violates the federal Americans with Disabilities Act and the federal Supreme Court ruling in Olmstead regarding access to medically necessary services for individuals with disabilities and the need to provide services in the least restrictive environment—in outpatient arrangements, not institutions.
- Likely violates the State's existing Medi-Cal Mental Health Waiver in which the State obtains over $2 billion annually.
- Likely violates federal Medicaid (Medi-Cal in CA) law which requires mental health parity in Managed Care arrangements.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Adjustments for Mental Health Managed Care & Update on the Status of Waiver.** | -$530 total | In the Subcommittee #3 hearing of March 11th, action was taken to reject the Governor's proposal to amend Proposition 63 (The Mental Health Services Act). |
| Governor proposes a net decrease of $530,000 (increase of $61.2 million General Fund) to reflect *deletion* of January's proposal to seek voter approval to amend Proposition 63 to backfill for General Fund support, as well as minor technical adjustments. | $61,150 GF<br>-$61,176 Prop 63 | May Revision also deletes the redirection of Proposition 63 and reflects minor adjustments related to caseload and federal funding. No issues have been raised. |
| California's Medi-Cal Specialty Mental Health Services Waiver covers two programs within the DMH: (1) the Early and Periodic, Screening Diagnosis and Treatment (EPSDT) Program for children; and (2) Mental Health Medi-Cal Managed Care Program. | -$504 Reim | A status update regarding the Administration's discussions with the federal CMS on extending California's Waiver for another year should be provided. This Waiver provides California with over $1.5 billion annually. |
| The Administration was informed by the federal Centers for Medicare and Medicaid (CMS) in September 2009 that California's comprehensive Medi-Cal Specialty Mental Health Services Waiver would *only* be approved for one-year, to September 30, 2010, instead of the requested two-year renewal period which is standard. | | Specifically, will the federal CMS requirements be met and what are the revised timelines? |
| Changes to the Waiver and California's State Medi-Cal Plan need to be made and several of these changes are due to continued federal audit concerns related to State administration of the program. A State Plan Amendment is to be provided to the federal CMS by June 30, 2010. | | |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Adjustments to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.**<br><br>Governor proposes a series of adjustments for EPSDT for a net increase of $145 million ($30.7 million General Fund) as compared to January for 2010-11. This net increase is due to the following *key* factors:<br><br>• Increase of $391.2 million (General Fund) to reflect the deletion of the redirection of Proposition 63 Funds.<br>• Increase of $31.5 million (General Fund) and corresponding federal funds to reflect a revised projection for EPSDT claims which are mainly due to projected cost, utilization, and caseload increases in the Mental Health Services category of EPSDT.<br>• Increase of $20.8 million (General Fund) for cost settlement amounts for 2007-08.<br>• Decrease of $11.1 million (General Fund) to reflect increased participation by the County contribution of local Proposition 63 Funds contributed to the EPSDT Program for new or expanded EPSDT services based on updated claims data.<br>• Increase of $69.5 million to reflect adjustments to the EPSDT County baseline for reimbursements which had not been included in previous estimates, according to the Department of Finance. | $145,027 total<br><br>$30,716 GF | EPSDT is a federally mandated program that requires States to provide Medi-Cal enrollees under age 21 any health or mental service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a State's Medi-Cal plan. EPSDT operates under California's Medi-Cal Specialty Mental Health Services Waiver.<br><br>Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.<br><br>County Mental Health Plans are responsible for the *delivery* of EPSDT mental health services to children. Counties must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on Counties through a Governor Davis administrative action in 2002. This equates to about $90 million or so in County Realignment Funds. The State and federal governments have primary financial responsibility for EPSDT funding.<br><br>Due to several court cases over the years, California was required to expand its penetration rate for providing services, as well as the types of services it provides.<br><br>DMH should provide a summary of each key factor of the EPSDT May Revision. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Supplemental Mental Health Services in Healthy Families Program.**<br><br>Governor proposes a *net* decrease of $6.2 million (federal funds) for supplemental mental health services for children in the Healthy Families Program.<br><br>DMH states this decline in federal reimbursement provided to County Mental Health Plans is *primarily* due to a decrease in forecast of approved claims. It is believed this decrease is attributable to the fact that the Managed Risk Medical Insurance Board stopped enrollment of children in the Healthy Families Program for a brief period in 2009 due to the State's fiscal condition. Minor technical adjustments are also reflected. | -$6,242 federal | Medically necessary mental health services are provided for children who are seriously emotionally disturbed beyond the basic mental health benefit provided within the Healthy Families Program.<br><br>County Mental Health Plans provide these services and use County Realignment Funds to obtain the federal match (66 percent match provided under the federal States-Children Health Insurance Program). |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 4440 Department of Mental Health: State Hospitals & State Support

**May Revision for State Hospitals.**

$5,669 GF

Governor proposes an increase of $5.7 million (General Fund) for the State Hospitals to fund Level-of-Care staff for projected increases in the State Hospital patient population.

DMH states this increase reflects an overall net increase of 95 patients in the Judicially Committed/Penal Code population.

This net 95 estimate assumes an increase of 158 Incompetent to Stand Trial (ISTs) patients, a decrease of 42 Mentally Disordered Offenders (MDO), and a net decrease of 21 patients in other categories of commitment.

DMH directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton, and two acute psychiatric programs at the California Medical Facility at Vacaville and the Salinas Valley State Prison.

Governor's May Revision for the State Hospitals provides a total of $1.343 billion ($1.3 billion General Fund) which reflects an increase of $172.4 million (General Fund) as compared to the revised 2009-2010 budget. A total of 6,477 patients are estimated to be treated at the facilities in 2010-11.

The LAO contends the May Revision over-estimates caseload for 2010-11, as well as for the current-year. Specifically, the LAO recommends a reduction of $6 million (General Fund) for the current-year, *and* a reduction of $14.7 million (General Fund), for a *total reduction* of $20.7 million (General Fund).

The LAO estimate reflects caseload adjustments primarily associated with Mentally Disordered Offenders and Sexually Violent Predators (SVPs).

The LAO caseload adjustments appear to be reasonable. It is recommended to adopt their reduction for both years.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **State Hospital Capital Outlay--Napa.**<br><br>Governor's January budget includes a request for reappropriation of $10.8 million (General Fund) for working drawings ($605,000) and construction phases ($10.2 million) of the "satellite" kitchens at Napa State Hospital.<br><br>In addition, the budget includes a reappropriation of $31.6 million (bond funds) for the "main" kitchen (working drawings of $2.7 million, and construction phases of $28.9 million) at Napa State Hospital.<br><br>The DMH states these reappropriations are needed due to current delays. | $10,783 GF | Subcommittee #3 deleted a reappropriation similarly created for the Patton State Hospital "satellite" kitchens due to the State's fiscal crisis.<br><br>Committee staff recommends *deletion* of $10.8 million (General Fund) from the proposed reappropriation for the satellite kitchens at Napa State Hospital. The main kitchen project, funded with bonds, is recommended to proceed.<br><br>This would be consistent with prior action taken in Subcommittee. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Deletion of Budget Bill Language for Conditional Release Program.**<br><br>Governor proposes a decrease of $750,000 (General Fund) and related Budget Bill Language since the patient population is not expected to materialize. | -$750 GF | Historically, this funding provides for (1) outpatient services to patients into the Conditional Release Program (CONREP) via either a court order or as a condition of parole; and (2) hospital liaison visits to patients continuing their in-patient treatment at State Hospitals who may eventually enter CONREP. The patient population includes: (1) Not Guilty by Reason of Insanity, (2) Mentally Disordered Offenders, (3) Mentally Disordered Sex Offenders, and (4) Sexually Violent Predators.<br><br>LAO *concurs* with the DMH reduction. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Reduction to Sex Offender Commitment Program.**<br><br>Governor proposes reduction of $10.3 million (General Fund) in the Sex Offender Commitment Program due to several factors but mostly it reflects a change in the mix of individuals referred by the CDCR to the DMH for clinical evaluation.<br><br>DMH states an increasing share of the individuals referred for clinical evaluation have already been evaluated by the DMH, and since evaluations of "re-referrals" are less costly than initial evaluations, this has resulted in savings. About 70 percent of the individuals being evaluated are "re-referrals".<br><br>The current-year budget is $21.6 million (General Fund). | -$10,266 GF | The Sex Offender Commitment Program (SOCP) evaluates individuals to determine if they meet the statutory criteria, enacted in 2006 by Proposition 83 (Jessica's Law), for Civil Commitment as a Sexually Violent Predator.<br><br>The CA Department of Corrections and Rehabilitation (CDCR) and the Board of Parole Hearings refer sex offenders to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.<br><br>LAO concurs with the DMH reduction. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **DMH Request for Legal Staff.**<br><br>Governor is requesting an increase of $3.1 million (General Fund) to hire *six positions*—four Staff Counsel, a Legal Assistant, and a Legal Secretary—, and to contract with *private* counsel for its legal workload.<br><br>The DMH contends these resources are necessary due to changes at the Attorney General's (AG's) Office regarding "non-billable" departments.<br><br>Historically, the AG's Office has performed legal work for the DMH. Unlike many other departments, DMH is not billed by the AG for legal work performed by its staff. Rather, the AG is provided General Fund support for legal work associated with all "non-billable" departments.<br><br>However, due to budget reductions at the AG's Office, the AG has reduced the number of hours of legal work it will perform for the DMH by 8,000 (5,000 hours of attorney work and 3,000 hours of paralegal work). As such, the DMH states they are requesting this augmentation. | $3,076 GF | LAO recommends to provide *only* $1.2 million (General Fund) to the DMH to contract with the AG's Office for legal services; and thereby, save almost $2 million (General Fund).<br><br>Specifically, the LAO notes the AG's Office bills for legal services at a much lower rate than private counsel. Further, no new State positions are needed at the DMH since the AG's Office has clarified that they are indeed continuing to provide certain legal services which the DMH may have thought they were not going to continue. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 4280 Managed Risk Medical Insurance Board: Healthy Families Program

**Background.** The Healthy Families Program (HFP) provides health, dental, and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of federal poverty who are not eligible for Medi-Cal but meet citizenship or immigration requirements. All families pay monthly premiums for enrollment of their children and there are copayments for many services.

The Managed Risk Medical Insurance Board (MRMIB) directly contracts with health, dental, and vision plans and administers the overall program. HFP is not an entitlement. The MRMIB has authority to establish waiting lists if necessary.

A 65 percent federal match is provided through a federal allotment. California matches this allotment through (1) family premium payments; (2) General Fund support; (3) the Children's Health and Human Services Fund; and (4) Proposition 10 Funds.

**Summary of Governor's May Revision.** A total of $1.1 billion ($114.5 million General Fund, $186.2 million Children's Health and Human Services Fund, $81.4 million Proposition 10 Funds, $710.8 million federal funds, and $8 million in reimbursements). It is estimated that 964,864 children will be enrolled as of June 30, 2011. Of the total projected enrollment, about 80 percent of the children are in families with incomes at or *below* 200 percent of poverty.

**Prior Cost Containment and Fund Shifts.** A series of cost-containment actions and fund shifts have occurred over past years. Key changes have included: **(1)** Premium increases in 2005 and twice in 2009; **(2)** Implementing an annual limit on dental coverage; **(3)** Increasing copayments for various services; **(4)** Extending the gross premium tax to Medi-Cal Managed Care organizations to provide increased funds to children's health, including the HFP; and **(5)** obtaining additional Proposition 10 funds.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## Increases to Healthy Families Premiums.

-$29,700 GF TBL and BBL

Governor increases monthly premiums paid by families, effective September 1, 2010, for a reduction of $29.7 million (General Fund). Trailer bill legislation proposes to **(1)** obtain federal approval of premium increases *prior* to implementation due to risk of violating MOE provisions under federal Patient Protection & Affordable Care Act; and **(2)** increase premiums as noted.

The increases reflect a *75 percent to 88 percent increase* to existing premiums. California would be at the higher end of premiums charged by other states. Increases are as follows:

**1. 151 to 200 percent of poverty.**
Monthly premium *increase* of $14 per child, for a total premium of $30 per child, with a family maximum of $90 per month (3 or more children). A reduction of $ 10.4 million (General Fund) is assumed for this component.

**2. 201 to 250 percent of poverty.**
Monthly premium increase of $18 per child, for a total premium of $42 per child, with a family maximum of $126 per month (3 or more children). A reduction of $13.3 million (General Fund) is assumed for this component.

Budget Bill Language proposes to provide notification to Legislature if federal government disallows the proposed premium increases.

All families pay a monthly premium and copayments. The amount paid varies according to family income and health plan selected. Certain premium discount options can offset some costs. Premiums *and* copayments for families were *increased* in 2005 and *twice* in 2009. More increases creates considerable financial hardship.

The table below displays the May Revision proposal.

| HFP Subscriber Family Income (Assumes 3 in family) | Current Month Premium | Governor's Proposed Increase |
|---|---|---|
| 100 to 150% up to $27,468 | $7 per child, maximum of $14 | No change. Federal law prohibits. |
| 151 to 200% up to $36,620 | $16 per child maximum of $48 | $14 increase or $30 per child Maximum of $90 |
| 201 to 250% up to $45,775 | $24 per child maximum of $72 | $18 increase or $42 per child Maximum of $126 |

The federal Patient Protection & Affordable Care Act's maintenance of effort (MOE) provisions prohibit States from making restrictive changes in eligibility standards, methodologies, and procedures. This proposal *may violate* this law.

In addition, federal law *limits* cost-sharing to a maximum of *five percent* of monthly family income. As such, California may be required to directly track and monitor family out-of-pocket expenditures if premium increases approved. This would be a costly administrative burden.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Increases in Copayments for Healthy Families.**<br><br>Governor proposes two new copayments, effective February 2011, as follows:<br><br>1. Emergency Room Use. Copayments of $50 would be charged for Emergency Room use that does *not* result in a patient being hospitalized or being held for outpatient observation.<br><br>Presently the HFP has copayments of $15 for this purpose. As such, the May Revision represents a $45 dollar increase, or a 300 percent jump in cost sharing. A reduction of $2.5 million (General Fund) is assumed from the copayment increase.<br><br>2. Hospital In-patient Day. Copayments of $100 per day, with a maximum of $200 per admission/stay, would be charged for Hospital In-patient days. Presently there is no copayment for hospitalization. A reduction of $712,000 (General Fund) is assumed from the copayment increase.<br><br>Trailer bill legislation is proposed to **(1)** obtain federal approval of copayment increases *prior* to implementation due to risk of violating MOE provisions under federal Patient Protection & Affordable Care Act; and **(2)** increase copayments as noted. | -$9,269 total<br><br>-$3,244 GF<br><br>TBL | In addition to monthly premiums, families must also provide copayments for their children to receive services. Copayments count towards the federal cost-sharing calculation of five percent of monthly family income.<br><br>The same concerns regarding potential violation of the federal Patient Protection & Affordable Care Act's MOE apply here, as well as concern with federal limits on cost-sharing as noted under the premium discussion, above.<br><br>The 300 percent increase in copayments here is unreasonable, particularly for low-income families. Both proposals present an extreme hardship on families with sick children.<br><br>As of November 2009, copayments were increased for families with incomes from 150 percent to 250 percent. Current copayments are as follows:<br><br>• $10 for non-preventive health, dental and vision services.<br>• $10 for generic prescription drugs.<br>• $15 for brand name drugs, unless no generic option.<br>• $15 for Emergency Room visits, unless child admitted to hospital.<br><br>The HFP copayment proposals mirror those the Governor has also proposed under the Medi-Cal Program for the May Revision. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Eliminate Vision Coverage for Children.**<br><br>Governor proposes to eliminate vision coverage in Healthy Families as of September 1, 2010. Children would no longer have access to eye exams and glasses.<br><br>A reduction of $21.6 million ($7 million General Fund) is assumed from this proposal.<br><br>Trailer bill language is required. | -$21,600 total<br><br>-$7,000 GF<br><br>TBL | Elimination of vision coverage would result in children not being diagnosed for vision anomalies and would likely lead to poor school outcomes and potentially further eye damage without diagnosis and treatment.<br><br>Only medically necessary vision-related services, such as eye surgery and treatment for eye injuries would be covered. All other eye exams and glasses would not be covered. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Availability of Special Funds to Offset GF.**<br><br>The Legislative Analyst's Office has identified a miscalculation within the Healthy Families Program regarding the amount of revenues available from the Children's Health and Human Services (CHHS) Fund.<br><br>Specifically, about $11 million more in revenues is available to offset General Fund support by reflecting revenues available from 2008-09 and capturing enhanced federal funds (American Recovery and Reinvestment Act [ARRA] extension to June 30, 2011). | -$11,000 GF<br><br>$11,000 CHHS | Among other things, AB 1422, Statutes of 2009, extended the State's existing gross premium collection on insurance to Medi-Cal Managed Care plans effective from January 1, 2009. As such, revenues are available from 2008-09 and can be used to match with enhanced federal funds as noted.<br><br>LAO has identified an additional $11 million offset to the General Fund due to a miscalculation. This should be reflected. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

**Increases for Federal CHIPRA Implementation for State Support—Three Components.**

MRMIB increases by $882,000 ($308,000 General Fund) in State support for *nine two-year limited-term positions* to begin implementation of federal requirements as contained in the federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009. Trailer bill language is also proposed for conformity. Positions are as follows:

- FQHC and Rural Health Changes. A total of 4.5 positions and $153,500 GF to (1) establish reconciliation process to ensure all Federally Qualified Health Centers (FQHCs) and Rural Health Centers are compensated their actual costs; and (2) measure increased utilization and delivery of services resulting from enhanced funds to these health clinics.
- Medicaid Managed Care Standards for HFP. A total of 2.0 positions and $81,600 to make numerous changes regarding processes for enrollment, the amount and type of information provided to HFP enrollees, quality assurance standards, and other items as directed.
- Quality Management and Consumer Assessment of Health Plan Services. A total of 2.5 positions and $73,320 to implement the child health and dental quality management and consumer assessment of health plan services as required by CHIRPA.

$308 GF

TBL

The Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009 reauthorized federal law and allocations for children's health insurance programs, including Healthy Families. Various changes were included in this reauthorization.

Key aspects include:

- Compliance with FQHC and Rural Health Center payments for cost-based prospective payment as done in Medi-Cal;
- Changes to ensure enrollee access statewide;
- Provide certain enrollment options; and
- Obtain certain encounter data from health plans.

A total of $6.3 million ($2.2 million GF) is reflected in HFP local assistance to reflect these key component changes.

It should be noted that the proposed trailer bill language, in addition to the CHIRPA conformity, also requests to extend emergency regulation authority for one-year to provide for cost-containment, such as the ability to establish waiting lists if needed, during the 2011-12 period.

MRMIB states resources are needed in order to comply with required changes. Federal penalties and/or loss of federal funding could occur if California does not implement the required changes.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

## 4260 Department of Health Care Services (DHCS): The Medi-Cal Program (Local Assistance)

Summary. Medi-Cal provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. Generally, California receives a 50 percent federal match for most Medi-Cal Program expenditures. This federal match will increase to 61.59 percent under the federal American Recovery and Reinvestment Act (ARRA) for at least a 27-month period (until December 31, 2010), and most likely extend to June 30, 2011.

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

The Governor's May Revision proposes a total of $52.1 billion ($12.9 billion General Fund) for 2010-11. This reflects an increase of $23.4 million General Fund over the January 2010-11 proposal. The number of Medi-Cal eligibiles is estimated to be 7,558,700 people.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Mandatory Enrollment in Managed Care for Seniors and Persons with Disabilities.**<br><br>DHCS assumes phase-in of mandatory enrollment for Medi-Cal enrollees who are designated as Seniors or Persons with Disabilities who reside in Medi-Cal Managed Care counties (14 counties) and are *not* dually eligible for federal Medicare. About 431,683 people would be phased-in over a 12-month period. The phase-in would begin February 2011.<br><br>May Revision reflects a reduction of $357.5 million ($182.1 million General Fund) for 2010-11. Key fiscal assumptions:<br><br>• Managed Care capitation rates will equate to 90 percent of Fee-For-Service costs, based on DHCS analysis.<br><br>• 66 percent of these enrollees will meet definition of Home Health Option under federal Patient Protection and Affordable Care Act, and 5 percent of capitation rate is for home health services which are eligible for a 90 percent federal match.<br><br>• Savings assumes the June 2011 capitation payment for Two-Plan Model and Geographic Managed Care (GMC) Model plans will be deferred in 2011-12, including the new enrollees. (Deferral period is two-weeks). DHCS states this is requested due to the cross-over of paying Fee-For-Service and Managed Care capitation as Medi-Cal enrollees transition from one system to the other. | -$357,496 total<br><br>-$182,052 GF | With the existing Medi-Cal Hospital Financing Waiver scheduled to sunset as of August 30, 2010, trailer bill legislation--AB X4 5, Statutes of 2009—was enacted to begin the framework for a new, more comprehensive 1115 Medi-Cal Waiver for California. A comprehensive Stakeholder Work Group process has convened for several months to engage in the development of this Waiver.<br><br>The goals of the Waiver are to: (1) strengthen California's health care safety net; (2) reduce the number of uninsured individuals; (3) optimize opportunities to increase federal financial participation; (4) promote long-term, efficient and effective use of State and local funds; (5) improve health care quality and outcomes; and (6) promote home and community-based care.<br><br>Among many aspects, it also provides for more comprehensive enrollment of individuals into specified organized delivery systems, such as Medi-Cal Managed Care, enhanced primary care case management or a medical home model.<br><br>DHCS has proposed trailer bill language to proceed with mandatory enrollment of Seniors and Persons with Disabilities who reside in Medi-Cal Managed Care counties as specified. Since this language was released on Monday, May 17th, it is recommended to refer the language to policy committee for more comprehensive discussions. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Trailer Bill on Three Aspects of Pending 1115 Medi-Cal Waiver.**<br><br>Governor is proposing three pieces of trailer bill language pertaining to the phase-in of the pending 1115 Medi-Cal Waiver as follows:<br><br>• Development of pilot projects for Children with Special Health Care Needs;<br>• Development of pilot projects for Dual Eligible Service Integration Projects; and<br>• Development of the Coverage Expansion and Enrollment Projects.<br><br>These three trailer bills have *no* budget year implications with respect to Medi-Cal expenditures.<br><br>The May Revision trailer bill language pertains to the development and implementation of pilot projects in these three areas. | TBL | As noted above, a new comprehensive 1115 Medi-Cal Waiver is pending for California.<br><br>On May 13, 2010, the DHCS released an Implementation Plan for this Waiver. The Implementation Plan is organized around four principle vulnerable Medi-Cal populations:<br><br>• Seniors and Persons with Disabilities;<br>• Children with Special Health Care Needs;<br>• Persons with Behavioral Health Disorders and/or Substance Abuse Requiring Integration of Care; and<br>• Persons with Dual Medi-Cal and Medicare Eligibility.<br><br>A phase-in approach is to be used to address the health care needs of these populations as discussed in the Plan.<br><br>The development of pilot projects under the Waiver requires a *considerable* amount of policy discussion. There are no budget year implications for these pilots. Therefore, it is recommended to refer these trailer bills to the policy committee process. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Medi-Cal Managed Care Baseline Adjustments and Capitation Rates.** | $348,400 total | DHCS is the largest purchaser of managed health care services in California with almost 3.5 million Medi-Cal enrollees, or about 48 percent of the Medi-Cal population enrolled in these arrangements. |
| Governor proposes several adjustments to Medi-Cal Managed Care, including **(1)** baseline adjustments due to anticipated enrollment; and **(2)** rate adjustments to reflect cost trends. | $174,200 GF | DHCS annually reviews, more frequently when warranted, the rates paid to Medi-Cal Managed Care plans. Their analysis is based on actual data regarding utilization trends and financial information provided by the plans. |
| Baseline. An increase in expenditures for the base are due to the transition of Medi-Cal enrollees moving from Fee-for-Service to Managed Care, as noted above (more Seniors and People with Disabilities), along with the increase in caseload of traditional Medi-Cal enrollees (woman and children). An increase of $404.4 million (total funds) is projected for this baseline adjustment (comparing 2009 to 2010). | | DHCS then applies a trend analysis, which is to be verified as actuarially sound, to discern the final rates. |
| Rate Adjustment. May Revision provides an increase of $348 million ($174.2 million General Fund) to provide an estimated 3.7 percent average rate increase for health care plans participating in Medi-Cal Managed Care. | | |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Reassign Contract Negotiations for Geographic Managed Care (GMC) Plans in Medi-Cal.**<br><br>Governor proposes trailer bill language to shift existing responsibility for negotiating contract terms with Managed Care plans and dental plans under the Geographic Managed Care (GMC) Model of Medi-Cal Managed Care from the California Medical Assistance Commission (CMAC) to the DHCS.<br><br>The Administration states this proposal is in response to concerns from health plans and others that rate negotiations conducted cooperatively with CMAC and the DHCS were inefficient, cumbersome, and lengthy.<br><br>The trailer bill would also allow for public disclosure of these GMC rates as specified, as is done with all other Medi-Cal Managed Care plans.<br><br>The May Revision does not reflect any resource changes between departments. | TBL | Since 1994, the California Medical Assistance Commission (CMAC), with considerable support from the DHCS, has negotiated contracts with managed care plans for the provision of Medi-Cal services under the Geographic Managed Care (GMC) Model in both Sacramento and San Diego counties, as well as dental managed care plans in Sacramento.<br><br>The May Revision proposal will consolidate this effort to have all negotiating of contract terms and conditions regarding the Medi-Cal Managed Care Program reside *solely* with the DHCS. This makes sense and is overdue.<br><br>According to information obtained by Committee staff from the DOF, the CMAC uses two staff positions and $240,000 ($120,000 General Fund) for this purpose. It is therefore recommended to approve the trailer bill and to shift CMAC resources to the DHCS for this purpose. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **New Control Section 23.25 in Budget Bill.**<br><br>Governor proposes a new Control Section 23.25 for the Budget Bill which authorizes adjustments to *any* Item of appropriation in the annual Budget Act for the purpose of implementing the federal Patient Protection and Affordable Care Act of 2010.<br><br>Specifically the Control Section is as follows:<br><br>(a) Notwithstanding any other provision of law, the Director of Finance may adjust any item of appropriation in this Act for the purpose of implementing the federal Patient Protection and Affordable Care Act of 2010.<br><br>(b) The Director of Finance shall report to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees of each house of the Legislature that consider appropriation at least 30 days prior to making any adjustment(s) pursuant to this section. The report shall list any proposed adjustment(s) by department and agency and provide supporting detail that explains why the costs are required pursuant to the Patient Protection and Affordable Care Act of 2010. | BBL | The proposed new Control Section 23.25 provides overly broad authority to the Director of Finance to adjust any Item of appropriation in the annual Budget Act for the purpose of implementing the federal Patient Protection and Affordable Care Act of 2010.<br><br>At this time it is unclear as to the intended purpose of this new Control Section. No examples have been provided as to how this mechanism would operate, and there are no specific budget proposals regarding the implementation of the federal Patient Protection and Affordable Care Act of 2010.<br><br>The Legislative Analyst's Office (LAO) contends that changes to appropriations for the purpose of implementing the federal Patient Protection and Affordable Care Act of 2010 should be subject to the same legislative oversight by other changes to appropriations. The LAO recommends deletion of the language. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **New Control Section 8.65.**<br><br>Governor proposes new Control Section 8.65 as follows:<br><br>Nothwithstanding any other provision of law, each item of appropriation in this act shall be adjusted, as determined by the Director of Finance, to reflect changes to General Fund, Federal Trust Fund, and Reimbursement expenditures resulting from the following:<br><br>(a) Continuation through June 30, 2011, of enhanced funding currently provided to Health and Human Services Agency programs pursuant to the American Recovery and Reinvestment Act of 2009.<br><br>(b) Additional federal flexibility or support in a number of targeted areas, including federal reimbursement for the cost of incarcerating undocumented immigrant felons, monies owed the State for incorrect Medicare disability determinations, recalculation of State Medicare Part D Clawback payments, and General Fund relief through the new comprehensive Section 1115 Medi-Cal Waiver.<br><br>(c) Adjustments authorized pursuant to this section shall not be implemented before notification is provided to the chairpersons of the Committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee. | BBL | The federal government has provided California with considerable assistance in the Medi-Cal Program and additional discussions are ongoing with (1) the pending federal ARRA extension to June 30, 2011; (2) monies owed for Medicare disability claiming; and (3) the pending 1115 Medi-Cal Waiver.<br><br>As such, a Control Section is probably necessary to facilitate the management of these funds over the next fiscal year and to offset General Fund support where applicable.<br><br>Presently the proposed Control Section is broadly crafted. As such, it is recommended to adopt placeholder language to further clarify its direction. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **10 Percent Reduction to Designated Public Hospitals.**<br><br>Governor proposes trailer bill language to shift $54.2 million in federal funds, or 10 percent, from payments received by Designated Public Hospitals under the existing Medi-Cal Hospital Financing Waiver to backfill for General Fund support in certain State-operated programs.<br><br>The trailer bill would reduce payments for hospitals provided during the period of July 1, 2010 through June 30, 2011. As such, the DHCS assumes this reduction would be applied under the presently being developed 1115 Medi-Cal Waiver. | -$54,200 GF<br><br>$54,200 federal | The Omnibus Health trailer (AB 4X 5, Statues of 2009) redirected $54.2 million in federal funds, or 10 percent, from Designated Public Hospitals to backfill for General Fund support last year on a one-time basis.<br><br>The existing Medi-Cal Hospital Waiver expires as of August 2010. A new 1115 Medi-Cal Waiver is under discussion with the federal CMS. As such, it is unknown whether this reduction could be enacted.<br><br>In addition, pending federal legislation (H.R. 4213) regarding extension of federal ARRA funds to June 30, 2011, contains a provision clarifying the voluntary nature of local government contributions and the receipt of federal funds. This new provision may make this proposal moot. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **10 Percent Reduction to Private Hospitals.**<br><br>Governor proposes a reduction of $52 million, or 10 percent, the amount Private Hospitals and District Hospitals receive through the existing Hospital Financing Waiver. This issue corresponds to the 10 percent Public Hospital reduction.<br><br>The trailer bill would reduce payments for hospitals provided during the period of July 1, 2010 through June 30, 2011. As such, the DHCS assumes this reduction would be applied under the pending 1115 Medi-Cal Waiver. | -$52,000 GF | The Omnibus Health trailer (AB 4X 5, Statues of 2009) redirected $52 million in federal funds, or 10 percent, from Private Hospitals to backfill for General Fund support last year on a one-time basis.<br><br>The Omnibus Health trailer (AB 4X 5, Statues of 2009) redirected $52 million in federal funds, or 10 percent, from Private Hospitals and District Hospitals to backfill for General Fund support last year on a one-time basis.<br><br>The existing Medi-Cal Hospital Waiver expires as of August 2010. A new 1115 Medi-Cal Waiver is under discussion with the federal CMS. As such, it is unknown whether this reduction could be enacted. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Extend Hospital Quality Assurance Fee for Six Months (to June 30, 2011).**<br><br>Governor proposes trailer bill to extend existing Hospital Quality Assurance Fee (QAF) for another six months, to June 30, 2011, to conform to the anticipated federal ARRA extension (61.59 percent federal match).<br><br>This six month extension of the Hospital QAF will generate about $1 billion in revenue of which $160 million will be available to offset General Fund support in the Medi-Cal Program for children's health services.<br><br>The $160 million General Fund offset is *in addition* to the $560 million offset identified in January. Therefore, a total of $720 million is being used to offset General Fund support in 2010-11.<br><br>The remaining Hospital QAF funds will be used to match federal dollars to provide supplemental Medi-Cal payments to Hospitals as specified. | -$160,000<br>GF | AB 1383, Statutes of 2009, authorized implementation of a Hospital Quality Assurance Fee (QAF) on General Acute Hospitals for the period of April 2009 through December 2010. Implementation of the Hospital QAF requires federal CMS approval which is still pending.<br><br>Under AB 1383, Hospital QAF revenues are used to obtain federal funds to make supplemental Medi-Cal payments to certain Hospitals for Outpatient and Inpatient services to stabilize those Hospitals serving Medi-Cal enrollees.<br><br>AB 1383 also provides $320 million annually in Hospital QAF revenues for health care coverage of children (in Medi-Cal and Healthy Families).<br><br>Due to the timing of the enabling legislation and the proposed trailer bill extension of six months, a total of $720 million is available to offset General Fund support in Medi-Cal for children's health services in 2010-11. This includes the additional $160 million identified in the May Revision. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Hospital Inpatient Rate Freeze.**<br><br>Governor proposes a reduction of $169 million ($84.5 million General Fund) by imposing a rate freeze to Medi-Cal Inpatient Hospital rates paid to all hospitals, *except* for Designated Public Hospitals, at the rate that was in effect on January 1, 2010.<br><br>This rate freeze would apply to both contract hospitals (through the CA Medical Assistance Commission—CMAC) and non-contract hospitals. Any CMAC negotiated rate increases for contract hospitals enacted after January 1, 2010, would be nullified upon implementation of this legislation. An October 1, 2010 date is assumed.<br><br>Designated Public Hospitals are not included in this rate freeze since there is no General Fund expenditure associated with their rates. These hospitals utilize their own "certified public expenditures" (CPEs) to obtain federal funds. | -$168,962 total<br><br>-$84,481 GF | DHCS' proposal would require submission of a State Plan Amendment to the federal CMS for approval, and would require public notice to be sent. The federal CMS may not allow the DHCS to freeze rates retroactively prior to a public notice period.<br><br>In addition, the federal CMS may require DHCS to conduct a rate study in order to justify the proposed rate(s) freeze.<br><br>DHCS states that, if approved by federal CMS, Hospitals will receive substantial Medi-Cal reimbursement increases through the Hospital Fee (AB 1383, Statutes of 2009). |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

**Medi-Cal Quality Assurance Fee (QAF): Summary--Freestanding Nursing Home Reimbursement and Quality and Accountability Proposal.** ***(Page 1 of 2)***

Summary. Considerable change is proposed for the method in which DHCS reimburses Freestanding Nursing Homes (NFs). A phased-in approach over *three-years* is proposed.

Key components are to:

1. Modify existing QAF in several ways to obtain increased revenues to match with federal funds to increase rates paid to NFs by an average of *3.93 percent*, effective August 2010. No General Fund impact. Current QAF structure sunsets as of June 30, 2011.
2. Establish a "Quality and Accountability" (Q&A) special fund to be used in 2011-12 as a supplemental payment pool for rewarding NFs that meet identified quality measurements.
3. Cap NF reimbursement for professional liability insurance at 75th percentile and place savings into Q&A Fund.
4. Disallow reimbursement for legal costs related to cases that have not been found in favor of facilities.
5. Review NF compliance with 3.2 nursing hours per patient ratio. Any penalties from this review will be placed into Q&A Fund.

Certain Nursing Home (NF) rates are reimbursed under Medi-Cal using a combination of federal funds, General Fund and revenues collected from Quality Assurance Fees (QAF). Use of QAF has enabled California to provide reimbursement increases to NFs with *no* added General Fund support.

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

Current QAF structure sunsets as of June 30, 2011. If QAF sunsets, over $400 in General Fund support is at risk.

The Omnibus Health trailer (AB X4 5, Statutes of 2009) expanded the QAF to include Medicare revenue and lowered the allowable *overall* rate increase from five percent to zero for rate years 2009-10 and 2010-11. This DHCS proposal would provide for a 3.93 percent increase for 2010-11, in lieu of the freeze.

The Administration proposes **(1)** comprehensive trailer bill legislation to enact changes to the existing Medi-Cal reimbursement structure ; **(2)** changes to the QAF trending methodology; **(3)** lowering of licensing and certification fees to increase QAF for increased federal funds; and **(4)** extension of the QAF to Multi-Level Retirement Communities.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

**Medi-Cal Quality Assurance Fee (QAF): Changes to Freestanding Nursing Home Reimbursement and Quality and Accountability Proposal.** ***(Page 2 of 2)***

Summary.(continued)

6. Establish and publish quality and accountability measures and benchmarks in consultation with stakeholders.
7. Develop an overall framework to provide increased oversight of NFs and enforcement of penalties of non-compliance.
8. Develop an overall framework for NFs that meet performance targets to receive financial incentives of supplemental quality and accountability payments.
9. Makes other adjustments related to rates and the Q&A Fund in 2011-12, including adjustments to the Labor Driven Operating Allocation (contingency margin).

*Each of the May Revision proposals is discussed individually below.*

DHCS states a total of $ 61.4 million in additional QAF revenues can be obtained from the changes. These revenues, coupled with federal ARRA funds (to June 30, 2011), would provide about $160 million (total funds) for a *3.93 percent* average rate increase for 2010-11, effective August 1, 2010. The QAF changes are contained within three May Revision proposals discussed on the next pages of this Agenda.

Extensive stakeholder conversations have also occurred regarding quality assurance measures, or a pay for performance approach.

The Omnibus Health trailer bill of 2008 provided for an extensive stakeholder process for this purpose. An April 2009 report to the Legislature articulated the discussions from this stakeholder process.

Key concerns of consumer groups included the need to **(1)** provide oversight regarding the 3.2 nursing hours staff to patient ratio; **(2)** develop a uniform data collection system to measure quality improvement; **(3)** create incentives to facilitate quality improvement and accountability measures; **(4)** develop and implement resident, family, and staff satisfaction measures; and **(5)** many other factors related to quality assurance.

The DHCS contends its proposal addresses many of the quality assurance components discussed in these meetings.

*Each of the May Revision proposals is discussed individually below.*

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Medi-Cal Quality Assurance Fee (QAF): Changes to Trending Methodology.**<br><br>DHCS proposes trailer bill to increase the amount of revenues upon which the QAF is assessed by using two-year old actual data as the base, and applying growth and trending adjustments to project the actual revenues expected for the fiscal year.<br><br>Increased QAF revenues from this revised method, matched with federal funds, provides for increased rates. May Revision reflects the enhanced ARRA federal fund rate (61.59 percent).<br><br>This change, coupled with the other changes, discussed below, would provide an average rate increase of 3.93 percent. This rate increase is expected to be cost neutral to the General Fund. | $88,777 (total)<br><br>$39,239 (QAF)<br><br>$49,538 (federal) | As noted above, there are many aspects to the Administration's proposal which will need to be discussed in-depth, including the trending factors used by the DHCS.<br><br>The revised trending factors will also coincide with the following:<br>• Changes in how QAF is assessed and collected, including penalties for non-payment of QAF;<br>• Disallowance of reimbursement for legal costs related to cases that have not been found in favor of facilities;<br>• Capping of reimbursement for professional liability insurance at the 75th percentile; and<br>• Changes to the Labor Driven Operating Allocation.<br><br>DHCS needs to provide a further explanation of the various components for the Committee, and to continue various stakeholder discussions. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Medi-Cal Quality Assurance Fee (QAF): Lower L&C Fees & Increase QAF for Rate Increase.**<br><br>The QAF is comprised of a general quality assurance fee component, as well as a licensing and certification component and is capped at 5.5 percent of gross revenues.<br><br>The Department of Public Health (DPH), who conducts licensing and certification functions, is proposing to lower their fees for Nursing Homes. This will allow the DHCS to *increase* the QAF component, resulting in an increase in rates for these facilities effective as of August 2010.<br><br>This requires trailer bill language and is another component to the Administration's proposed restructuring of Nursing Home rates and quality accountability. | $9,325 (total)<br>$4,122 QAF | AB 1629, Statutes of 2004, established the QAF under the Medi-Cal Program. Revenue generated from QAF is used to draw federal funds and provide additional reimbursement to, and support of, Nursing Home quality improvement efforts.<br><br>DPH states that about $4 million in Licensing and Certification Fees can be reduced, and therefore not counted towards the 5.5 percent QAF. This will provide for an increase in the QAF up to the 5.5 percent and more federal funds can be generated. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Medi-Cal Quality Assurance Fee (QAF): Include Multi-Level Retirement Communities.**<br><br>DHCS proposes trailer bill legislation to expand the revenues upon which the QAF is assess to include revenue from MLRC facilities, resulting in *increased rates* for the Nursing Home-Level B component of these facilities.<br><br>The increase in rate payments is $40.8 million (total funds), effective as of August 2010. There is no affect on the General Fund.<br><br>DHCS states that about 50 percent of the MLRC facilities serve Medi-Cal enrollees.<br><br>This is another component to the Administration's proposed restructuring of Nursing Home rates and quality accountability. | $40,824 total<br>$18,044 QAF<br>$22,780 federal | AB 1629, Statutes of 2004, established the QAF under the Medi-Cal Program. Revenue generated from QAF is used to draw federal funds and provide additional reimbursement to, and support of, Nursing Home quality improvement efforts.<br><br>Presently, Multi-Level Retirement Communities (MLRC) are *exempt* from paying the QAF but do benefit from rate adjustments associated with this mechanism.<br><br>It seems reasonable that these facilities should participate in QAF. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Trailer Bill. Exception to Timely Filing Rule for Medi-Cal Third-Party Liability.**<br><br>Governor proposes trailer bill language to allow Medi-Cal providers three-years to bill commercial health insurers to ensure that the DHCS continues to be able to recover the maximum amount of claims due to the Medi-Cal Program.<br><br>DHCS contends that $10 million (General Fund) is at-risk if trailer bill is not enacted.<br><br>Specifically, an issue has emerged for the timely collection of third-party payment for Medi-Cal enrollees with other coverage.<br><br>Though the DHCS has up to three years to bill commercial health insurers for payment recovery when applicable, *other Medi-Cal providers* do not have this same window.<br><br>Presently, DHCS contends that some insurers are denying claims based upon "timely filing" provisions/restrictions (typically 30 to 180 days) as delineated in each individual contract with the provider. This results in a loss or reduction in the expected or estimated amount of recoveries for Medi-Cal. | TBL<br><br>cost avoidance | Federal law requires that when a Medi-Cal enrollee has third-party health coverage or insurance, the Medi-Cal Program shall be the payer of last resort. As such, a State is required to identify and to recover from liable third-parties the costs of claims paid by Medi-Cal.<br><br>DHCS has Third Party Liability and Recovery staff that utilize internal processes, as well as competitively procured vendors, to identify Medi-Cal enrollees having "other coverage". When "other coverage" is identified, DHCS determines which claims Medi-Cal paid that were eligible for reimbursement under that coverage. DHCS has three-years to bill commercial health insurers for payment recovery for services provided to Medi-Cal enrollees when applicable.<br><br>As of January 2010, DHCS is prohibited from disclosing Hospital provider rates negotiated under Medi-Cal to commercial health insurers. (They are confidential.) To avoid disclosure, DHCS has to indirectly bill the insurance plans to recoup the funds. DHCS does this by notifying the provider, the provider submits the claim to the commercial insurer for payment, and then DHCS recoups from the provider when the insurance payment is received. *However*, some insurers are denying claims based upon "timely filing provisions" as noted.<br><br>As such, DHCS believes $10 million (General Fund) is at risk unless the trailer bill language is adopted. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Reduction to Radiology Rates.**<br><br>Governor reduces the rates paid for radiology services to 80 percent of federal Medicare rates for the same or similar service, effective October 1, 2010. This requires trailer bill language.<br><br>There are more than 450 service codes pertaining to radiology services in which Medi-Cal rates are *greater* than 80 percent of the federal Medicare rate. This reduction is only applicable to those radiology services that currently have rates *exceeding* 80 percent of federal Medicare rates.<br><br>Further, this reduction only applies to Medi-Cal Fee-for-Service arrangements since capitation rates in Medi-Cal Managed Care Plans are *at or lower than* 80 percent of federal Medicare rates for these services. | -$27,240 total<br><br>-$13,620 GF | DHCS policy for establishing Medi-Cal outpatient rates is based in part on a percentage of the corresponding rate on the federal Medicare fee schedule. DHCS current standard is 80 percent of federal Medicare rate when establishing new rates.<br><br>Medi-Cal rates for radiology services vary within the Medi-Cal Program since there are hundreds of service codes for radiology. DHCS states the majority of radiology services are reimbursed from 100 to 120 percent of federal Medicare rates. As such, it is this higher end reimbursement level for which the proposal is directed.<br><br>Implementation requires trailer bill language and a Medi-Cal State Plan Amendment to be approved by the federal Center for Medicare and Medicaid (CMS). |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Elimination of Selected Over-the-Counter-Drugs.**<br><br>Governor proposes to *eliminate* cough and cold products and specific non-prescription acetaminophen-containing products (such as Tylenol) as Medi-Cal benefits. Children's liquid Tylenol would *remain* as a benefit.<br><br>An implementation date of October 1, 2010 is assumed. This requires trailer bill. Federal CMS approval of a Medi-Cal State Plan Amendment is also required.<br><br>DHCS states most of the reduction associated with this proposal would occur from the elimination of nonprescription acetaminophen-containing products since most of its use is in the dual eligible population (enrolled in Medi-Cal and federal Medicare). Dual eligibles may switch to *prescription products* covered by the federal Medicare Part D Program. | -$13,291 total<br><br>-$6,645 GF | Under federal law, non-legend drugs ("over-the-counter") are considered an optional benefit. These drugs are not a covered benefit under the federal Medicare Part D program either.<br><br>Medi-Cal has covered Over-the-Counter drugs for many years as an inexpensive alternative to prescription drugs. These include pre-natal vitamins, insulin, nicotine patches, calcium supplements, cough and cold products, acetaminophen-containing products, and others.<br><br>DHCS would only eliminate cough and cold products and specific non-prescription acetaminophen products under this proposal.<br><br>If enacted, individuals could seek a Physician prescription for the product, or similar product, or pay out-of-pocket. For dual eligibles, costs may be shifted to the federal Medicare Part D Program.<br><br>It should be noted this proposal does *not* account for any cost-shifts to other services—such as physician visits, clinic visits or emergency rooms—which may occur as people seek medical treatment for flu, cold, muscle ache, arthritis, headache, and toothaches. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Hard Cap: Six-Prescription Outpatient Drugs.**<br><br>Governor proposes trailer bill language for a "hard cap" on the *existing* six-prescription per month limit for Medi-Cal enrollees. This also requires a State Plan Amendment and federal CMS approval.<br><br>This would apply to Adults *not* residing in Long-Term-Care facilities. Children (21 years and under) and Pregnant women are also exempt.<br><br>Medi-Cal would *not* pay for prescriptions beyond the six-prescription per month limit *unless* Medi-Cal deems the drugs to be life-saving, such as those used for the treatment of HIV/AIDS, cancer, hypertension, diabetes, coagulation disorders, and mental health disorders. However, the trailer bill language is broadly crafted and provides no criteria.<br><br>Any drugs exempted from the "hard cap" would still be subject to utilization controls and prior authorizations.<br><br>DHCS would only implement this proposal only to the extent permitted by the federal CMS. | -$10,898 total<br><br>-$5,449 GF | The six-prescription per month limit for Medi-Cal enrollees was effective November 1, 1994 and is still in effect. Any prescriptions beyond this limit must receive "prior authorization" approval by the DHCS.<br><br>The existing prescription limit is not the number of different drugs dispensed in a month, or the number of drugs a recipient is currently taking. Rather, it is the limit of pharmacy drug claim lines submitted within a calendar month. For example, if the same drug is dispensed four times a month, it counts as four of the six prescriptions. There are exemptions to this limit, such as cancer drugs, HIV/AIDS, nursing facility patients, medical supplies, and others.<br><br>The Administration's trailer bill for the "hard cap" is very broadly crafted and states that exempted drugs will be established by the DHCS. No criteria are referenced.<br><br>The trailer bill also states it will only be implemented to the extent federal approval is obtained, which is questionable given its magnitude.<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur if appropriate medications are not provided. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Hard Cap: Durable Medical Equipment (DME).**<br><br>Governor proposes trailer bill language to cap the maximum expenditures per Medi-Cal enrollee for Durable Medical Equipment (DME) at a level in which 90 percent of the enrollees who use DME benefits would not be affected, based on DHCS available data. Trailer bill language is required. This also requires a State Plan Amendment and federal CMS approval.<br><br>This would apply to Adults *not* residing in Long-Term Care facilities. Children (21 years and under) and Pregnant women are also exempt.<br><br>DME includes various products such as: wheelchairs and accessories, hospital beds, patient lifts, traction and trapeze equipment, communication devices, ambulation devices, bathroom equipment, IV equipment, decubitus care equipment, and oxygen and respiratory equipment.<br><br>The *only* DME product exempt from this hard cap is respiratory and oxygen equipment.<br><br>Based on available data, the DHCS states 6,773 people would be affected by this cap. Their average cost is about $4,666 per person. (Clearly this is an average and the actual amount would vary based on DME needs.)<br><br>An implementation date of February 1, 2011, is assumed. | -$7,145 total<br><br>-$3,572 GF | Under federal law, Durable Medical Equipment (DME) is considered an optional benefit. Medi-Cal has covered it as a benefit since at least 1988. Medi-Cal requires DME to be ordered by a written prescription of a licensed practitioner within the scope of their practice.<br><br>A key concern with this hard cap are those individuals who require a combination of DME products due to their fragile medical state, as well as people who need more costly customized wheelchairs in order to live independently and to be mobile (access to school, work, and quality of life issues).<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur if appropriate DME products are not provided.<br><br>Further, it does not take into account cost shifts to the Department of Developmental Services for the provision of DME products that would be needed for those individuals above the hard cap who are clients of the Regional Center system and entitled to services.<br><br>The trailer bill language contains the specified dollar amounts for the hard cap. As such, legislation would be necessary to change them in the future. The trailer bill also states it will only be implemented to the extent federal approval is obtained, which is questionable given its magnitude. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## Hard Cap: Certain Medical Supplies.

-$1,566 total

-$783 GF

Governor proposes trailer bill to cap the maximum expenditures per Medi-Cal enrollee for specified medical supplies at a level in which 90 percent of the enrollees who use this benefit would not be affected, based on DHCS available data. Trailer bill language is required. This also requires a State Plan Amendment and federal CMS approval.

The "hard cap" would apply to wound dressings, incontinence products, and urinary catheters for Adults *not* residing in Long-Term-Care facilities. Children, aged 21 years and under, and Pregnant women are also exempt.

Based on available data, DHCS states the hard cap would be as shown below. The dollar amount is specified in the trailer bill and it would be based on the State's fiscal year, not a calendar year.

| Medical Supply Item | Dollar Cap (Fiscal Year) | People Affected Outside 90% |
|---|---|---|
| Wound Care | $391 | 882 |
| Incontinence Supplies | $1,659 | 9,050 |
| Urologicals-- catheters | $6,435 | 459 |
| Total | N/A | 10,391 |

Federal law considers medical supplies to be an optional benefit. Medi-Cal has included medical supplies in its program since 1976. Medical supplies are a benefit in Medi-Cal when prescribed by a Physician.

Certain prior authorization approvals also apply. State law also establishes Medi-Cal reimbursement rates for these products, and the DHCS has authority to contract with providers for certain supplies, including incontinence supplies.

The medical supplies targeted for the "hard cap" already are closely monitored as noted. The individuals who fall outside of the 90 percentile are people who have significant medial conditions. Without these medical supplies, it is likely that infections and other more severe medical conditions will occur.

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

The trailer bill language contains the specified dollar amounts for the hard cap. As such, legislation would be necessary to change them in the future. The trailer bill also states it will only be implemented to the extent federal approval is obtained, which is questionable given its magnitude.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Hard Cap: Hearing Aid Expenditures.**<br><br>Governor proposes trailer bill to cap the maximum expenditures per Medi-Cal enrollee for Hearing Aids at a level in which 90 percent of the enrollees who use this benefit will not be affected, based on DHCS available data. Trailer bill language is required. This also requires a State Plan Amendment and federal CMS approval.<br><br>The cap would apply to Adults *not* residing in Long-Term-Care facilities. Children, 21 years and under, and Pregnant women are exempt.<br><br>The hard cap would be $1,510 per Medi-Cal enrollee per fiscal year, based on available data. This hard cap includes *total* expenditures for Hearing Aid, repairs, and ear molds.<br><br>For those Medi-Cal enrollees *above* the 90 percentile, the average amount spent is $1,579 annually, or $69 more than proposed under the hard cap.<br><br>An implementation date of February 2011 is assumed. | -$529 total<br><br>-$265 GF | Federal law considers Hearing Aids to be an optional benefit. Medi-Cal has included Hearing Aids in its program since 1988.<br><br>Hearing Aids are a benefit in Medi-Cal when supplied by a Hearing Aid Dispenser through the prescription of an Otolaryngologist or attending Physician.<br><br>The trailer bill language contains the specified dollar amounts for the hard cap. As such, legislation would be necessary to change them in the future. The trailer bill also states it will only be implemented to the extent federal approval is obtained.<br><br>The LAO suggests an alternative to the Administration's proposal would be to limit coverage of Hearing Aids for Adults, as specified, to once very three or four years as done in 17 other States. This alternative would likely result in a lower level of savings than proposed by the Administration. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Hard Cap: 10 Visits for Outpatient Primary and Specialty Care provided under Physicians.**<br><br>Governor proposes a "hard cap" of 10 office visits per year for Medi-Cal enrollees in both the Fee-for-Service and Medi-Cal Managed Care programs. Trailer bill is required. This also requires a State Plan Amendment and federal CMS approval.<br><br>This affects outpatient primary care and specialty care provided under the direction of a physician in the following settings: **(1)** Hospital Outpatient Department; **(2)** Outpatient Clinic; **(3)** Federally Qualified Health Centers; **(4)** Rural Health Centers; and **(5)** Physician offices. Trailer bill language is required.<br><br>The cap would apply to Adults *not* residing in Long-Term-Care facilities. Children, 21 years and under, and Pregnant women are exempt.<br><br>DHCS states that a total of 3.3 million office visits were provided and *40 percent*, or 1.3 million, would be above this proposed cap of 10 visits per year.<br><br>An implementation date of January 2011 is assumed. | -224,526 total<br><br>-$112,263 GF | Federal law *mandates* the provision of Physician services.<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as emergency rooms and hospitalizations—that would most likely occur from this action due to the lack of primary and specialty care which would result.<br><br>This proposal would negatively impact people with the greatest need for health care services.<br><br>The fiscal calculation assumes an average cost per visit of $143 in the outpatient setting. It would not take many emergency room visits or hospitalizations to negate the assumed savings from this hard cap.<br><br>Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.<br><br>The trailer bill also states it will only be implemented to the extent federal approval is obtained which is questionable given its magnitude. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Mandatory Copayments for Physician & FQHC/RHC Office Visits.**<br><br>Governor proposes trailer bill to implement mandatory copayments of $5 for Physician, Federally Qualified Health Centers (FQHCs) and Rural Health Center's office visits at the point of service. This requires trailer bill. In addition, mandatory copayments require a *federal waiver* in order to obtain federal CMS approval.<br><br>The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees,* including children, people in Long-Term Care facilities, and pregnant women, are included.<br><br>In addition, no place or type of service—except emergency services in a hospital—would be exempted. Providers will be able to deny service if the Medi-Cal enrollee does not provide payment.<br><br>The provider would collect the $5 copayment at the time of service, and the providers would be reimbursed their Medi-Cal rate *minus* the $5 copayment.<br><br>An implementation date of February 1, 2011 is assumed. | -$157,686 total<br><br>-$78,843 GF | Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).<br><br>Currently, Medi-Cal enrollees have a $1 copayment per office visit. It is a voluntary copayment and services cannot be denied if the enrollee doesn't pay.<br><br>This mandatory proposal would enable providers to deny care. In fact, a significant aspect of savings is from a reduction in office visits. DHCS assumes an 8 percent reduction in office visits once the copayment is implemented. This component is to result in a reduction of $53.5 million (total funds) for 2010-11.<br><br>A mandatory copayment for Physician visits would serve more as a deterrent to obtaining preventive medical care services and would make health care access for low-income children, families and people even more problematic. Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as emergency rooms—that would likely occur from this action. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Mandatory Copayments: Dental Office.**<br><br>Governor proposes trailer bill to implement mandatory copayments of $5 for Dental Office visits. No reduction is reflected budget year due to the timing of the dental contract negotiations. But a reduction of $1.5 million (General Fund) would begin in 2011-12 from this proposal.<br><br>The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees*, including children, people in Long-Term Care facilities, and pregnant women, are included.<br><br>Providers will be able to deny service if the Medi-Cal enrollee does not provide payment.<br><br>The provider would collect the $5 copayment at the time of service, and the providers would be reimbursed their Medi-Cal rate *minus* the $5 copayment. | $1,500 in out-year | Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).<br><br>DHCS would seek a waiver of federal laws and regulations for the types of populations affected, their federal poverty levels, the types of services provided, and the maximum amount of copayments that can be charged.<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services—such as emergency rooms for dental pain—that would likely occur from this action.<br><br>Oral health is a significant concern in children and the elderly and can lead to considerable health care problems. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Mandatory Copayments for Hospital Inpatient Days.**<br><br>Governor proposes trailer bill to implement mandatory copayments of $100 per Hospital Inpatient Day up to a maximum of $200 per admission. This requires trailer bill. Mandatory copayments require a *federal waiver* in order to obtain federal CMS approval.<br><br>The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees*, including children, people in Long-Term Care facilities, and pregnant women, are included.<br><br>The Hospital would collect the $100 copayment at the time of admission, and the Hospitals would be reimbursed their Medi-Cal rate *minus* the $100 copayment (or $200 per admission).<br><br>DHCS notes that Hospitals must still comply with the Emergency Medical Treatment and Active Labor Act. As such, most care still would need to be provided by Hospitals.<br><br>An implementation date of February 1, 2011 is assumed. | -$156,205 total<br><br>-$72,561 GF | Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).<br><br>DHCS would seek a waiver of federal laws and regulations for the types of populations affected, their federal poverty levels, the types of services provided, and the maximum amount of copayments that can be charged.<br><br>A significant aspect of this DHCS proposal is an assumed reduction in Hospital Inpatient admissions. Specifically, a 5 percent reduction is assumed once the copayment is implemented, which is about 30 percent of the reduction.<br><br>It should also be noted that only 21 percent of the Hospital In-patient days are for one day, with the remaining 78 percent for two or more days. This reflects a more medically needy population. Further, Medi-Cal's treatment authorization system and reimbursement method for Hospital In-patient days serves to already dissuade frequent use by Medi-Cal enrollees or Hospitals.<br><br>The Administration's "hard cap" does not take into consideration *any* cost shifts to other services that would likely occur from this action, or that people will become more ill and require more services. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## Mandatory Copayments for Emergency Room Visits.

Governor proposes trailer bill to implement mandatory copayments of $50 for *emergency use* of emergency room visits at the point of service. This requires trailer bill language. Mandatory copayments require a *federal waiver* in order to obtain federal CMS approval.

The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees*, including children, people in Long-Term Care facilities, and pregnant women, are included.

The Hospital would collect the $50 copayment at the time of admission, and the Hospitals would be reimbursed their Medi-Cal rate *minus* the $50 copayment (or $200 per admission).

DHCS states the average cost of an emergency room visit is $143.57.

An implementation date of February 1, 2011 is assumed.

Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).

This mandatory copayment is for *medically necessary* emergency room visits. Clearly, significant medical treatment is required for individuals needing emergency services and to mandate a $50 copayment at the point of service seems extreme, particularly coupled with no exemptions and the low-income level of Medi-Cal enrollees.

The DHCS assumes an eight percent reduction in the number of emergency visits once the copayment is implemented. This represents about 25 percent of the overall reduction.

The Administration's "hard cap" does not take into consideration *any* cost shifts to other services that would likely occur from this action, or that people will become more ill and require more services.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Mandatory Copayments for Non-Emergency Room Visits.**<br><br>Governor proposes trailer bill to implement mandatory copayments of $50 for non-emergency room use of emergency rooms at the point of service. Mandatory copayments require a *federal waiver* in order to obtain federal CMS approval.<br><br>The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees,* including children, people in Long-Term Care facilities, and pregnant women, are included.<br><br>The Hospital would collect the $50 copayment at the time of admission, and the Hospitals would be reimbursed their Medi-Cal rate *minus* the $50 copayment (or $200 per admission).<br><br>DHCS states the average cost of a non-emergency room visit is $125.94.<br><br>An implementation date of February 1, 2011 is assumed. | -$70,848 total<br><br>-$35,424 GF | Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).<br><br>DHCS would seek a waiver of federal laws and regulations for the types of populations affected, their federal poverty levels, the types of services provided, and the maximum amount of copayments that can be charged.<br><br>The no exemption policy, particularly for children and fragile medically needy individuals will likely result in people not seeking assistance and becoming potentially more medically involved. The level of copayment is too high for this lower income population as well. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Mandatory Copayments: Pharmacy Copayments.**<br><br>Governor proposes trailer bill to implement mandatory copayments of $3 per prescription for preferred drugs (generics) and $5 for per prescription for non-preferred (brand) at the point of service. Mandatory copayments require a *federal waiver* in order to obtain federal CMS approval.<br><br>The copayment would apply in Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. *No* exemptions to this mandatory copayment would be provided. As such, *all enrollees*, including children, people in Long-Term Care facilities, and pregnant women, are included.<br><br>The Pharmacy would collect the $3 or $5 copayment at the time of service, and the Pharmacists would be reimbursed their Medi-Cal rate *minus* the $3 or $5 copayment.<br><br>The average cost of a prescription is $92. | -$149,227 total<br><br>-$74,613 GF | Under federal law, States can charge *only* nominal copayments on Medi-Cal enrollees unless a federal waiver is obtained. For people with incomes between 100 percent and 150 percent of poverty, only a limited copayment can be charged (i.e., 10 percent of the cost of service up to a maximum of 5 percent of monthly family income).<br><br>DHCS would seek a waiver of federal laws and regulations for the types of populations affected, their federal poverty levels, the types of services provided, and the maximum amount of copayments that can be charged.<br><br>Currently, Medi-Cal enrollees have a $1 copayment per prescription. It is a voluntary copayment and services cannot be denied if the enrollee doesn't pay.<br><br>The DHCS assumes a 5 percent reduction in the number of emergency visits once the copayment is implemented.<br><br>They also assume that 25 percent of prescriptions will be switched from non-preferred (brand) to preferred (generic) for a cost savings of about $240 per prescription.<br><br>The no exemption policy, particularly for children and fragile medically needy individuals will likely result in people not seeking assistance and becoming potentially more medically involved. The level of copayment is too high for this lower income population as well. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Limit Enteral Nutrition to Tube Feeding.**<br><br>Governor proposes trailer bill to limit enteral nutrition products to only Adults who must be tube-fed. This would affect both the Fee-for-Service and Medi-Cal Managed Care programs.<br><br>This limit would *not* apply to Adults residing in Long-Term Care facilities. Children, 21 years and under, and Pregnant women are also exempt.<br><br>DHCS states conditions which require tube feeding include, but are not limited to, anatomical defects of the digestive tract or neuromuscular diseases.<br><br>DHCS states this proposal would more closely align Medi-Cal with the current Medicare benefit, which limits this benefit to those individuals who are tube fed.<br><br>An implementation date of October 1, 2010 is assumed. | -$20,574 total<br><br>-$10,287 GF | Under federal law, enteral nutrition benefits are an optional benefit. Medi-Cal enteral nutrition products are covered only when supplied by a Pharmacy provider upon the prescription of a licensed practitioner within the scope of their practice. Common household food items are not covered.<br><br>All enteral nutrition products require prior authorization approval prior to Medi-Cal reimbursement.<br><br>Medi-Cal also has statutory authority for contracting for specific nutrition products, including enteral nutrition.<br><br>The trailer bill language does provide for a narrow exemption from the limitation for when an enteral nutrition product is used as part of a therapeutic regimen for patients with conditions for which regular food, or processed food, cannot be consumed without causing a health risk. Such conditions include malabsorption syndromes or inborn errors of metabolism. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Eliminate Payment of federal Medicare Part B Premiums for Medi-Cal Enrollees with an Unmet Share-of-Cost.**<br><br>Governor proposes trailer bill to eliminate the payment of federal Medicare Part B premiums for those Medi-Cal enrollees with an *unmet* share-of-cost of $500 or less. A reduction of $1 million (General Fund) is assumed from this action.<br><br>According to DHCS, California is the only State with this program.<br><br>DHCS states 951 average monthly eligibles would be affected by this change.<br><br>An implementation date of July 1, 2010 is assumed with savings beginning as of October 1, 2010. | -$1,038 GF | Prior to September 2008, the DHCS paid federal Medicare Part B premiums for individuals who qualify for *both* Medi-Cal and Medicare (dual eligibles) even when they had *not met* their share-of-cost.<br><br>To address a budget deficit AB 1183, Statutes of 2008, eliminated Medicare Part B premium payments for elderly and disabled enrollees having an unmet share-of-cost in *excess* of $500.<br><br>May Revision would eliminate the DHCS payment of Medicare Part B premiums for individuals who do not meet their share-of-cost obligation for the remainder of the program (unmet share-of-cost of $500 or less). |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Medi-Cal Program Eligibility Processing: Methodology Change on Eligibility Growth.**<br><br>Governor proposes to re-calculate the County Administrative Baseline for Medi-Cal caseload growth by changing the methodology.<br><br>Specifically, DHCS is proposing to change the existing method for determining baseline funding and growth funding (to account for new Medi-Cal caseload) and to trend them differently by only accounting for one year of caseload growth instead of trending over a two-year period as has been done historically.<br><br>Use of this new methodology would result in a reduction of about $84 million ($42 million General fund).<br><br>*In addition*, the Governor proposes to *continue* two reductions from 2009 forward, and to *not* provide a cost of doing business increase for 2010-11. These adjustments are shown below:<br><br>• Reduction of $121.1 million (total funds) from a Governor's veto in the Budget Act of 2009.<br>• Reduction of $49.3 million (total funds) from not providing the cost of doing business in 2009-2010.<br>• Reduction of $21.7 million (total funds) from not providing a cost of doing business in 2010-11. | -$84,000 total<br><br>-$42,000 GF | County Welfare Departments serve as surrogate for the State in administering the Medi-Cal eligibility determination process for all individuals applying for enrollment and all aspects of enrollment redeterminations.<br><br>Funds allocated to counties for caseload growth enable counties to hire staff to handle increased workload due to increases in Medi-Cal eligible persons and enrollment. The accuracy and timeliness of the decisions made by eligibility workers are important for maintaining an up-to-date listing of Medi-Cal enrollees (which is tied to the payment of services).<br><br>DHCS has proposed a completely *new methodology* at the May Revision for calculating caseload growth-related funding for staffing purposes. At this point in time, it is unclear as to how this methodology is calculated or how it is applicable to the considerably increased caseload in Medi-Cal resulting from the Great Recession.<br><br>Given the other reductions contained in the May Revision for County processing, as noted, it is suggested to adopt placeholder trailer bill language to revisit the methodology for base and growth, and to better discern what data will be used for this purpose and incorporate these changes into 2011-12. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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## 4260 Department of Health Care Services (DHCS): Primary Health Care Services

**Expanded Access to Primary Care Clinics.**

Governor proposes to eliminate the Expanded Access to Primary Care (EAPC) Program by shifting its remaining $10 million (Proposition 99 Funds) appropriation to the Medi-Cal Program to backfill for General Fund support.

-$10,000 Prop 99

-$10,000 GF (fund shift)

The EAPC Program was created to ensure that safety net providers have resources to cover the delivery of uncompensated care. EAPC provides access to primary care services for individuals that are uninsured, including newly unemployed. Clinics provide an important medical home for many low-income Californians.

In the Budget Act of 2009, the Governor vetoed all remaining General Fund support for various clinic programs. The only State support remaining is the $10 million (Proposition 99 Funds) for the EAPC.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

## 4260 Department of Health Care Services (DHCS): State Support

**Resources for Implementation of 1115 Waiver.**

$9,498 total

$4,122 GF

$182 MHSA

$5,194 Federal

Governor proposes an increase of $9.5 million ($4.1 million General Fund) to proceed with implementation of the pending 1115 Medi-Cal Waiver presently under development for California.

The $9.5 million consists of these key components:

- $3.3 million in contracts for: **(1)** development of Managed Care Capitation Rates and actuarial support; **(2)** outreach and education for providers and mandatory populations regarding Managed Care; **(3)** interface to support movement of mandatory population into Managed Care; **(4)** development of performance measures regarding mandatory populations; **(5)** an External Quality Review Organization (EQRO) as required by federal law.
- $6.193 million for 56 DHCS staff (three-year limited-term) to conduct various activities related to developing and implementing the 1115 Medi-Cal Waiver.

DHCS states these resources are needed to: **(1)** Implement mandatory enrollment of Seniors and Persons with Disabilities; **(2)** Implement four alternative health care delivery models in the CA Children's Services Program; **(3)** Implement and test alternative methods of integrating behavioral health services into the health care delivery system; and **(4)** Enhance and expand the current Health Care Coverage Initiative.

As discussed above, a new comprehensive 1115 Medi-Cal Waiver is under development and an Implementation Plan, as required by AB X4 5, Statutes of 2009, was released on May 13, 2010.

DHCS will need resources for successful development, operation and monitoring of this comprehensive endeavor. This is particularly true for the mandatory enrollment of Seniors and Persons with Disabilities into the Medi-Cal Managed Care Program.

However, as noted in the DHCS Implementation Plan, the pending 1115 Medi-Cal Waiver will utilize a *phased-in* approach for implementation, as it should given the task at hand. As such, a more gradual phase-in of resources is appropriate.

Further, considerable clarification is needed regarding the role and responsibilities of the DHCS and that of the Department of Managed Health Care (DMHC). Specifically, the DMHC has a traditional role with Knox-Keene Act expertise and managed care, including determination of health plan network adequacy, health plan material modification, and the monitoring and auditing of various aspects of the health care system, such as health care access standards. As presently crafted, the roles and responsibilities of the DHCS and DMHC with regards to these aspects are murky in this budget request.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
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| **Resources for Freestanding Nursing Home Changes. (Relates to AB 1629 changes.)** | $1,699 total | As discussed above, a framework for potential changes needs to be crafted. Until this framework is determined, providing resources for State positions is premature. |
| Governor is proposing an increase of $1.7 million ($849,000 General Fund) to fund seven DHCS staff to implement various changes to Nursing Home reimbursement under the Medi-Cal program as referenced in the Governor's May Revision package for the Medi-Cal Program. | $849,000 GF | |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Resources for Health Information Technology Act: Medi-Cal Electronic Health Record Incentive Program.**<br><br>Governor proposes an increase of $1.8 million ($180,000 foundation funds and $1.6 million federal funds) for eleven DHCS staff and $450,000 in contract funds to implement the Medi-Cal Electronic Health Record Incentive Program.<br><br>The program is a component of the federal Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the federal American Recovery and Reinvestment Act (ARRA) of 2009.<br><br>Substantial federal funds over the course of ten years will be available to California for federal Medicare and Medi-Cal incentives to qualified health care providers who adopt and use electronic records in accordance with the federal Acts' requirements. | $1,797 total<br><br>$0 GF | In November 2009, the federal CMS approved California's HITECH advanced planning document for the purpose of creating an implementation plan<br><br>DHCS has obtained foundation funds which will be used to obtain a federal match for the purpose of hiring these positions. These types of arrangements have been done in other projects over the years.<br><br>The May Revision also includes $3 million (federal funds) in Medi-Cal local assistance for provider incentive payments related to e-prescribing and other meaningful use of electronic health records as directed by federal law and California's approved plan. |

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|

4265 Department of Public Health

## Proposed Proposition 99 Program Reductions.

Governor is proposing reductions to certain programs funded with Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) due to (1) desire to use the Unallocated Account to backfill for General Fund support in the DHCS Medi-Cal Program; and (2) a decline in revenues in the Health Education Account and Research Account.

DPH is proposing to make adjustments in the following areas:

- Asthma Public Health Initiative. A reduction of $1.2 million (Unallocated Account) is proposed for this Initiative in order to use the funds to backfill for General Fund support in the DHCS Medi-Cal Program. The goal of this boutique program is to reduce the impact of asthma and eliminate related health inequities in California. As noted by the LAO, it provides direct local assistance, including clinical expertise in Asthma.
- CA Breath Program. A reduction of $106,000 (Unallocated Account) is proposed. This would eliminate the contract that is assessing the high asthma rates for American Indian/Alaska Native communities.
- Research Account. Reduces by $153,000 cancer surveillance due to shortfall in revenues.
- Health Education Account. Reduces by $1.2 million the Tobacco Control Program Media campaign due to revenue shortfall.

Asthma Public Health Initiative.

LAO recommends rejecting the $1.2 million (Proposition 99, Unallocated Account) reduction for the Asthma Public Health Initiative since it provides direct care and is a critical project in the Central Valley and instead,

CA Breath Program
LAO recommends adopting the reduction of the $106,000 study within the Environmental Health Investigations Branch (CA Breathing Program) for General Fund savings.

| Governor's Proposal | 2010-11 ($ in thousands) | Comments |
|---|---|---|
| **Every Woman Counts (EWC) Program.**<br><br>Governor is proposing a total of $40.7 million ($22.1 million Proposition 99 Unallocated Account Funds, $6.3 million federal grant, and $12,3 million Breast Cancer Control Account) for EWC Program for 2010-11.<br><br>DPH administratively capped this program last Fall due to a shortfall of funding based upon clinical claims and a lack of adequate monitoring. This resulted in ceasing enrollment of woman aged 40 to 49 years, and a freeze on new enrollment for women aged 50 and over.<br><br>DPH has proposed several cost containment items that they should articulate for the Committee.<br><br>Due to uncertainties in program fiscal monitoring and related factors, the Bureau of State Audits is conducting a review, as well as the OSAE within the DOF. | cost containment | The Every Woman Counts Program provides free breast cancer screening and diagnostic services to women aged 50 (40 until the beginning of this year) and over whose income is below 200 percent of poverty and uninsured or under-insured.<br><br>Due to concerns in obtaining clear information from the DPH, the Assembly has requested the Bureau of State Audits to audit the program which is anticipated to be released by June 10, 2010. The Office of State Audits with the DOF will also be releasing an audit on the program imminently.<br><br>The Assembly has augmented by $38.6 million (General Fund) to fund estimated clinical claims, a digital mammography mandate (AB 359), and a decline in the Breast Cancer Control Account.<br><br>Both the DPH and LAO have identified cost containment measures which should be further discussed and clarified. This should also include a discussion of other revenue sources.<br><br>In addition, fiscal calculations within the program are still being refined at this point in time. |