CPCA
California Primary Care Association
Health Care Access for All

The Governor's January Budget Proposal
Fiscal Year 2012-13

CPCA Policy Team- COMPREHENSIVE ANALYSIS

GENERAL OVERVIEW

A year ago, the state faced an immediate $26.6 billion shortfall and future estimated annual budget gaps of $20 billion. This year, the state faces a $9.2 billion budget problem and future annual budget gaps of $5 billion or less.

This year, the Governor's Budget proposes a balanced solution by cutting more deeply into spending while also increasing revenues. The Governor will ask voters in November to approve a Constitutional Amendment to prevent deep cuts to education and guarantee funding for public safety at the local level.

The Governor further proposes a set of trigger cuts that would occur if the state's voters reject his tax proposal. Brown's budget calls for another $5.4 billion in cuts. Under these cuts, which only would be triggered if the ballot measure fails, schools would lose $4.8 billion while the University of California and California State University systems would each lose $200 million.

Also getting cut would be the state court system ($125 million) and the Department of Forestry and Fire Protection ($15 million), among others. Under the trigger cuts, the number of park rangers and Fish and Game wardens would be reduced and the state would stop staffing its beaches with lifeguards.

In the area of health, the Governor's Budget contains ugly cuts to the Department of Health Care Services including:

*** $842 Million Cut to Medi-Cal, including cuts to clinics, hospitals, and the shifting of "dual-eligible" seniors & people with disabilities to managed care plans;**

*** $152 Million Cut to MRMIB, including a 25.7% cut to Healthy Families managed care plans that cover 875,000 children**

Beyond the cuts and taxes, this budget also clearly reflects and the Governor has stated it publicly, his disappointment that the federal government has failed to approve previous changes in the Medi-Cal program including co-pays and visit caps and this lack of action has caused a higher budget deficit. He also stated that he is unable to implement other cuts because people are always suing him (the Governor has money in this budget specifically for litigation).

The Governor is using this budget to implement broader policy that should be vetted through a thoughtful process including stakeholders rather than through the budget process. This includes a "so called" reform proposal that

fundamentally changes the FQHC reimbursement model. We have been and will continue to be very clear with the Administration that these types of policy changes should never be part of the budget process.

Other changes include a shift to an annual open enrollment process in Medi-Cal and the transfer from DPH to DHCS effective July 1, 2012 of Every Woman Counts, Prostate Cancer Treatment, and Family Planning Access Care and Treatment.

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

DEPARTMENT OF HEALTH CARE SERVICES: Medi-Cal

In addition to the array of reductions approved by the legislature as part of the 2011-12 state budget that await federal approval from CMS, the Brown Administration proposes several changes to Medi-Cal to address the remaining shortfall.

Medi-Cal: Operational Flexibilities — The Administration proposes to undergo a process to evaluate changes to Medi-Cal programs, such as reducing laboratory rates and no longer funding avoidable hospital admissions. The process will include stakeholder input and evaluate cost-effectiveness before implementing any changes in benefits. The Administration stresses that any changes in rate methodologies or payment policies will comply with federal requirements to assess the impact on beneficiary access. The Administration believes these flexibilities to the Medi-Cal program will result in General Fund savings of $75 million in 2012-13.

Impact on Community Clinics and Health Centers:

At the moment, the direct impact on community clinics and health centers is unclear as DHCS has not unveiled a formal proposal. However, the estimate of achieving $75 million in General Fund savings means that CPCA and member clinics will need to closely monitor and weigh in heavily during stakeholder meetings to assure that no services, such as FQHC services, are impacted.

Federally Qualified Health Center Payment Reform — Beginning July 1, 2012, the Administration proposes to waive the Prospective Payment System (PPS) for FQHCs and RHS in managed care counties, in favor of a per-member, per-month (PM/PM) rate. According to DHCS Director Toby Douglas, the PM/PM amount will result in a 10 percent reduction to FQHCs and RHCs. In return for waiving PPS, DHCS will waive certain service restrictions to allow FQHCs and RHCs to perform services such as group visits and telehealth. As PPS for FQHCs and RHCs in mandated by federal law, the State must seek an 1115 Medicaid Waiver in order to waive the PPS provision. The Administration believes that this proposal will achieve General Fund savings of $27.8 million in 2012-13 and $58.1 million in 2013-14.

Impact on Community Clinics and Health Centers:

This proposal would fundamentally change the way that FQHCs, FQHC Look-Alikes, and RHCs are paid. While an exact proposal detailing the changes has not yet been released to the public, it is anticipated that DHCS will seek to change each FQHC and RHC's PPS rate into a per-member, per-month fixed amount, which would then be reduced by 10 percent. The Administration also proposes to move all rural fee-for-service counties into Med-Cal Managed Care,

thereby extending this proposal to every FQHC and RHC in the state. The Administration believes that the proposal will achieve General Fund savings of nearly $30 million in 2012-13 and nearly $60 million in 2013-14; however, this only accounts for State savings and not the federal match. The actual amount in lost revenue is actually double the GF savings estimate. More analysis by FQHC CFOs will need to be conducted to assess the impact on delayed patient care that would result from this reduction.

Managed Care Expansion to Rural Counties — Beginning in June 2012, the Administration proposes to expand Medi-Cal managed care into rural counties that are currently fee-for-service only. The Administration claims this proposal will achieve General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14.

Impact on Community Clinics and Health Centers:

There are currently 27 counties in California that are fee-for-service only. This managed care expansion to these counties would ensure that the above PPS waiver proposal would apply to all California FQHCs and RHCs. Other concerns around impact to community clinics and health centers are the concerns around moving rural FFS counties into Medi-Cal managed care around network adequacy and the availability of plans and providers in these remote, rural areas. Clinic patients already have difficulty accessing specialists and this move may make it more difficult.

Annual Open Enrollment — The Administration proposes to limit the number of times Medi-Cal beneficiaries may change Medi-Cal plans to once a year. Currently, they may change Medi-Cal plans once per month or up to 12 times a year. The Administration states that this proposal will align Medi-Cal with other health care plans, such as CalPERS and Healthy Families. This proposal will result in General Fund savings of $3.6 million in 2012-13 and $6 million in 2013-14.

Impact on Community Clinics and Health Centers:

Medi-Cal patients who do not select a plan will be automatically assigned to one. This could impact current clinic patients who may be assigned to a Medi-Cal managed care plan that does not have the health center in the network. As a result, CCHCs could lose some of their patients without any recourse to get them back. This could result in lost revenue for CCHCs and the loss of an established health home for their patients. In addition, CCHCs would have to expend resources to engage in outreach to their current Medi-Cal patients, letting them know what plan they should select in the coming year.

Improved Care Coordination for Seniors and Disabled Beneficiaries — California has 1.2 million dual eligible beneficiaries, which represents 14.1 percent of the total Medi-Cal caseload. In addition, the majority of the 423,000 IHSS recipients (85 percent) are dual eligible beneficiaries. Medicare is the primary payer source, and Medi-Cal, as the secondary payer source typically covers Medicare cost sharing and services not covered by Medicare, as well as service delivered after Medicare benefits have been exhausted. Most long-term care costs for these beneficiaries are paid for by Medi-Cal, including longer nursing home stays and home and community-based services designed to prevent institutionalization. The current system incentivizes payers to shift costs to one another.

These individuals will benefit the most from a care model that provides benefits in a more coordinated manner. Coordinating care for these beneficiaries generally means having the same health plan responsible for the delivery of all benefits. In addition to aligning program responsibility and financial incentives, this proposal increases the number of individuals in managed care and broadens the scope of managed care services.

The proposal seeks to:

- Promote coordinated care. The initiative provides managed care plans with a blended payment consisting of federal, state, and county funds and responsibility for delivering the full array of health and social services to dual eligible beneficiaries.
- Enhance the quality of home and community-based services. Merging long-term services into managed care will increase access to home and community-based medical and social services. When necessary, care will also be coordinated with behavioral health services.

The proposal will be phased in over a 3 year period starting January 1, 2013. The transition to managed care for Medi-Cal benefits will occur in the first year, with the benefits becoming a more integrated plan responsibility over the subsequent two years. The transition of Medicare benefits to managed care will occur over a 3 year period starting first with 8-10 counties that already have the capacity to coordinate care for these individuals. Those counties that do not have the capacity to make this transition will begin in 6-12 months later. Individuals in the counties that will have the managed care expansion (primarily rural counties) will begin the transition in 2014-2015.

Savings: This proposal will achieve savings of approximately $678.8 million General Fund in 2012-13 and $1 billion General Fund in 2013-14.

Impact to Clinics and Health Centers

There is a direct impact to clinics and health centers as these patients move from fee for service to managed care. If this proposal is adopted, CCHCs will again be faced with the yet another movement of part of their patient population into managed care.

Medical Therapy Program Eligibility — The Budget proposes to align income eligibility requirements for the Medical Therapy Program with the broader California Children's Services (CCS) Program. Currently, there is no financial test for eligibility. Under the proposed eligibility standards, families with annual income less than $40,000 or with annual CCS-related medical expenses exceeding 20 percent of their annual income will continue to be eligible for the Medical Therapy Program. This is consistent with the eligibility requirements already in place for all other CCS benefits. In addition to state savings, counties will also realize savings.

Impact on Community Clinics and Health Centers:

There is no direct impact to CCHCs; however, there is a direct impact to children who may not receive services or specialized equipment based on these new eligibility standards.

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

Impact on Community Clinics and Health Centers:

There is no direct impact to CCHCs; however, the sustainability of the General Fund supports the existence of programs for individuals who access them.

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

Impact on Community Clinics and Health Centers:

This proposal has no direct impact on CCHCs. It will, however, bring more money to California, preventing even further reductions to health and human services.

Other Significant Adjustments:

Medi‑Cal Base Benefit Costs — A decrease of $395.9 million General Fund in 2011‑12 and an increase of $493.9 million General Fund in 2012‑13 based on cost and utilization trends in the base program.

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

Impact on Community Clinics and Health Centers:

This simply reflects that the state has not received approval from CMS on the 7 day visit cap or co-pays, also the successful litigation challenging the elimination of the ADHC program and litigation that has delayed the implementation of the 10% provider rate cut.

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

Impact on Community Clinics and Health Centers:

This proposal has no direct impact on CCHCs. It will, however, bring more money to California, preventing even further reductions to health and human services.

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

Nursing Home Fee Program — The Budget includes funding to restore the 10‑percent provider rate reduction ($171.2 million General Fund) and also includes supplemental payments ($245.6 million General Fund). The Budget does not include the maximum 2.4‑percent cumulative rate increase for 2011‑12 and 2012‑13 because preliminary fee revenues are insufficient to support such an increase. The Budget also proposes to permanently extend the rate

methodology and nursing home fee initially established by Chapter 875, Statutes of 2004 (AB 1629). This extension is necessary to continue to fund the current payment methodology without a greater impact to the General Fund.

Impact on Community Clinics and Health Centers:

This proposal has no direct impact on CCHCs.

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

Impact on Community Clinics and Health Centers:

This is an acknowledgement by the Governor that more budget issues are being resolved through court action.

MANAGED RISK MEDICAL INSURANCE BOARD

The Budget includes $965.6 million ($136.2 million General Fund) for the Board, a **decrease of $152.4 million** General Fund from the Budget Act of 2011. This significant decrease is primarily due to the proposed Healthy Families rate reduction.

Healthy Families Program Rate Reduction — The Budget proposes to reduce Healthy Families managed care rates by **25.7 percent** effective October 1, 2012. This rate reduction will achieve General Fund savings of approximately $64.4 million in 2012‑13 and $91.5 million in 2013‑14.

Impact on Community Clinics and Health Centers:

This is a significant cut to CCHC funding. CCHCs in California currently treat about 124,000 Healthy Families enrollees and although this is a small percentage of our overall patient population, this cut is still very

Transition of Children from the Healthy Families Program to Medi‑Cal — The Budget proposes transferring approximately 875,000 Healthy Families Program beneficiaries to Medi‑Cal over a nine‑month period beginning in October 2012. This transition will create benefits for children, families, health plans, and providers, by: (1) simplifying eligibility and coverage for children and families; (2) improving coverage through retroactive benefits, increased access to vaccines, and expanded mental health coverage; and (3) eliminating premiums for lower‑income beneficiaries.

Transition of Other Programs — In preparation for California's implementation of federal health care reform, the Budget proposes to eliminate the Board by July 1, 2013.

Impact on Community Clinics and Health Centers:
This transition may create lapses in coverage for the 124,691 Healthy Family patients that our CCHCs currently serve. Once the transition is complete it should make the program more affordable especially for lower‑income beneficiaries.

Transition of Additional Programs currently under MRMIB — These programs include the Access for Infants and Mothers, California Health Initiative Matching Fund Program, MRMIP, and PCIP programs. The two programs that provide insurance to individuals with pre‐existing conditions, MRMIP and PCIP, will be eliminated in January 2014 because these individuals will be able to purchase health insurance through the California Health Benefits Exchange as part of federal health care reform implementation.

Impact on Community Clinics and Health Centers:

This proposal is anticipated as these enrollees will be provided care through the exchange.

DEPARTMENT OF PUBLIC HEALTH

AIDS Drug Assistance Program (ADAP) — Increase Client Share of Costs for the AIDS Drug Assistance Program (ADAP)— The Budget reflects a decrease of $14.5 million in 2012‐13 as a result of increasing client share of cost in the ADAP to the maximum percentages allowable under federal law. Cost‐sharing for ADAP clients with private insurance will be limited to a maximum cost‐sharing of two percent. Implementing the federal share of cost maximum amounts for this client group will create a disincentive for many clients to continue ADAP participation because their cost‐sharing obligation will exceed their private insurance out‐of‐pocket costs. This proposal will result in General Fund savings of $16.5 million, which will be offset by program administrative costs of $2 million for a net General Fund savings of $14.5 million. Average monthly copayments will range between $28 and $385, depending upon the client's income.

Impact on Community Clinics and Health Centers:

There is no direct impact to CCHCs; however, there is a direct impact to individuals who qualify for ADAP as their share of cost for services and drugs will increase. The increased costs, as noted, will create a disincentive for many individuals to access ADAP and possible issues with medication and treatment management.

Transfer of Programs from DPH to DHCS — Effective July 1, 2012 Every Woman Counts, Prostate Cancer Treatment, and Family Planning Access Care and Treatment move to the Department of Health Care Services.

Impact on Community Clinics and Health Centers:

Both DPH and DHCS have committed that the transfer of these programs will not impact the beneficiaries. We will monitor this transfer if approved to ensure that our patients are protected.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) serves approximately 256,000 individuals with developmental disabilities in the community and 1,500 individuals in state‐operated facilities. Services are provided through the developmental centers, one community facility, and the regional center system. The Lanterman Developmental Disabilities Services Act established a statewide network of regional centers and related services to allow consumers to live independent and productive lives in the community.

Significant Adjustments:

Program Reductions — A decrease of $200 million in 2012-13 as a result of the reductions related to lower-than-expected revenues assumed in the 2011 Budget Act. The DDS is considering extending the 4.25-percent provider and regional center operations payment reduction, reductions in the developmental center budget, and other potential savings options in the department's budget. DDS will be engaging stakeholders to discuss savings proposals.

Developmental Centers — The Developmental Centers will be decreased by $14.4 million General Fund ($724,000 Proposition 98 General Fund) in 2012-13 as a result of a revised population estimate.

Reduced Costs — A decrease of $32 million General Fund in 2011-12 and a decrease of $2.9 million General Fund in 2012-13 as a result of changes and delayed implementation of Medi-Cal savings proposals regarding the Adult Day Health Care program, caps, and copayments, which will delay the need for regional centers to backfill these reductions.

Regional Center Caseload Adjustment — An increase of $5.9 million General Fund in 2011-12 and an increase of $115.2 million General Fund in 2012-13 as a result of a revised population estimate.

Expiration of Provider and Regional Center Operations Payment Reduction — An increase of $108.4 million General Fund in 2012-13 as a result of the 4.25-percent provider and regional center operations payment reduction that will expire on June 30, 2012.

Proposition 10 — An increase of $50 million General Fund in 2012-13 to backfill for the one-time use of Proposition 10 funding for services to consumers age 0-5 years.

Impact on Community Clinics and Health Centers:

There is no direct impact to CCHCs; however, we will continue to monitor the transition of funds as it relates to the delayed implementation of the Adult Day Health Care program, caps and copayments enacted in the previous budget. In addition, we will continue to monitor the impact to access to services provided at CCHCs and regional centers as a result of these funding transitions.

DEPARTMENT OF SOCIAL SERVICES

California Work Opportunity & Responsibility to Kids (CalWORKs) — The Administration proposes a decrease $946.2 million in 2012-13 through a combination of reducing grants to children and a restructuring of the CalWORKs Program. $736.4 million of the savings from cutting CalWORKs spending would be transferred to the CalGrants program.

Specific proposals include:

1) Support for children whose parents are not eligible for CalWORKs would be reduced from $463 to $392 per month. Would add a new requirement for an annual well child exam. Would move "child-only" families into a new Child Maintenance Program as of October 2012.

2) Creates a two-tier program in an attempt to "refocus" the CalWORKs as a work-first program that encourages and rewards employment.

CalWORKs Basic Program-Would provide a maximum of 24 months of support, including job search, employment training, child care, and barrier removal services. Current clients not complying with work requirement will be placed into the Basic Program as of October, 2012.

CalWORKs Plus Program-Would reward clients meeting federal work requirements with increased grant amounts (approximately $44/month for a family of 3). Access to child care and ancillary benefits would be available for up to 48 months.

3) Beginning July 1, 2013, working families receiving CalFresh benefits, but not in the CalWORKs program, would receive an additional $50/month work bonus.

In‑Home Supportive Services — The Budget proposes a decrease of $292.3 million General Fund from the revised 2011‑12 IHSS budget.

Eliminate Domestic and Related Services for Certain Recipients — IHSS beneficiaries residing in a shared living arrangement will not be eligible for domestic and related services that can be met in common with other household members. General Fund savings of $163.8 million in 2012‑13 and is estimated to impact approximately 254,000 recipients beginning July 1, 2012.

Coordinated Care for Dual Eligible Beneficiaries — This proposal will better coordinate IHSS, other home and community‑based services, and institutional long‑term care. All individuals receiving both Medi‑Cal and Medicare benefits (dual eligible beneficiaries) will be required to enroll in managed care health plans for their Medi‑Cal benefits. The IHSS program will operate as it does today during 2012‑13; all authorized IHSS benefits will be included in managed care plans. No IHSS savings are estimated to result from this proposal in 2012‑13. Refer to "Improved Care Coordination for Seniors and Disabled Beneficiaries" within Department of Health Care Services for more information.

Other Significant Adjustments:

20‑Percent Reduction in Service Hours — Because revised revenue projections have fallen short of previous estimates, pursuant to Chapter 41, Statutes of 2011, a 20‑percent across‑the‑board reduction in IHSS hours was to be implemented January 1, 2012. Because of a court injunction, the state currently is prevented from implementing this reduction. However, the Budget assumes this reduction will be implemented April 1, 2012. To be prudent, the Budget also includes a set‑aside to fully fund the IHSS program in the event of an adverse court ruling.

Medication Dispensing Machine Pilot Project — Current law requires the state to implement a Home and Community Based Medication Dispensing Machine Pilot Project that utilizes an automated medication dispensing machine with associated telephonic reporting service for monitoring and assisting Medi‑Cal recipients with taking prescribed medications. Current law also requires the DSS to implement an across‑the‑board reduction in authorized hours for IHSS recipients beginning October 1, 2012, to the extent the pilot project and/or alternative savings proposals enacted by the Legislature does not achieve a combined net annual General Fund savings of $140 million. Based on the assumed 20‑percent reduction described above, the Budget assumes neither savings from the pilot project nor savings from the associated across‑the‑board reduction, and proposes to repeal the associated statutory requirements.

DEPARTMENT OF STATE HOSPITALS

The Administration proposes to establish a new Department of State Hospitals (DSH). State hospitals operated by the DSH provide long-term care and services to individuals with mental illness. The state supports patients committed by the courts, including those committed for Penal Code violations and Sexually Violent Predators. The budget includes $1.3 billion General Fund in 2012-13 for support for the Department. The patient population is projected to reach a total of 6,439 in 2012-13.

Impact to Clinics and Health Centers

There is no direct impact.

IN SUMMARY

This state budget reflects a balanced approach, but reflects a continued focus of cuts to health human services. More “popular” programs such as K-12 and higher education are protected as long as the voting public supports the Governor’s tax proposal.

Most alarming is the Governor’s willingness to use the budget process to accomplish broader policy goals, which should be addressed directly with stakeholders to ensure that any changes include their consultation and input.

CCHCs continue to operate in a state budget structure in which they are expected to do more with less. Through our continued advocacy we must in the strongest of terms make the case that cuts and changes to our reimbursement model jeopardizes our ability to provide care to our 5 million plus patients and to prepare for the successful implementation of the Affordable Care Act(ACA). We desire to the be the partner with the state in these efforts but their attacks on our funding and care model puts us at odds when it is essential that we work together to ensure that we develop a new health program under the direction of the ACA that will better serve the needs of the people.