Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, March 23, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

Department of Managed Health Care Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0890 – Federal Trust Fund	$560,000	$100,000	$-
0933 – Managed Care Fund	$60,863,000	$73,549,000	$76,753,000
0995 - Reimbursements	$2,362,000	$2,679,000	$171,000
Total Department Funding:	**$63,785,000**	**$76,328,000**	**$76,924,000**
Total Authorized Positions:	**373.9**	**446.0**	**449.2**

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 138 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 25 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to regulatory requirements related to consumer protections and plans' financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability: 1) Urgent care without prior authorization: within 48 hours; 2) Urgent care with prior authorization: within 96 hours; 3) Non-urgent primary care appointments: within 10 business days; 4) Non-urgent specialist appointments: within 15 business days; 5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days. The Knox-Keene Act also requires plans to ensure primary care physicians are located within 15 miles or 30 minutes of a beneficiary and there is at least one primary care provider for every 2,000 beneficiaries in a plan's network.

Implementation of Timely Access Standards (SB 964). SB 964 (Hernandez), Chapter 573, Statutes of 2014, required DMHC to implement stricter oversight of health plans' compliance with standards meant to ensure timely access to care. SB 964 was introduced in response to significant expansions of managed care enrollment in both Medi-Cal and Covered California, as well as reports that certain plan products offered "narrow" provider networks that were inadequate to provide timely access to medical care for beneficiaries. SB 964 requires annual review of plans' compliance with Knox-Keene standards for providing timely access to care. DMHC previously reviewed plans' compliance every three years. SB 964 also requires plans to report the following information regarding provider networks:

1. Provider office location
2. Area of specialty
3. Hospitals where providers have admitting privileges, if any
4. Providers with open practices
5. Number of patients assigned to a primary care provider or a provider's capacity to be accessible and available to enrollees
6. Network adequacy and timely access grievances received by the plan

Plans are also required to provide these data separately for Medi-Cal and small group lines of business. DMHC is required to create a standardized methodology for plan reporting on timely access to care by January 2020.

In 2015-16, DMHC received 25 positions and expenditure authority from the Managed Care Fund of $3.8 million to implement the provisions of SB 964. Legal staff and health program analysts in the Office of Plan Licensing were approved to annually review provider networks and ensure compliance with timely access standards. Positions were also approved in the department's Help Center to review enrollee complaints regarding timely access and network adequacy.

In February 2017, DMHC published its timely access report for calendar year 2015. According to DMHC, 90 percent of the timely access compliance reports submitted by plans contained one or more significant inaccuracies including: 1) submission of data for providers not in the plan's network, 2) errors in calculating compliance rates, and 3) omission of compliance data for one or more required provider types. The use of an external vendor by 24 health plans to gather data and prepare compliance reports may have contributed to the submission of erroneous reports, despite 150 comments to health plans by DMHC prior to submission regarding these data issues.

The widespread inaccuracy of the data submissions has made it impossible for DMHC to analyze whether plans were in compliance with timely access standards for 2015. The report notes that plans that submitted inaccurate data are in violation of the Knox-Keene Act and DMHC's Office of Enforcement will be investigating for possible disciplinary action. DMHC also reports it will require the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions. Because of ongoing efforts to prevent submission of inaccurate data for 2016, DMHC reports it plans to extend the compliance report submission deadline by one to two months.

Complete and Accurate Provider Directories (SB 137). SB 137 (Hernandez), Chapter 649, Statutes of 2015, requires a health plan to implement several requirements to ensure its provider directories contain accurate information to allow consumers to access covered health care services. The bill was approved in response to several audits demonstrating health plans' provider directories were riddled with inaccuracies, preventing health care consumers from choosing plans with networks containing their preferred providers. DMHC is required to provide uniform standards for provider directories by December 31, 2016, and plans must begin using the department's provider directory standards for all plan products by July 1, 2017. The department's development of standards is exempt from the Administrative Procedures Act until January 1, 2021, during which time it may revise the standards twice.

Consumer Participation Program. SB 1092 (Sher), Chapter 792, Statutes of 2002, created the Consumer Participation Program (CPP) and authorized the director of DMHC to "award reasonable

advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees." The CPP has provided funding to organizations to represent consumer interests in a variety of DMHC proceedings. The statute allows DMHC to award a total of $350,000 each fiscal year. In 2016-17, Consumers Union, the Western Center on Law and Poverty, and Health Access California received awards for a combined total of approximately $50,000.

The statutory authority for the CPP is scheduled to sunset on January 1, 2018. The program's sunset date has been extended twice in trailer bill language, in 2007 and 2011. Because this program provides vital consumer representation in regulatory matters governed by DMHC, the Legislature may wish to consider trailer bill language to delete the statutory sunset date.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of DMHC's mission and programs.

2. What types of enforcement actions are available to the department in response to inaccurate data submissions for SB 964 timely access compliance reporting for 2015?

3. What steps is the department taking to ensure accurate data submissions for the 2016 reporting?

4. How is the department monitoring whether plan enrollees are receiving timely access to medical care in the absence of reliable reporting demonstrating plan compliance?

5. What is the status of health plan adoption of the department's uniform provider directory standards required pursuant to SB 137? How will these standards improve the accuracy of provider directories? Are any updates or additional components planned before 2021?

Issue 2: Help Center Case Backlog and Workload

Budget Issue. DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.4 million in 2017-18, $3.3 million in 2018-19 and 2019-20, and $2.7 million annually thereafter. If approved, these resources would allow DMHC's Help Center to address increased workload and subsequent backlog attributed to full implementation of the Affordable Care Act and conforming legislation.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,422,000
Total Funding Request:	**$-**	**$3,422,000**
Total Positions Requested:	**11.0**	

Background. DMHC's Help Center provides a range of services to assist consumers with health care issues and ensure managed care patients receive the services to which they are entitled. The Help Center responds to enrollee calls, reviews and resolves complaints, administers Independent Medical Reviews (IMRs), and addresses urgent nurse complaints. The Help Center is composed of several branches that are responsible for supporting this workload.

The Contact Center processes and responds to incoming correspondence and consumer telephone inquiries, educates consumers regarding various health plan issues, provides referrals to other entities or agencies for issues outside of its jurisdiction, and collects demographic and other data to track problems and trends. The Complaint Resolution Branch is responsible for the initial processing of complaints, case creation, and resolution. After certain conditions are met, complaints regarding a health plan's denial of services are eligible for Independent Medical Review (IMR). An IMR is a review of a case by independent physicians that are not part of the health plan that has denied services. The Independent Medical/Clinical Review Branch is responsible for the initial review and analysis of IMRs; referral to an external review organization, which provides the independent physicians that make IMR determinations; and closes the IMR after the determination is made.

In addition to these branches, Help Center staff are assisted by the Legal Affairs and Policy Development Division, which investigates and resolves complex complaints and provides legal counsel, and the Division of Management Support Services, which provides administrative and technical support.

Previous Help Center Budget Augmentations. Since 2014, DMHC has received additional resources for its Help Center in two of the last three fiscal years for workload related to the federal Affordable Care Act. In 2014-15, DMHC received 37 positions and annual expenditure authority from the Managed Care Fund of $4.4 million for increased workload related to the state's expansions of Medi-Cal and coverage in the individual market. Because these expansions significantly increased enrollment of individuals in managed care who had previously been uninsured, DMHC experienced an increase in call and complaint volume from these new consumers, many of whom were unfamiliar with how to use their health care coverage benefits. In 2015-16, DMHC received an additional 7 positions and annual expenditure authority from the Managed Care Fund of $1.1 million after reporting the percentage of new enrollees in a health plan regulated by the department was higher than anticipated.

According to DMHC, total consumer calls to the Help Center increased from 60,809 in 2014 to 92,996 in 2016, an increase of 52.9 percent. During this period, standard complaints increased 74.7 percent (from 9,217 to 16,098) and IMRs increased 157.4 percent (from 3,148 to 8,104). Despite the increase in staff, DMHC is reporting a backlog of complaints and IMRs. In response, the department has implemented mandatory overtime and utilized temporary help resources to support the increased workload and attempt to clear the backlog.

DMHC is requesting the following resources:

1. Contact Center - 2 Staff Services Analysts to respond to increased call volume
2. Complaint Resolution and IMR Branch – 1 Staff Services Manager I and 8 Associate Governmental Program Analysts (5 permanent, 3 from limited-term resources) to screen, process and close complaints and IMRs
3. Legal Affairs and Policy Development Division – 1 Attorney and 3 Senior Legal Analysts (1 permanent, 2 from limited-term resources) to provide legal support for complaint and IMR case processing and closure
4. Management Support Services – 1 Associate Governmental Program Analyst to provide administrative and technical support to Help Center staff

DMHC indicates the request for limited-term resources for three years (equivalent to 5 positions) is intended to clear the complaint and IMR backlog within the three-year period. The department expects the permanent resources in this request to be sufficient to prevent future complaint or IMR backlogs.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Information Technology Resource Request

Budget Issue. DMHC requests two positions and expenditure authority from the Managed Care Fund of $746,000 in 2017-18, $722,000 in 2018-19 and 2019-20, and $289,000 annually thereafter. If approved, these resources would allow DMHC to address information security needs and transition to an efficient information technology (IT) systems architecture and forward looking roadmap to meet business intelligence requirements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$746,000
Total Funding Request:	**$-**	**$746,000**
Total Positions Requested:	**2.0**	

Background. DMHC reports significant challenges from increased technological complexity, aging IT infrastructure, and increased security risks. The Office of Technology and Innovation (OTI) maintains the department's outdated infrastructure and supports several in-house developed legacy applications utilized by nearly every departmental division. These legacy applications, while custom designed for DMHC's workload, require customized support and experience interoperability problems with other systems. OTI receives over 2,500 change and service requests each year and currently has a backlog of such requests.

Statewide "Cloud First" Technology Policy. In August 2014, the California Department of Technology (CDT) published Technology Letter 14-04, which outlined the Administration's "Cloud First" policy. CDT's Office of Technology Services (OTech) developed a secure state government-wide private cloud, which offers support for three common cloud service models: Software as a Service (SaaS), Platform as a Service (PaaS), and Infrastructure as a Service (IaaS). The technology letter, as well as addition of Section 4983 to the State Administrative Manual (SAM 4983), directed state entities to shift to the "Cloud First" policy for all new reportable and non-reportable IT projects.

According to DMHC, the resources contained in this budget request will allow it to implement a forward looking IT roadmap, reduce use and continued investments in its legacy applications, and accelerate migration of its systems to the OTech Cloud. One Senior Programmer Analyst would support systems development to consolidate and replace legacy systems and to improve the department's IT processes. One Systems Software Specialist II would be responsible for security enhancements and monitoring of all systems to prevent security breaches. Three-year, limited-term resources equivalent to one Systems Software Specialist II would specialize in updating the department's IT infrastructure to enhance security, deliver high performance network communications and enable migration of applications, servers, and workstations to the OTech Cloud.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Prohibition of Surprise Balance Billing (AB 72)

Budget Issue. DMHC requests 16 positions, limited-term resources (equivalent to 3.75 staff) and expenditure authority from the Managed Care Fund of $3,588,000 in 2017-18, $3,173,000 in 2018-19, $2,963,000 in 2019-20, and $2,251,000 annually thereafter. If approved, these resources would allow DMHC to regulate the elimination of "surprise balance billing" pursuant to the requirements of AB 72 (Bonta), Chapter 492, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,588,000
Total Funding Request:	**$-**	**$3,588,000**
Total Positions Requested:	**16.0**	

Background. AB 72 (Bonta), Chapter 492, Statutes of 2016, establishes a provider reimbursement, reconciliation, and complaint resolution infrastructure to eliminate "surprise balance billing", the practice of billing consumers for health care services delivered by out-of-network (non-contracting) providers at an in-network (contracting) health facility. Specifically, AB 72 establishes a reimbursement rate formula for non-contracting providers, an independent dispute resolution process (IDRP) to resolve claim disputes between non-contracting providers and health plans, and regulatory and reporting requirements for DMHC and the California Department of Insurance. For consumers, AB 72 ensures that consumers are only billed for the in-network cost sharing amounts pursuant to their health care service plan contract when selecting an in-network facility for their care.

DMHC Implementation Requirements. AB 72 requires DMHC to:

1. Establish an IDRP for claim disputes between health care service plans and non-contracting providers by September 1, 2017.
2. Establish uniform written procedures for the submission, receipt, processing and resolution of claim payment disputes.
3. Provide a report to the Governor and the Legislature containing data related to the IDRP, a summary of payments related to AB 72, and findings regarding the impact of the bill on network adequacy by January 1, 2019.
4. Develop a standardized methodology for plans and delegated entities to determine the average contracted rates for services subject to AB 72 by January 1, 2019.
5. Engage stakeholders throughout the development process with a stakeholder meeting no later than July 1, 2017.
6. Review average contracted rates and the policies and procedures for calculating these rates as part of the Office of Financial Review's examination of plans' fiscal and administrative affairs. Plans provide DMHC with the data, methodology and policies and procedures used to determine their average contracted rates for the 2015 calendar year, which is the base year for rate development in 2017 and beyond.

DMHC requests resources to support increased workload in the following programs:

1. Help Center – The requested resources would allow DMHC to respond to increased provider complaint call volume and process IDRP requests

- 1 Associate Governmental Program Analyst
- 1 Attorney
- 1 Legal Secretary
- 1 Office Technician
- Three-year limited-term resources equivalent to 3 staff
- Three-year limited-term resources for IDRP consultant costs.

2. Office of Plan Monitoring – The requested resources would support monitoring of plan compliance with the network adequacy requirements for non-contracting providers implemented by AB 72. In addition, these resources would support review of plans' grievance systems for compliance with AB 72.
   - 2 Associate Health Program Advisers
   - 2 Attorney III
   - 1 Staff Health Care Service Plan Analyst
3. Office of Financial Review The requested resources would support creation of the methodology for determining average contracted rates for providers, review contracted rate submissions, train DMHC staff for review of plan policies used to calculate rates, and develop data format submissions to facilitate the IDRP process.
   - 1 Associate Life Actuary
   - 1 Corporation Examiner
4. Office of Enforcement – The requested resources would support enforcement actions arising from health plan non-compliance with the provisions of AB 72.
   - 1 Attorney III
   - 1 Legal Secretary
5. Office of Administrative Services – The requested resources would provide administrative support related to the new positions.
   - 2 Staff Services Analysts
6. Office of Technology and Innovation – The requested resources would provide IT and technical support related to the new positions.
   - 1 Staff Information Systems Analyst

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the process for plans to submit initial rates for July 1, 2017. What guidance has DMHC provided to plans to ensure completeness and accuracy of the submissions?

3. What stakeholder engagement has occurred to date? Has the required meeting been scheduled?

4. Which division is responsible for the January 1, 2019, report to the Governor and Legislature? Are there resources in this request allocated for preparation of the report?

Issue 5: Medi-Cal Interagency Agreement Reduction

Budget Issue and Trailer Bill Language Proposal. The DMHC is requesting a reduction of 18.5 positions and a reduction in expenditure authority of $5.3 million ($3.4 million Managed Care Fund and $1.9 million reimbursements) in 2017-18 and $4.3 million ($2.9 million Managed Care Fund and $1.4 million reimbursements) annually thereafter. If approved, these reductions and the related trailer bill language proposal would reflect the termination of existing interagency agreements between DMHC and the Department of Health Care Services (DHCS).

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	($3,398,000)
0995 – Reimbursements	$-	($1,870,000)
Total Funding Request:	**$-**	**($5,268,000)**
Total Positions Requested:	**(18.5)**	

Background. Since 2010, DMHC has received resources to perform workload focused on Medi-Cal managed care plans on behalf of DHCS. These services are currently provided through four interagency agreements between the two departments. DHCS reimburses DMHC for 50 percent of costs associated with the agreements, and 100 percent of consulting services costs incurred to support the Cal MediConnect Ombudsman Program. The four interagency agreements are as follows:

1115 Waiver Demonstration Project. Beginning in 2010, DMHC conducts medical surveys, medical loss ratio financial examinations, and network adequacy reviews related to the 1115 Waiver, a federal waiver program to enable Medicaid participants to receive benefits through certain providers and permit the State to require certain individuals to receive benefits through managed care providers.

Rural Expansion. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the transition of approximately 400,000 individuals in 28 rural counties from fee-for-service to Medi-Cal managed care plans. AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to conduct financial audits, medical surveys, and a review of the provider networks with the expansion of Medi-Cal managed care into the 28 rural counties.

Medi-Cal Dental Managed Care. DHCS began contracting with six Dental Managed Care (DMC) plans in 2013. These dental plans receive a negotiated, monthly capitated reimbursement rate for each Medi-Cal beneficiary enrolled in the plan. Beneficiaries enrolled in the contracted plans receive dental benefits from providers within the plan's provider network. Under the interagency agreement, DMHC conducts financial examinations and medical surveys focused on the Medi-Cal line of business for these six DMC plans.

Coordinated Care Initiative. The Coordinated Care Initiative (CCI) seeks to provide better health outcomes for individuals eligible for both Medicare and Medi-Cal (dual-eligibles) by enrolling them into managed health care plans. SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to perform health plan

surveys and financial reviews, readiness review activities, and provide consumer assistance to eligible beneficiaries of CCI. The Ombudsman Program conducts outreach and enhances awareness of Ombudsman service availability, investigates and resolves Cal MediConnect enrollees' issues with managed care plans and refers Cal MediConnect enrollees to various resources and assistance programs.

Federal Medicaid Managed Care Regulations. Released in May 2016 by the federal Centers for Medicare and Medicaid Services, Final Rule 2390-P changed Medicaid regulations to align the rules governing Medicaid managed care plans with those of other major sources of coverage, such as Qualified Health Plans and Medicare Advantage. The rule also implements statutory provisions, changes actuarial payment provisions, promotes quality of care, and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

The new rulemaking requires DHCS to substantially expand its oversight and monitoring of Medi-Cal managed care plans, county mental health plans, Prepaid Inpatient Hospital Plans (PIHP), and DMC plans by requiring greater detail in oversight activities and verification of information, including data on provider networks according to an expanded range of provider types, cultural and language standards, and quality improvement projects. The new rules also require states to demonstrate their willingness to issue sanctions to plans that repeatedly fail to comply with program requirements. DHCS received 38 positions and $10.4 million ($4.9 million General Fund and $5.4 million federal funds) in 2016-17 and is requesting an additional 15 positions and $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 to manage the new regulatory workload.

According to DHCS and DMHC, the increased monitoring of Medi-Cal managed care plans required by the new rulemaking is more stringent than the surveys, reviews and other regulatory oversight provided by DMHC under the interagency agreements. DHCS reports this workload will be completed by staff in its Managed Care Operations, Managed Care Quality and Management, Capitated Rates, Dental Services, and Audits and Investigations Divisions. As a result, DMHC is proposing to terminate the four interagency agreements with DHCS, which expects to assume this workload within its overall compliance with the requirements of the final rule. The department's proposal includes trailer bill language implementing the termination of the agreements and a reduction in positions and expenditure authority as follows:

1115 Waiver Demonstration Project: Reduction of $2,005,000 and 13.0 Positions

Office of Plan Monitoring - Division of Provider Networks

- 2.0 Health Program Specialist I
- 1.0 Associate Health Program Adviser
- Ongoing consultant costs in the amount of $300,000 to assess and monitor the availability and adequacy of Medi-Cal managed care plans' provider networks.

Office of Plan Monitoring - Division of Plan Surveys

- 1.0 Supervising Health Care Service Plan Analyst
- 4.0 Staff Health Care Service Plan Analysts

Office of Financial Review - Division of Financial Oversight

- 1.0 Corporation Examiner IV (Supervisor)
- 4.0 Corporation Examiners

Rural Expansion: Reduction of $487,000 and 3.5 Positions

Help Center
- 2.0 Consumer Assistance Technicians
- 0.5 Nurse Evaluator II
- 0.5 Associate Governmental Program Analyst

Office of Plan Monitoring - Division of Plan Surveys
- 0.5 Associate Health Care Service Plan Analyst
- Ongoing consultant costs in the amount of $130,000 to assist the DMHC with conducting medical surveys.

Medi-Cal Dental Managed Care: Reduction of $384,000 and 2.0 Positions

Office of Plan Monitoring - Division of Plan Surveys
- 0.5 Health Program Specialist II
- 0.5 Associate Health Care Service Plan Analyst
- Ongoing consultant costs in the amount of $130,000 to assist the DMHC with conducting DMC surveys.

Office of Financial Review - Division of Financial Oversight
- 1.0 Corporation Examiner

Coordinated Care Initiative: Reduction of $522,000 in FY 2017-18

Office of Plan Monitoring - Division of Provider Networks
- Limited-term expenditure authority equivalent to 0.5 Health Program Specialist I until December 31, 2017 to perform this workload.

Help Center
- Limited-term expenditure authority equivalent to 0.5 Associate Governmental Program Analyst until December 31, 2017 to perform this workload.

Short-term consultant costs were provided through December 31, 2017 to partner with California community-based organizations to provide consumers with local, hands-on assistance with enrollment into Cal MediConnect health coverage. This request reflects a reduction in the amount of $400,000 in 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending evaluation of the companion proposal from DHCS to assume the responsibilities of the interagency agreements DMHC proposes to terminate.

Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

2. If the elimination of the interagency agreements is approved, what regulatory oversight of Medi-Cal managed care plans will still be under the jurisdiction of DMHC?

3. Please describe how DMHC and DHCS will coordinate their oversight and monitoring activities to avoid duplication of efforts.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services Funding Summary				
Fiscal Year:	**2015-16**	**2016-17**	**2017-18**	**BY to CY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$176,186,000	$203,591,000	$202,958,000	($633,000)
Federal Funds[1]	$301,977,000	$374,560,000	$373,879,000	($681,000)
Special Funds/Reimb	$46,230,000	$59,638,000	$52,232,000	($7,406,000)
Total Expenditures	**$524,393,000**	**$637,789,000**	**$629,069,000**	**($8,720,000)**
Total Auth. Positions	**3518.3**	**3835.4**	**3770.7**	**(64.7)**
LOCAL ASSISTANCE				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$17,917,490,000	$19,939,167,000	$19,410,746,000	($528,421,000)
Federal Funds[1]	$55,445,670,000	$67,133,809,000	$67,069,323,000	($64,486,000)
Special Funds/Reimb	$9,822,122,000	$15,163,325,000	$18,156,027,000	$2,992,702,000
Total Expenditures	**$83,185,282,000**	**$102,236,301,000**	**$104,636,096,000**	**$2,399,795,000**
[1]*Federal Funds include Funds 0890, 7502, 7503, and 8500*				

Background. The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering health care services to eligible individuals. DHCS programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

- ***Children's Medical Services.*** Children's Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 budget acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

Subcommittee Staff Comment and Recommendation. This is an informational item.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of DHCS programs and budget.

Issue 2: November 2016 Medi-Cal Estimate - Overview

Budget Issue. The November 2016 Medi-Cal Local Assistance Estimate includes $100.1 billion ($19.6 billion General Fund, $66.8 billion federal funds, and $13.7 billion special funds and reimbursements) for expenditures in 2016-17, and $102.6 billion ($19.1 billion General Fund, $66.8 billion federal funds, and $16.7 billion special funds and reimbursements) for expenditures in 2017-18.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$18,580,262,000	$18,118,289,000	($461,973,000)
Federal Funds	$63,114,015,000	$62,976,866,000	($137,149,000)
Special Funds/Reimbursements	$13,681,542,000	$16,693,070,000	$3,011,528,000
Total Expenditures	**$95,375,819,000**	**$97,788,225,000**	**$2,412,406,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$859,237,000	$858,771,000	($466,000)
Federal Funds	$3,397,740,000	$3,502,083,000	$104,343,000
Special Funds and Reimbursements	$11,956,000	$11,819,000	($137,000)
Total Expenditures	**$4,268,933,000**	**$4,372,673,000**	**$103,740,000**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$120,524,000	$152,982,000	$32,458,000
Federal Funds	$-	$-	$-
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$120,524,000**	**$152,982,000**	**$32,458,000**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$19,560,023,000	$19,130,042,000	($429,981,000)
Federal Funds	$66,808,522,000	$66,750,097,000	($58,425,000)
Special Funds and Reimbursements	$13,693,498,000	$16,704,889,000	$3,011,391,000
Total Expenditures	**$100,062,043,000**	**$102,585,028,000**	**$2,522,985,000**

Caseload. In 2016-17, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 0.6 percent compared to assumptions for the 2016 Budget Act. In 2017-18, the budget assumes annual

Medi-Cal caseload of 14.3 million, a 1.8 percent increase compared to the revised caseload estimate for 2016-17.

Significant General Fund Changes. The November 2016 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

2016-17 General Fund Deficiency - The budget includes increased expenditures in the Medi-Cal program of approximately $1.8 billion General Fund compared to the 2016 Budget Act. The current year increase is primarily attributable to a one-time retroactive payment of drug rebates to the federal government and miscalculation of costs associated with the Coordinated Care Initiative in prior estimates. (For more information, see Issue 3: Medi-Cal Unanticipated Costs – 2016-17 Deficiency)

Managed Care Organization Tax - The budget includes reduced General Fund expenditures in the Medi-Cal program of approximately $1.1 billion in 2016-17 and $1.6 billion in 2017-18 from the tax on enrollment of managed care organizations authorized by SBX2 2 (Hernandez), Chapter 2, Statutes of 2016.

Coordinated Care Initiative (CCI) - The budget reflects savings of approximately $20 million General Fund from the extension of the duals demonstration pilot project (Cal MediConnect). The Governor's Budget estimate of CCI projects that it will no longer be cost-effective and, consistent with current law, will be discontinued in 2017-18. Based on the lessons learned from the CCI demonstration project, the budget includes the extension of the duals demonstration pilot (Cal MediConnect) for an additional two years, through December 31, 2019.

Optional Expansion of Medi-Cal - The budget includes General Fund expenditures of $888.4 million in 2016-17 and $1.6 billion in 2017-18 for the optional Medi-Cal expansion population. Beginning in 2017, the state assumes a 5 percent share of cost for optional expansion expenditures.

Full-Scope Medi-Cal Coverage for Undocumented Children (SB 75) - The budget includes General Fund expenditures of $279.5 million to provide full-scope benefits to approximately 185,000 children, pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015. (For more information, see Issue 6: Undocumented Children Full-Scope Expansion)

Children's Health Insurance Program (CHIP) Reauthorization - The budget assumes Congress will reauthorize the CHIP program, but at the previous federal matching percentage of 65% effective October 1, 2017. The budget includes General Fund costs of $536.1 million to account for the loss in federal funding. (For more information, see Issue 8: Title XXI Federal Match Reduction)

New Qualified Immigrants (NQI) Affordability and Benefits Wrap Program - The budget includes General Fund savings of $48 million from transitioning coverage for NQI adults from Medi-Cal to an Exchange plan. The budget proposes all NQI adults be included in the wrap program January 1, 2018. (For more information, see Issue 7: New Qualified Immigrant Wrap Proposal)

Major Risk Medical Insurance Fund Abolishment – The budget includes reduced General Fund expenditures of $62.3 million offset by a one-time transfer of the remaining fund balance in the Major Risk Medical Insurance Fund. The budget abolishes the fund, and proposes the transfer of the remaining

fund balance to the newly established Health Care Services Plans Fines and Penalties Fund to fund MRMIP and to offset General Fund expenditures in the Medi-Cal program. (For more information, see Issue 10: Elimination of Major Risk Medical Insurance Fund Proposal)

Hospital Quality Assurance Fee Extension - The budget includes General Fund savings of over $1 billion in 2017-18 from the extension of the hospital quality assurance fee. On November 8, 2016, voters passed Proposition 52, which amends the state Constitution to permanently extend the fee.

Drug Medi-Cal Organized Delivery System Waiver - The budget includes $141.6 million General Fund expenditures for a five-year pilot program for participating counties to use an organized delivery system to provide substance use disorder services to eligible Medi-Cal beneficiaries.

Proposition 56 - The budget includes reduced General Fund expenditures of $1.2 billion offset by revenue received from voter approval of Proposition 56, which increased the excise tax rate on cigarettes, tobacco products, and electronic cigarettes. After backfills and specified allocations, Proposition 56 requires 82 percent of the funds remaining be transferred to the Healthcare Treatment Fund for DHCS to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services. Proposition 56 also provided that "funds shall not be used to supplant existing state general funds for these same purposes", "the funding shall be used only for care provided by health care professionals, clinics, health facilities" and "health plans contracting with the State Department of Health Care Services to provide health benefits".

The Administration has interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in program expenditures over the level contained in the 2016 Budget Act. Although these expenditures would have otherwise been funded with state General Fund, the Administration asserts this use of funds does not violate the non-supplantation provisions of Proposition 56. According to the Administration, Proposition 56 revenue deposited in the Healthcare Treatment Fund is allocated to the following expenditures in 2017-18:

PC #	PC Title	Amount of New Program Growth Funded by Proposition 56 Compared to 2016 Budget Act Level (Whole Dollars)
96	Two Plan Model	$464,092,000
97	County Organized Health Systems	$166,112,000
99	Geographic Managed Care	$81,150,000
167	Medicare Pmnts.- Buy-In Part A & B Premiums	$37,956,000
168	Medicare Payments - Part D Phased-Down	$285,485,000
102	Regional Model	$16,795,000
104	Pace (Other M/C)	$35,803,000
112	Capitated Rate Adjustment for FY 2017-18	$150,000,000
	Total	**$1,237,393,000**

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open as updated estimates of caseload and expenditures will be provided at the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2017-18 fiscal year.

2. Please describe the allocations of Proposition 56 funding in the Medi-Cal budget.

3. Please describe the department's interpretation of the provisions of Proposition 56 allowing revenues to fund growth in program expenditures that would otherwise be funded by General Fund. How do these allocations comply with the non-supplantation language in the Proposition 56 statute governing Medi-Cal expenditures?

Issue 3: Medi-Cal Unanticipated Costs – 2016-17 Deficiency

Budget Issue. The Administration estimates unanticipated increases in Medi-Cal program expenditures in 2016-17 will exceed its 2016 Budget Act appropriation, resulting in a current year General Fund deficiency of approximately $1.8 billion.

Background. The 2016 Budget Act appropriated $17.8 billion of General Fund for the Medi-Cal program in 2016-17. According to DHCS, updated estimates of Medi-Cal expenditures for 2016-17 will be $19.6 billion, an increase of $1.8 billion over the 2016 Budget Act appropriation. DHCS reports this substantial increase in expenditures is primarily due to two factors: 1) a miscalculation of costs related to the Coordinated Care Initiative (CCI), and 2) a one-time repayment to the federal government of pharmacy rebates collected on claims for ACA beneficiaries.

CCI Miscalculation. The budget references a miscalculation in CCI, California's demonstration project for individuals eligible for both Medicare and Medi-Cal (dual-eligibles), that contributed to the significant deficiency in the Medi-Cal program in 2016-17. According to the Administration, the 2016 Budget Act underestimated General Fund resources for CCI by approximately $1.5 billion. Specifically, the 2016 Budget Act:

Underestimated costs for managed care payments for CCI beneficiaries' care	**$573.2 million**
Overestimated savings to fee-for-service system for transition to managed care	**$913.1 million**
TOTAL CCI-Related Deficiency (General Fund):	**$1.486 billion**

Authorized by SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, CCI integrates medical, behavioral health, and long-term services and supports for dual-eligible beneficiaries in seven demonstration counties: San Mateo, Santa Clara, Los Angeles, Riverside, San Bernardino, Orange, and San Diego. Dual-eligible beneficiaries were passively enrolled into Cal MediConnect, which coordinates Medicare and Medi-Cal benefits, beginning in 2014. Dual-eligible beneficiaries who opted out of Cal MediConnect and Medi-Cal-only beneficiaries such as seniors and persons with disabilities, were mandatorily enrolled in managed care for Medi-Cal benefits, including long-term services and supports (LTSS) like In-Home Supportive Services (IHSS) and skilled nursing facility care.

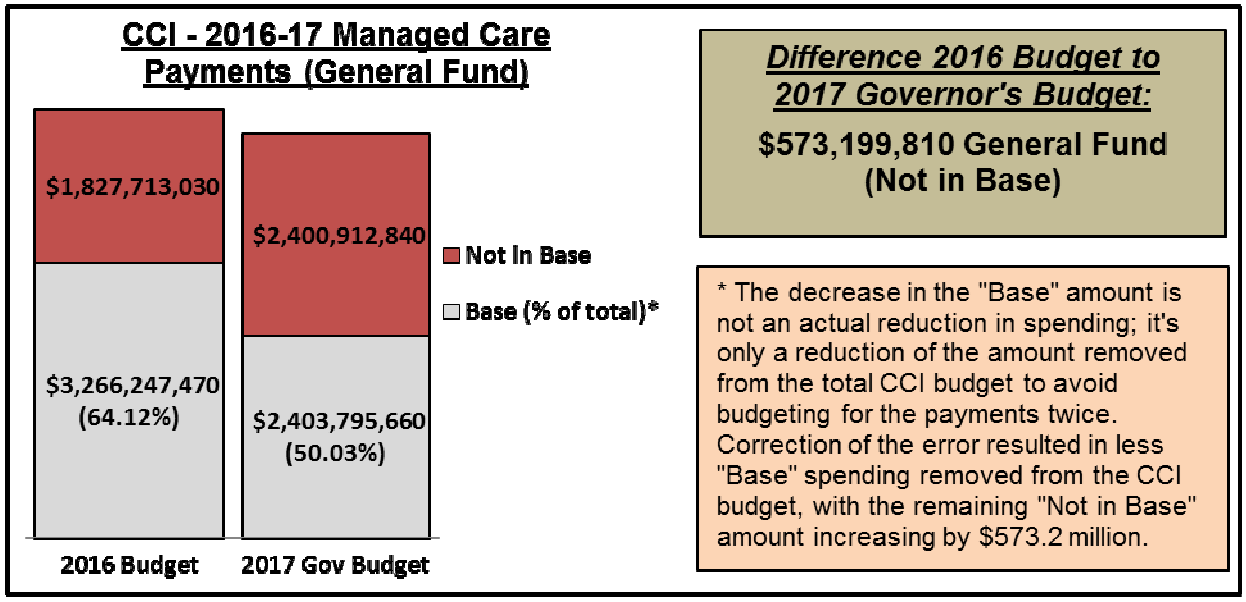
Most Medi-Cal beneficiaries enrolled in CCI already receive a portion of their Medi-Cal benefits through a managed care plan. However, LTSS benefits were previously provided through the fee-for-service delivery system, except in San Mateo and Orange Counties. Because of the integration of LTSS into managed care, the budget for CCI includes two main components:

- Costs for capitation payments to managed care plans for the delivery of benefits, either in Cal MediConnect or in managed care including LTSS.
- Savings in the fee-for-service delivery system from no longer providing LTSS, as beneficiaries transition into managed care for those benefits.

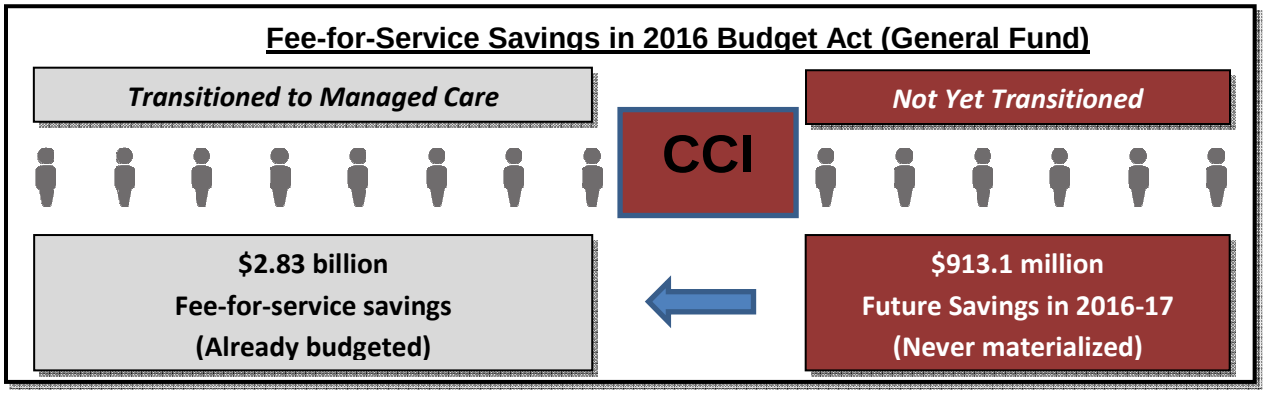
In general, the annual costs for capitation payments and the savings from fee-for-service should be roughly equivalent, since the capitation payments are based on the fee-for-service equivalent costs. The program receives some additional General Fund savings from Cal MediConnect plans that have savings targets built into their rates.

The overall miscalculation was the result of estimation errors in each of these components. Both estimation errors resulted in the inclusion of less General Fund authority in the 2016 Budget Act than needed for the operation of the program, and contributed to the total $1.8 billion current year Medi-Cal deficiency in the 2017 Governor's Budget.

Managed Care Payments. When the Medi-Cal program estimates the budget for managed care payments to CCI plans, there are two components to the estimation. First, DHCS determines the total cost for capitation payments to plans for CCI beneficiaries. Then, because most CCI beneficiaries were already receiving non-LTSS benefits through managed care, DHCS determines what percentage of the total capitation payments are already captured in the program's base trend estimate. The amount captured in the base is removed from the CCI budget to avoid budgeting for the payments twice (once in the base and again in the CCI budget). For the 2016 Budget Act, DHCS miscalculated how much it should have removed from the CCI budget due to a spreadsheet formula error that counted the base amounts from San Mateo and Orange Counties twice. An additional $573.2 million General Fund was necessary to correct the error.



Fee-For-Service Savings. Medi-Cal's estimate for fee-for-service savings in CCI assigned a per-member per-month (PMPM) savings value to each individual transitioning into managed care. This strategy was generally sound for the seven counties that had previously transitioned, because there was a significant population of individuals receiving LTSS in the fee-for-service system. However, by the 2016 Budget Act the only county left to transition was Orange County. Orange County operates a county organized health system (COHS) plan for all Medi-Cal beneficiaries in which LTSS services are already integrated into the managed care capitation payments. Because no care in Orange County is delivered in fee-for-service, no fee-for-service savings would occur from transitioning individuals into managed care. The Medi-Cal estimate for CCI savings in the 2016 Budget Act, however, still assumed a standard PMPM for each individual and built in $913.1 million of savings that never materialized.



Retroactive Federal Recoupment of Pharmacy Rebates. Federal Medicaid law and regulations allow the Medi-Cal program to receive rebates from drug manufacturers for prescriptions provided to beneficiaries. In addition to required federal rebates, Medi-Cal negotiates supplemental state rebates that increase the total amount of rebate received. DHCS collects rebate revenue from manufacturers and reimburses the federal government for the federal matching funds provided for the original claim. Traditional Medi-Cal beneficiaries' claims receive a 50 percent match, Children's Health Insurance Program (former Healthy Families Program) beneficiaries currently receive an 88 percent match, and optional expansion (ACA) beneficiaries currently receive a 95 percent match.

Until April 2016, the department's Rebate Accounting and Information System was unable to identify ACA pharmacy claims. As a result, federal reimbursement was never remitted for drug rebates on claims between April 2015 and June 2016. According to DHCS, these revenues were reported as General Fund savings in the 2015-16 fiscal year and supported additional Medi-Cal expenditures in subsequent fiscal years. The retroactive recoupment owed to the federal government for these claims, funded with state General Fund, is approximately $487.3 million. DHCS reports this payment was made in September 2016.

Supplemental Appropriation. Government Code section 16531.1 provides $1 billion of General Fund loan authority to DHCS in the event of a deficiency in the Medi-Cal budget for the purpose of making payments to Medi-Cal providers. Because the current year General Fund deficiency exceeds the $1 billion loan authority, the program may experience problems with cash flow leading to interruptions in payments to Medi-Cal providers. The Administration reports it is evaluating options for addressing potential cash flow issues, including additional General Fund loan authority or accelerated consideration of supplemental appropriation legislation, and will provide further information on its proposed response in the coming weeks.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended this issue be held open pending further updates to Administration estimates of the 2016-17 deficiency at the May Revision or earlier, further guidance on the scope of the department's cash flow challenges, and the Administration's proposed response to those issues.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the deficiency related to the miscalculation for the Coordinated Care Initiative.

2. Please provide a brief overview of the deficiency related to the retroactive federal repayments for pharmacy rebates.

3. Based on current estimates, when does the department expect to exceed its appropriation and loan authority in 2016-17? How would payments be prioritized if this occurs?

Issue 4: County Administration Estimate and Budget Proposals

Budget Issue and Trailer Bill Language Proposal. The budget includes $1.3 billion ($651.3 million General Fund and $651.3 million federal funds) in both 2016-17 and 2017-18 for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocations represent no change from the amounts included in the 2016 Budget Act.

In addition to the base allocation, the budget includes $655.3 million ($327.7 million General Fund and $327.7 million federal funds) for additional county eligibility workload related to implementation of the federal Affordable Care Act. These additional funds also are unchanged from amounts included in the 2016 Budget Act.

DHCS requests expenditure authority of $1.5 million ($731,000 General Fund and $730,000 federal funds) in 2017-18 and 2018-19, and $244,000 ($122,000 General Fund and $122,000 federal funds) in 2019-20. If approved, these resources would allow the department to continue development of a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act, pursuant to the requirements of SB 28 (Hernandez), Chapter 442, Statutes of 2013.

DHCS also requests trailer bill language to clarify legislative intent not to appropriate funds for a cost of living adjustment to counties for Medi-Cal eligibility workload in 2017-18.

County Administration Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
County Administration Base			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$651,341,500	$651,341,500	$-
0890 – Federal Trust Fund	$651,341,500	$651,341,500	$-
Total Expenditures	**$1,302,683,000**	**$1,302,683,000**	**$-**
Implementation of ACA			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$327,655,000	$327,655,000	$-
0890 – Federal Trust Fund	$327,655,000	$327,655,000	$-
Total Expenditures	**$655,310,000**	**$655,310,000**	**$-**

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$731,000
0890 – Federal Trust Fund	$-	$730,000
Total Funding Request:	**$-**	**$1,461,000**
Total Positions Requested:	**0.0**	

Background. DHCS provides funding for county staff and support costs to perform administrative activities associated with the Medi-Cal eligibility, enrollment, retention, and redetermination process. Counties have traditionally served as the primary access point for low-income individuals to apply for Medi-Cal coverage and other public assistance programs. Using workload data, expenditure data, and other available information, DHCS determines a base allocation for each county based on estimates of staff costs, support costs, and staff development costs. Two years after development of the base allocation for a fiscal year, DHCS reconciles the budgeted base allocation with a county's actual expenditures, with additional funds provided to counties that spent more than their allocation and repayment to the state of unspent county funds. The budget includes $1.3 billion ($651.3 million General Fund and $651.3 million federal funds) in both 2016-17 and 2017-18 for the base allocation.

Implementation of the federal Affordable Care Act (ACA) significantly changed county Medi-Cal eligibility workload. Changes to the enrollment and redetermination processes designed to simplify beneficiaries' application for the program result in additional complexity. The new process included an interface with the California Healthcare Eligibility, Enrollment and Retention (CalHEERS) system, California's portal for health insurance affordability program applications. System implementation issues with CalHEERS' county interfaces led to significant increases in county eligibility workload and delay in eligibility determinations. In response to these issues, DHCS has provided counties additional funding over their base allocation to account for the increase in workload. The budget includes $655.3 million ($327.7 million General Fund and $327.7 million federal funds) in both 2016-17 and 2017-18 for implementation of the ACA.

In anticipation of the workload changes required by ACA implementation, the Legislature approved SB 28, which requires DHCS to develop and implement a new budgeting methodology for county administration of the Medi-Cal program. The methodology, to be developed in consultation with county stakeholders, is meant to reflect the changes in county operations as a result of implementation of the ACA. In 2014-15, the Legislature approved two limited-term positions and contract funding to begin working on the new methodology. According to DHCS, the approved staff have been engaged in efforts to learn current county processes and spending patterns, research prior efforts to create a new budgeting methodology, and prepare documents required to engage the services of a contractor. DHCS also reports it worked with the County Welfare Directors Association and the Service Employees International Union to develop a scope of work for the contractor to perform time/motion studies and make other estimates of county costs to assist in the development of the new methodology.

DHCS requests limited-term extension of the resources previously approved, as follows:

- Three-year expenditure authority of $244,000 ($122,000 General Fund and $122,000 federal funds) equivalent to one Staff Services Manager I and one Associate Governmental Program Analyst to continue working with counties and the contractor to develop the new budgeting methodology.
- Two-year expenditure authority of $1.2 million ($608,000 General Fund and $607,000 federal funds) to continue funding the contractor to assist in development of the new budgeting methodology.

According to DHCS, the data and other information provided through the contractor's work will inform the development of the new budgeting methodology and determine how it will be implemented. If these resources are approved, DHCS expects implementation no sooner than 2017-18.

County Administration COLA Trailer Bill Language. ABX4 12 (Evans), Chapter 12, Statutes of 2009, prohibits automatic cost of living adjustments (COLAs) to state departments and agencies. However, Welfare and Institutions Code section 14154(c)(1) states legislative intent that counties receive adequate funding, including an annual COLA, for the eligibility work performed on behalf of the Medi-Cal program. Since 2009, the Legislature has approved trailer bill language annually to state legislative intent to not appropriate funds for a COLA for county's eligibility workload in that year. DHCS proposes trailer bill language to add 2017-18 to the list of fiscal years beginning in 2008-09 during which it is the intent of the Legislature not to appropriate funds for a county COLA.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these issues open as updated estimates of caseload and expenditures will be provided at the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the local assistance estimate for County Administration.

2. Why are base allocations and ACA implementation funding flat between the 2016-17 and 2017-18 fiscal years?

3. Please provide a brief overview of the budget change proposal for extension of resources related to the new budgeting methodology for county administration costs.

4. How will the implementation of the new MEDS system, pursuant to the request previously heard by the subcommittee, lead to efficiencies in counties' administration of eligibility for the Medi-Cal program? Would these efficiencies be captured by the new budgeting methodology?

Issue 5: Use of CalWORKs Eligibility to Determine Medi-Cal Eligibility

Trailer Bill Language Proposal. DHCS proposes trailer bill language to provide statutory authority to seek federal approval to use determination of eligibility for the California Work Opportunity and Responsibility to Kids (CalWORKs) program as a determination of eligibility for the Medi-Cal program.

Background. DHCS considers a CalWORKs eligibility determination to also confer automatic eligibility for the Medi-Cal program. This consideration is based on an analysis that demonstrates individuals qualifying for CalWORKs, under CalWORKs program rules, would also qualify for Medi-Cal, under Medi-Cal's eligibility rules. Currently when an individual's eligibility for CalWORKs ends, Medi-Cal eligibility continues under the 1931(b) program until the next annual renewal or unless the reason for the CalWORKs discontinuance is also a reason for discontinuance for Medi-Cal. The federal Centers for Medicare and Medicaid Services recently recommended DHCS request federal approval through a state plan amendment to continue using CalWORKs eligibility determination as a basis for eligibility to the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates at May Revision, as well as potential federal actions regarding the status and funding of health coverage in the Medi-Cal program.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Undocumented Children Full-Scope Expansion (SB 75)

Budget Issue. The budget includes $292.3 million ($230.4 million General Fund and $61.9 million federal funds) in 2016-17 and $354.4 million ($279.5 million General Fund and $74.8 million federal funds) for the enrollment of undocumented children into full-scope Medi-Cal, pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$230,369,000	$279,533,000
0890 – Federal Trust Fund	$61,927,000	$74,825,000
Total Funding Request:	**$292,296,000**	**$354,358,000**

Background. SB 75 expands eligibility for full-scope Medi-Cal to all income-eligible children under age 19, regardless of immigration status. Undocumented children were previously eligible for restricted-scope Medi-Cal coverage, which includes emergency and pregnancy related services only. Services provided under restricted-scope Medi-Cal receive a 50 percent federal match, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimates there are 250,000 undocumented children under age 19 covered under the expansion of eligibility, which includes two distinct populations:

1. **Restricted-Scope Medi-Cal Beneficiaries** – DHCS estimates there were 119,076 undocumented children previously enrolled in restricted-scope Medi-Cal coverage. All of these children completed the transition into full-scope Medi-Cal coverage between May and September 2016.
2. **Not Currently Enrolled.** DHCS estimates there are 130,924 undocumented children that were eligible for, but not enrolled in, restricted-scope Medi-Cal. These children must undergo eligibility determinations through the ordinary Medi-Cal application process. The department estimates that 50 percent of these children will enroll in coverage over the 12 month period beginning in May 2016. As of March 2, 2017, 61,917 children in this category were enrolled in full-scope benefits, or 47.3 percent of the estimated population of undocumented children not currently enrolled. Based on these trends, enrollment is likely to exceed the department's estimate of 50 percent of this population.

Immigration Enforcement Concerns from Beneficiaries. Various stakeholders have reported an increase in inquiries from parents of undocumented children considering disenrollment from Medi-Cal, citing concerns about immigration enforcement actions by the new federal administration. The department does not capture information on the reasons for disenrollment, but has observed a slowdown in enrollment in recent months.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide an update on the progress of enrollment for undocumented children, both for those transitioning from restricted-scope coverage and those not previously enrolled.

Issue 7: New Qualified Immigrant Wrap Proposal

Budget Issue and Trailer Bill Language. The budget includes savings of $120.8 million ($48 million General Fund and $72.8 million federal funds) to implement the transition of New Qualified Immigrants (NQIs) into the New Qualified Immigrant Affordability and Benefit Program (NQI Wrap)

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($48,035,000)
0890 – Federal Trust Fund	$-	($72,775,000)
Total Funding Request:	**$-**	**($120,810,000)**

Background. The federal Personal Responsibility and Work Opportunity Act prohibits federal financial participation for full-scope Medi-Cal services provided to qualified, nonexempt immigrants who have resided in the United States for less than five years. These individuals, known as New Qualified Immigrants (NQIs), are still eligible for restricted-scope Medi-Cal for emergency and pregnancy related services, for which the federal match is available. California provides full-scope Medi-Cal coverage for NQIs, with the nonemergency services funded with 100 percent state General Fund. The budget assumes $707 million of additional General Fund expenditures for full-scope coverage of this population in 2016-17.

Existing Transition of NQI Adults Without Children. SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, provides for the transition of NQIs over age 21 without children into an individual market health plan through the Covered California health benefit exchange. The bill requires Medi-Cal to cover the beneficiary's premium costs, minus the advance premium tax credit provided by federal law, as well as any cost-sharing charges. This coverage and payment structure is referred to as the NQI Wrap.

The 2016 Governor's Budget assumed savings of $83.9 million ($31.8 million General Fund and $52.1 million federal funds) for implementation of the NQI Wrap transition in January 1, 2017. However, by the May Revision the Administration requested a delay of one year (from January 1, 2017 to January 1, 2018) for the transition.

DHCS Proposal Expands Wrap to NQIs With Children. DHCS is proposing trailer bill language to expand the transition of NQI adults to include those with children, in addition to the current population of NQI childless adults. DHCS contends that the state's full-scope Medi-Cal coverage for NQIs does not meet federal minimum essential coverage (MEC) requirements. Individuals that do not maintain MEC are required to pay a federal tax penalty under the Affordable Care Act's individual mandate.

The proposed trailer bill language also makes changes to income eligibility requirements to address differences between eligibility rules in Medi-Cal compared to Covered California.

The budget includes savings of $120.8 million ($48 million General Fund and $72.8 million federal funds) for implementation of its expanded NQI Wrap proposal. However, DHCS reports these savings figures only account for transition of the existing population of NQI childless adults, with no budgeted savings for the expansion to NQI adults with children. The Administration expects to include additional savings attributed to this population in the May Revision.

Minimum Essential Coverage Designation. According to the federal Centers for Medicare and Medicaid Services (CMS), final regulations (45 CFR 156.604) promulgated under the Affordable Care Act (ACA) outline a process by which other types of coverage not statutorily specified and not designated through regulation as MEC may apply to be recognized as MEC. Such plans or policies must meet substantially all of the coverage and consumer protection requirements of Title I of the ACA.

In general, full-scope Medi-Cal coverage for NQIs meets the requirements to be recognized as MEC, as this coverage is identical to that received by other Medi-Cal beneficiaries. However, this program is not statutorily specified or designated through regulation as MEC and DHCS has never applied to the federal government for an MEC designation. According to DHCS, the only barrier to designation of the full-scope NQI program as MEC is for the department to apply for, and CMS to approve, the designation. Given the uncertainty of federal policy regarding both health care and immigration issues, it is unclear whether an application for an MEC designation for the NQI program would be approved by the new federal administration.

Immigrant Rights and Health Consumer Advocates Have Raised Concerns. A coalition of immigrant rights and health consumer advocacy organizations has expressed their opposition to implementation of the existing NQI Wrap proposal, as well as its expansion to NQI adults with children. The coalition notes that, although most NQIs eligible for Medi-Cal are not required to file income taxes, transition to coverage in the Covered California exchange would require tax filing to determine eligibility for federal advance premium tax credits. NQIs would also be required to navigate the different enrollment requirements for both Medi-Cal and the Covered California exchange, potentially leading to coverage disruptions for beneficiaries. The coalition includes the California Pan-Ethnic Health Network, the California Immigrant Policy Center, Health Access California, the National Immigration Law Center, and the Western Center on Law and Poverty.

Health Plans May Not Be Ready for Implementation. The California Association of Health Plans (CAHP) has also expressed its opposition to the department's proposal, indicating that the planned implementation of the NQI Wrap on January 1, 2018 does not allow sufficient time to address technical and operational aspects related to the transition. CAHP reports there has been no agreement between Covered California and DHCS on the design of a plan to maintain zero cost-sharing for NQI beneficiaries under the wrap. According to Blue Shield of California, depending on the design of the product, plans could be required to process claims multiple times in order to comply with state and federal rules and maintain federal cost-sharing reduction and advance premium tax credit subsidies.

According to DHCS, no plans have submitted the required product filings with Covered California to provide coverage under an NQI Wrap program. Product filings for the provision of exchange coverage in the 2018 calendar year are due in early May 2017.

Panel Discussion. The subcommittee has requested the following panelists, in addition to the Department of Health Care Services and the Department of Finance, to provide comments on this proposal:

- **Christopher Galeano**, Policy Associate, California Immigrant Policy Center
- **Kimberly Chen**, Government Affairs Manager, California Pan-Ethnic Health Network
- **Jennifer Alley**, Legislative Advocate, California Association of Health Plans

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions about the implementation readiness of health plans, stakeholder and beneficiary concerns, and potential changes to the availability of federal funding.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the existing transition populations and the expanded populations covered under this proposal.

2. Has DHCS provided plans with sufficient information on the geographic distribution of this population to allow for appropriate plan and product filings?

3. How many plans have submitted product filings to Covered California that would support implementation of this proposal? How would the proposal move forward if there are no qualifying products?

Issue 8: Title XXI Federal Match Reduction

Budget Issue. The budget includes an increase of $536.1 million General Fund, which assumes a reduction of the federal matching percentage for the Children's Health Insurance Program (CHIP) from 88 percent to 65 percent. Unless reauthorized by Congress, CHIP is scheduled to expire on October 1, 2017.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$536,059,190
0890 – Federal Trust Fund	$-	($592,024,190)
Total Funding Request:	**$-**	**($55,965,000)**

Background. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), permits states to provide health care services to children up to 250 percent of the Federal Poverty Level. CHIP allows states to integrate these children into an existing state Medicaid program, or to create a stand-alone program. California originally chose the latter option, establishing the Healthy Families Program administered by the Managed Risk Medical Insurance Board to provide health, dental and vision coverage to eligible children. The 2012 Budget Act, as part of a package of budget-balancing solutions, eliminated the Healthy Families Program, transferring its beneficiaries to Medi-Cal over a 12 month period. The new program for these beneficiaries is known as the Optional Targeted Low-Income Children Program (OTLICP). The budget assumes OTLICP caseload of approximately 1 million children in 2017-18.

Enhanced Federal Match and Maintenance of Effort. Title XXI provides an enhanced federal match for states' CHIP expenditures. California's traditional matching percentage for Title XXI spending has been 65 percent.

Approval of the federal Affordable Care Act (ACA) made two significant changes to the state-federal requirements and fiscal relationship regarding CHIP:

1. **Enhanced Match to 88 Percent --** ACA provided for an increase in the enhanced match for CHIP to 88 percent effective October 1, 2015 until September 30, 2019.
2. **Maintenance of Effort –** ACA also required states to maintain eligibility levels and requirements for children in both Medicaid and CHIP until September 30, 2019.

Despite the enhanced federal match for CHIP contained in the ACA statute, the CHIP program and its funding is scheduled to expire on October 1, 2017. It is unclear how expiration of the CHIP statute in 2017 would impact states' requirements to maintain eligibility levels for children pursuant to the ACA until 2019. According to DHCS, under a scenario in which CHIP is allowed to expire while the ACA maintenance of effort requirements remain, the state would likely receive a 50 percent match for expenditures for OTLICP beneficiaries.

There is significant uncertainty regarding how federal actions related to CHIP or the ACA would interact to affect the state's OTLICP. Under various scenarios, the federal matching percentage could range from zero to 88 percent. For the purposes of the Medi-Cal budget, DHCS assumes that CHIP will

be reauthorized, but at the previous enhanced matching rate of 65 percent. This assumption results in an increase of $536.1 million General Fund expenditures in 2017-18 to account for the loss of federal funding. Alternatively, if CHIP were reauthorized at the existing 88 percent federal match, the state would realize General Fund savings of that amount in 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further monitoring and evaluation of efforts to secure Congressional reauthorization of CHIP and associated changes in funding levels.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of Medi-Cal expenditures supported by Title XXI funding.

2. What is the underlying rationale for assuming reauthorization with a 65 percent federal match?

3. What are the fiscal and programmatic consequences to Medi-Cal if Congress fails to reauthorize CHIP?

Issue 9: Denti-Cal

Dental Services for Medi-Cal Beneficiaries. The budget includes $992.2 million ($310.6 million General Fund and $681.6 million federal funds) in 2016-17 and $1.2 billion ($430.7 million General Fund and $816.9 million federal funds) in 2017-18 for base fee-for-service expenditures for dental services in the Medi-Cal Dental Program, known as Denti-Cal.

The budget also includes $132.5 million ($49.8 million General Fund and $82.8 million federal funds) in 2016-17 and $147.6 million ($56.4 million General Fund and $91.2 million federal funds) in 2017-18 for base dental services provided through dental managed care (DMC) plans.

Dental Services Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
Denti-Cal Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$310,636,300	$430,696,140	$120,059,840
0890 – Federal Trust Fund	$681,597,700	$816,853,860	$135,256,160
Total Expenditures	**$992,234,000**	**$1,247,550,000**	**$255,316,000**
Dental Managed Care (DMC)			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$49,754,390	$56,443,760	$6,689,370
0890 – Federal Trust Fund	$82,764,610	$91,154,240	$8,389,630
Total Expenditures	**$132,519,000**	**$147,598,000**	**$15,079,000**

Background. Medi-Cal's Dental Program, known as Denti-Cal, provides an array of services to eligible Medi-Cal beneficiaries including diagnostic, preventive, restorative, and endodontic services; periodontics; removable and fixed prosthodontics; maxillofacial prosthetics; implant services; oral and maxillofacial surgery; and orthodontic and adjunctive services. Children under age 21 receive the full scope of dental benefits, while adults receive a more limited set of services.

DHCS provides dental services to Medi-Cal beneficiaries through two primary delivery systems:

1. Fee-for-Service – The department contracts with Delta Dental to provide dental care to most Medi-Cal beneficiaries in exchange for a prepaid capitation rate. The current contract requires Delta to provide dental fiscal intermediary (FI) services including claims processing, provider enrollment, beneficiary outreach, and underwriting.
2. Dental Managed Care (DMC) - The department contracts with six DMC plans that provide dental care to approximately 932,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. DMC plans are Knox-Keene licensed and are also regulated by the Department of Managed Health Care.

Partial Restoration of Adult Dental Benefits. ABX3 5 (Evans), Chapter 20, Statutes of 2009, discontinued optional dental benefits in the Medi-Cal program for adults including full denture procedures and "restore but not replace" procedures. Adults retained some limited sets of services that were federally required. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, restored partial adult optional dental benefits beginning in May 2014. The restored benefits included examinations; radiographs/photographic images; prophylaxis; fluoride treatments; amalgam and composite restorations; stainless steel, resin, and resin window crowns; anterior root canal therapy; complete dentures, including immediate dentures; and complete denture adjustments, repairs and relines. According to DHCS, the 2017-18 cost to restore all of the remaining adult dental services would be $190.7 million ($69.5 million General Fund and $121.2 million federal funds).

2014 Audit Findings. In 2014, the California State Auditor performed an audit of the Denti-Cal program which found several weaknesses in the program's operation that limited children's access to dental care. In particular, the audit reported the following:

1. Children's utilization rate of dental services, 43.9 percent, was 12th worst among states submitting data to CMS in 2013. The utilization rate is defined as the percentage of beneficiaries having one dental procedure performed during the year.
2. While the availability of dental providers was adequate on a statewide basis, many counties had insufficient providers, with five counties reporting no providers at all.
3. California's provider reimbursement rates for the 10 most common dental procedures were only 35 percent of the national average in 2011.
4. The department had not performed annual reimbursement rate reviews, as required by law, between 2001 and 2011.
5. The department had not enforced provisions of its contract with Delta Dental designed to improve outreach and increase utilization of services.

The audit also observed that provider surveys suggest that low provider participation is based in part on the program's low reimbursement rates compared to national averages.

The audit made 24 specific recommendations for improvements to the Denti-Cal program, including but not limited to: 1) establishing assessment criteria for beneficiary utilization and provider participation; 2) developing procedures for identifying areas with low utilization or provider participation; 3) simplifying administrative processes for providers; 4) monitoring beneficiary utilization, access and enrollment; 5) resumption of annual review of reimbursement rates; 6) requiring Delta Dental to provide additional dental services in underserved areas, either in fixed facilities or mobile clinics; and 7) requiring Delta Dental to develop a dental outreach and education program each year.

As of February 2016, the Auditor reported DHCS had fully implemented 15 of the recommendations, 8 recommendations were still pending, and 1 will not be implemented.

Forgiveness of AB 97 Provider Rate Reductions for Dental Services. As part of a budget-balancing General Fund reduction, AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, reduced most Medi-Cal provider rates by up to 10 percent, including for dental services. The rate reductions were enjoined by the courts until December 2012, when the reductions were allowed to be implemented for dates of service on or after June 2011. This period of injunction led to a retroactive recoupment liability for reductions not imposed between 2011 and the time the injunction was lifted. Most providers were

subject to both prospective 10 percent rate reductions and retroactive recoupment for the reduction applied to prior claims.

AB 97 also provided authority to the Director of DHCS to forgive any portion of the AB 97 reductions if there were concerns the reductions would lead to adverse impacts on the ability of Medi-Cal beneficiaries to access necessary medical care. Under this authority, the Director forgave retroactive recoupment amounts in 2014-15 for several classes of providers including dental. The forgiven recoupment amounts were intended to provide support to the state's health care delivery system during the implementation of the federal Affordable Care Act. In the 2015 Budget Act, the Legislature approved elimination of the prospective AB 97 provider rate reductions for dental services for dates of service on or after July 1, 2015.

Annual Dental Reimbursement Rate Review. After the 2014 audit, DHCS resumed its annual review of dental reimbursement rates in Denti-Cal. The most recent report was released in July 2016 for the 2014-15 fiscal year. The report found that in 2013-14 Denti-Cal paid an overall average between 65.5 and 129.2 percent of New York, Illinois, Florida, and Texas' Medicaid Programs' dental fee schedule. For 2014-15 the overall average was between 64.8 and 105.8 percent. The report also found a decrease in providers rendering Denti-Cal services, from 9,527 in calendar year 2008 to 8,001 in calendar year 2015.

Dental Outreach. The audit also recommended the department enforce and enhance its contract with Delta Dental to conduct outreach to Denti-Cal beneficiaries to improve utilization of dental services. One of the primary findings of the audit was that more than 50 percent of children had not visited a dentist in the preceding 12 months.

In its 2016 contract renewal, DHCS implemented several new outreach requirements for Delta Dental. Delta was required to:

- Adhere to DHCS established baseline target rates for utilization for precedent to payment items.
- Implement provider and beneficiary services to provide education in addition to dental services in clinics.
- Target all areas in the state for outreach, focusing on underserved areas/subpopulations.
- Increase utilization by selected adults, such as for systemic disease conditions.
- Maximize beneficiary awareness of the Medi-Cal Dental Program, information about the covered benefits available to them, and the tools at their disposal to schedule appointments and/or receive other assistance.
- Establish four major goals around the Annual Dental Visit, increase of preventive dental services for children, increase of sealants, and annual increases to precedent to payment items.
- Utilize and promote the use of evidence-based and age-appropriate preventive procedures, including fluoride varnish and dental sealants.
- Help families understand the importance of dental benefits and how to access dental services.
- Develop American Dental Association (ADA) compliant education for parents on the need to bring children in for their first dental visit by age one.
- Develop all beneficiary materials in both English and all threshold languages and assure that all written materials are at no higher than a sixth grade reading level.

- Develop material to inform parents/guardians, medical providers, other governmental and non-governmental organizations, and community advocates on key information to promote oral health and the utilization of dental services under the Medi-Cal Dental Program.
- For children, EPSDT Services must include identifying and contacting families of children who are due for a dental screening, examination, preventive visit, and those who have missed such visits, and assist them in scheduling any necessary appointments.

In addition to these new requirements for Delta Dental, the department has conducted its own outreach activities. In particular, the department identified beneficiaries between 0 and 3 years of age that had not had a dental visit in the preceding 12 months. The department mailed each of these beneficiaries' parents or legal guardians information about the importance of early dental visits and encouraged them to take their children to see a dental provider. According to DHCS, after its mailing campaign that began in January 2015, 29 percent of children whose families received a letter subsequently scheduled a dental visit.

1115 Waiver – Medi-Cal 2020 Dental Transformation Initiative. Effective January 2016, the federal Centers for Medicare and Medicaid Services approved California's new 1115 Demonstration Waiver, known as Medi-Cal 2020. Through the Medi-Cal 2020 Waiver, DHCS is implementing four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least 10 percent over a five year period. DHCS will offer financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.
2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under. This domain will initially be implemented on a pilot basis in select counties based on ratios of restorative to preventive services, representative sampling across the state, and likelihood of provider participation.
3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations will receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. Incentive payments will be made annually.
4. Local Dental Pilot Programs (LDPPs) – A maximum of 15 LDPPs will be approved to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three

domains. No more than 25 percent of the annual DTI funding will be allocated to this domain.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the Denti-Cal program and budget.

2. Please describe the department's dental outreach activities, particularly to children, and any resulting improvements in dental utilization.

3. Please describe the findings and any conclusions contained in the department's annual rate review.

4. Please provide a brief overview of the four domains of the Medi-Cal 2020 Waiver's Dental Transformation Initiative.

Issue 10: Elimination of Major Risk Medical Insurance Fund Proposal

Budget Issue and Trailer Bill Language Proposal. DHCS proposes budget actions and trailer bill language to abolish the Major Risk Medical Insurance Fund, transfer its $68.9 million fund balance to a new Health Care Services Plans Fines and Penalties Fund, redirect existing health plan administrative fines and penalties transfers to the new fund, and allow the fund to support expenditures in the Major Risk Medical Insurance Program and to offset General Fund spending in the Medi-Cal program.

Program Funding Request Summary		
Fund Source - Revenues	**2016-17**	**2017-18**
0313 – Major Risk Medical Insurance Fund	$-	($68,866,000)
3133 – Managed Care Admin Fines & Penalties Fund (DMHC)	$-	($6,000,000)
3311 – Health Care Services Plans Fines and Penalties Fund[1]	$-	$74,866,000
Fund Source – State Operations Expenditures	**2016-17**	**2017-18**
0313 – Major Risk Medical Insurance Fund	$-	($1,334,000)
3311 – Health Care Services Plans Fines and Penalties Fund	$-	$1,334,000
Fund Source – Local Assistance Expenditures	**2016-17**	**2017-18**
0001 – General Fund[2]	$-	($62,293,000)
0313 – Major Risk Medical Insurance Fund	$-	($11,237,000)
3311 – Health Care Services Plans Fines and Penalties Fund	$-	$73,530,000
Total Funding Request (Expenditures)	**$-**	**$-**
[1]*Fund 3311: $68,866,000 transfer from Fund 0313 balance and statutory $6,000,000 transfer from Fund 3133*		
[2]*General Fund: $62,293,000 GF expenditures in Medi-Cal offset by expenditures from Fund 3311*		

Background. The Major Risk Medical Insurance Program (MRMIP) was established in 1991 to provide health care coverage to individuals denied private health coverage due to a pre-existing medical condition. Prior to provisions of the federal Affordable Care Act (ACA) prohibiting coverage denials based on pre-existing conditions, MRMIP served as California's high-risk pool insurance program to provide coverage to individuals considered uninsurable. MRMIP coverage contains several limitations that have since been abolished in the private health insurance market, including annual and lifetime benefit caps. Beneficiaries pay premiums, which are subsidized by the state so they are equivalent to the market rate for comparable coverage.

Since 2014, MRMIP caseload has declined significantly as previously uninsurable individuals were able to find affordable coverage in the private market. However, the program still retains approximately 1,300 beneficiaries that have been unable to obtain coverage for a variety of reasons. MRMIP was previously funded by a combination of Proposition 99 tobacco tax revenue and administrative fines and penalties levied on health care service plans by the Department of Managed Health Care (DMHC). Since the decline in caseload, the program is supported exclusively by the fines and penalties revenues.

SB 1379 (Ducheny), Chapter 607, Statutes of 2008, established the Managed Care Administrative Fines and Penalties Fund, administered by DMHC. SB 1379 provided for the transfer of the first $1 million of fines and penalties deposited in the fund to the Office of Statewide Health Planning and Development (OSHPD) to fund the Steven M. Thompson Physician Corps Loan Repayment Program. Any revenue

remaining after the $1 million transfer to OSHPD is transferred to the Major Risk Medical Insurance Fund, now administered by the Department of Health Care Services, to fund MRMIP.

Significant Fund Balance. Since 2014 the Major Risk Medical Insurance Fund no longer receives transfers from Proposition 99 tobacco tax revenues. However, because of the decline in MRMIP caseload and expenditures, the fund has a significant remaining balance and its transfers from health plan administrative fines and penalties largely fund current health care expenditures. In recent budgets, the Legislature has reallocated these funds to the following purposes:

2014-15

1. **Robert F. Kennedy Health Plan - $3.2 million** in one-time funds to the Robert F. Kennedy Health Plan, a self-funded, self-insured plan for farmworkers. The funds were provided for the Plan to purchase stop-loss insurance to allow compliance with ACA requirements regarding annual and lifetime coverage limits.

2. **Electronic Health Records - $3.8 million** of one-time funds to provide the non-federal share for a federal Electronic Health Records (EHR) Meaningful Use grant. The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. Under the program, which provided a 90 percent federal match for eligible expenditures, Medi-Cal providers received incentive payments to assist in purchasing, installing, and using electronic health records in their practices.

2015-16

1. **Robert F. Kennedy Health Plan - $2.5 million** of one-time funds to the Robert F. Kennedy Health Plan for purposes of continuing its purchase of stop-loss insurance.

2. **Lifelong Community Clinic - $2 million** in one-time funds to the Lifelong Community Clinic in Contra Costa County to support extended hours for urgent care services. The clinic supported care for individuals previously served by Doctor's Medical Center, which closed on April 20th of that year due to unsustainable operating losses.

2016-17

1. **Medi-Cal Funding - $2 million** in one-time funds to DHCS to offset General Fund expenditures in the Medi-Cal program. The Administration had proposed trailer bill language to prospectively transfer managed care administrative fines and penalties revenue over $1 million to offset General Fund expenditures in the Medi-Cal program. The Legislature rejected the Administration's trailer bill proposal, but allocated the requested funding on a one-time basis.

Stability of MRMIP Funding. As previously stated, the transfer of health care service plan fines and penalties revenue is the only remaining funding source exclusively allocated for expenditures in MRMIP. The Administration's trailer bill proposal abolishes the Major Risk Medical Insurance Fund, transfers the remaining fund balance and redirects health care service plan fines and penalties revenue to the new Health Care Services Plans Fines and Penalties Fund. The proposal also allows funds to be spent on both MRMIP and to offset General Fund expenditures in the Medi-Cal program. Although the

Administration has indicated MRMIP expenditures would be fully funded prior to any allocation to Medi-Cal, the proposed language is not clear on the priority for expenditures from the new fund.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open to allow continued discussion with the Administration to clarify whether expenditures in MRMIP would be fully funded prior to any allocation to the Medi-Cal program. The Administration has indicated this priority of expenditures is consistent with the intent of its trailer bill proposal and its budgetary allocations.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Will the funding deposited in the new Health Care Services Plans Fines and Penalties Fund be allocated to fund MRMIP prior to allocation to any Medi-Cal expenditures?