SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mike Morrell

May 21, 2014

10 a.m.
Room 4203, State Capitol

Agenda – Part A
(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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VOTE ONLY

4260 Department of Health Care Services

1. Medi-Cal Estimate Update – Technical Adjustments (DOF ISSUE 101)

May 2014 Medi-Cal Estimate. It is requested that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

1. Item 4260-101-0001 be decreased by $98,125,000 and reimbursements be increased by $1,421,174,000
2. Item 4260-101-0232 be increased by $1,702,000
3. Item 4260-101-0236 be decreased by $1,702,000
4. Item 4260-101-0890 be increased by $5,833,052,000
5. Item 4260-101-3168 be increased by $9,617,000
6. Item 4260-102-0001 be increased by $18,251,000
7. Item 4260-102-0890 be increased by $18,251,000
8. Item 4260-106-0890 be increased by $1,669,000
9. Item 4260-113-0001 be increased by $235,150,000
10. Item 4260-113-0890 be increased by $453,253,000
11. Item 4260-113-3055 be decreased by $294,000
12. Item 4260-117-0001 be increased by $1,491,000
13. Item 4260-117-0890 be increased by $343,000

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

2. Fingerprinting and Criminal Background Checks

Budget Issue. DHCS seeks statutory authority to receive the results of criminal background checks of applicants and providers from the Department of Justice (DOJ) in order to screen or enroll the Medi-Cal provider applicants and providers.

Trailer bill language is also requested to clarify that applicant/providers will be responsible for reimbursing DOJ the costs to complete the expanded background checks and fingerprinting. The added language provides DOJ with clear legal authority to charge the providers for the fingerprinting and background checks.

This issue was heard in Subcommittee No. 3 on March 20th. Since then, the Administration has worked with the Department of Social Services to clarify in the trailer bill language that IHSS providers will

follow the current fingerprinting and criminal background check process required in Welfare and Institutions Code Section 15660.

Additionally, DHCS anticipates receiving final guidance for Medicaid providers within the next few months. DHCS will implement this requirement within 60 days of the issuance of the final guidance from CMS.

Subcommittee Staff Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to implement this proposal.

3. Pregnancy Only Proposal

Budget Issue. DHCS' pregnancy only proposal has two main components:

1. **Provide Full-Scope Medi-Cal for Pregnant Women Below 109 percent FPL.** DHCS proposes to provide full-scope coverage—rather than pregnancy-only coverage—to all pregnant women below 109 percent of the federal poverty level (FPL) who receive coverage from Medi-Cal (who are not otherwise eligible for full-scope coverage). DHCS estimates no additional costs associated with providing full-scope coverage instead of pregnancy-only coverage, based on the assumption that there are no significant differences in coverage.

2. **Provide Medi-Cal Cost-Sharing and Benefit Wrap for Pregnant Women between 109 percent and 208 percent FPL.** DHCS also proposes to shift pregnant women between 109 percent and 208 percent of FPL who qualify for Medi-Cal pregnancy-only coverage to plans offered through Covered California. The budget assumes General Fund savings of $17 million in 2014-15 related to this component of the proposal since the federal government (through Covered California) would pick up the costs of comprehensive health coverage for these women. DHCS would implement this provision beginning January 1, 2015 and estimates that 8,100 Medi-Cal enrollees currently receiving pregnancy-only coverage would shift into Covered California.

LAO Comments and Recommendations. The LAO finds that the Governor's proposal would (1) likely reduce General Fund spending, while potentially providing more generous benefits, (2) full-scope coverage would eliminate coverage inconsistencies for pregnant women, and (3) certain details of the proposal remain unclear, such as the differences in covered services and costs between full-scope and pregnancy-only coverage. The LAO recommends the Administration clarify (1) the differences in covered services between full-scope Medi-Cal and pregnancy-only Medi-Cal and (2) continuity of coverage and plan choice for individuals moving between Medi-Cal and Covered California.

This issue was discussed at the March 20th Subcommittee No. 3 hearing.

Subcommittee Staff Recommendation and Comment—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to implement this proposal. It is important to ensure that pregnant women are eligible for full-scope comprehensive health coverage.

4. Statewide Outpatient Medi-Cal Contract Drug List

Budget Issue. DHCS requests trailer bill language to:

1. **Statewide Formulary.** Establish a core statewide outpatient Medi-Cal contract drug list (CDL) formulary for all Medi-Cal beneficiaries, including the Family Planning, Access, Care and Treatment Program (FPACT). Any of the drugs on this statewide formulary would be available without a treatment authorization request. Managed care plans would be required to use this core formulary, as a minimum, and could add additional drugs at their discretion.

2. **Additional State Supplemental Drug Rebates.** Negotiate supplemental drug rebate contracts with manufacturers for all Medi-Cal programs, including managed care plans and FPACT. The budget estimates General Fund savings of $32.5 million in 2014-15 and annual General Fund savings of at least $65 million as a result of these supplemental drug rebates.

This issue was discussed at the March 20th Subcommittee No. 3 hearing.

LAO Findings and Recommendation. The LAO recently released its findings and recommendation regarding this proposal. The LAO finds that this proposal achieves short term savings, although the amount is uncertain, but that the Administration is downplaying the upward pressure of future managed care capitation rates which could lead to long-term net costs to the state. Additionally, the LAO finds that this proposal departs from a basic principle of managed care—that if plans are given financial risk for a benefit, they should also be given meaningful control over costs and utilization for that benefit. Consequently, the LAO recommends that the Legislature reject the Governor's proposal.

Subcommittee Staff Comment and Recommendation—Reject. Staff concurs with the LAO recommendation. It is recommended to reject this proposal. The Administration has not demonstrated that these savings would materialize and has not provided justification for limiting a managed care plan's ability to coordinate and manage the care and pharmacy benefit of its enrollees.

5. Monitoring Medi-Cal Dental Services Utilization

Oversight Issue. Over the last few years, concerns have been raised regarding access to and utilization of Medi-Cal dental services. As discussed in the prior agenda item, the state currently does not have tools to monitor Medi-Cal Denti-Cal fee-for-service (FFS) access or utilization in 56 counties. While there is the ability to monitor Medi-Cal dental services provided through dental managed care in Sacramento and Los Angeles counties, these monitoring reports indicate that plans have experienced difficulty in meeting performance benchmarks.

This issue was discussed at the April 24th Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill to establish a metrics to monitor utilization and access in the Denti-Cal program.

4265 Department of Public Health

1. Nutrition Education and Obesity Prevention Branch – Contract Conversion

Budget Issue. DPH's Nutrition Education and Obesity Prevention Branch (NEOPB) requests authority to convert 70 personal service contract positions to 45 state positions. These positions are federally funded by the United States Department of Agriculture's (USDA) Supplemental Nutrition Assistance Program for Education (SNAP-Ed) through a reimbursement contract with the California Department of Social Services (CDSS). This personal services contract expires on September 30, 2014.

This issue was heard at the March 20th Subcommittee No. 3 hearing. Since this hearing, the Administration has worked with stakeholders to develop an alternative to the January proposal. This alternative would:

- Create 45 new DPH positions and 13 new research positions, which will be contracted through an interagency agreement with the University of California, Berkeley. This is not change from the January proposal.

- DPH would propose a non-competitive bid (NCB) contract with the Public Health Institute (PHI), the current contractor, for a 12 month period. This one-time NCB contract will be for an amount ranging from $5.5M - $6.5M for services that include knowledge transfer, technical assistance to state staff, and other services that will enable a smooth transition to DPH state staff for SNAP-ED functions currently performed by PHI. This NCB will meet USDA's needs to ensure program continuity and efficacy, provide sufficient time for CDPH to transition to functions previously performed by PHI. This NCB would be funded with the savings ($12.7 million) identified as part of the contract conversion that would have been allocated to local health departments as proposed in the January budget proposal.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to modify the Governor's January budget request to convert the SNAP-Ed contract to state positions by adopting the alternative described above with conforming changes to the state operations and local assistance amounts. This alternative provides for a smoother transition of this contract and helps ensure program continuity.

2. Genetic Disease Screening Program

Budget Issue. DPH proposes total expenditures of $116.9 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP). This reflects a net increase of $8 million (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported. See table below for funding summary.

Table: Genetic Disease Screening Program Funding Summary

	2013-14	2014-15	BY to CY
	Projected	**Proposed**	**Change**
State Operations	$25,157,000	$28,258,000	$3,101,000
Local Assistance	$83,704,000	$88,654,000	$4,950,000
Total	$108,861,000	$116,912,000	$8,051,000

Included in the GDSP budget estimate are the following proposals:

- **Prenatal Screening Program Fee Increase.** DPH proposes to increase the fee in the Prenatal Screening Program by $45 to bring the total fee to $207, effective July 1, 2014. This fee covers a blood test for participating women and follow-up services offered to women with positive screening results. Although participation in the Prenatal Screening Program is voluntary, providers are required to offer screening to all women in California.

  DPH states that the fee increase is necessary to correct for the historic overstatement of caseload and the resulting inadequate fee revenue in recent years to cover costs. Historically, the Prenatal Screening Program has assumed a caseload of approximately 80 percent of the state's births; however, the caseload has been closer to 73 percent of the annual birth rate. DPH states that this fee increase will stabilize the fund over the next three years.

- **Consolidate Regional Screening Laboratories.** DPH proposes to consolidate the number of regional contract screening laboratories from seven laboratories down to five in order to achieve savings through economies of scale. Contract laboratories perform newborn screening and prenatal screening using state-supplied equipment, reagents, methods, and protocols; the labs provide qualified personnel to do the work for DPH. The savings would be realized primarily through a reduction of testing equipment and the related maintenance, operation, and repair expenses. The estimated one-time upfront moving costs in 2014-15 could range from $200,000 to $800,000, depending on the outcome of the competitive bidding process and how many existing Newborn and Prenatal Screening Labs are successful bidders for the newly consolidated regions. DPH anticipates savings of approximately $1.7 million dollars per year, which would occur no sooner than 2015-16.

- **Refine Algorithm for Detecting Positive Case.** DPH is investigating reducing the false positive rate for certain disorders. This would result in a decrease in reference laboratory services, follow-up diagnostic services, and case management and coordination services.

Subcommittee Staff Comment and Recommendation—Approve.

4120 Emergency Medical Services Authority (EMSA)

1. Statewide Emergency Medical Response Capacity

Oversight Issue. For several years, the Legislature has grappled with the impacts and consequences of diminishing resources at both EMSA and the Department of Public Health, with regard to the state's emergency medical preparedness capacity.

Subcommittee Staff Recommendation—Adopt Supplemental Reporting Language. It is recommended to adopt supplemental reporting language for EMSA that describes in detail the available state and local resources available in a medical disaster, a comparison of how the state's resources compare to other states and countries of similar size, and recommendations on California's unmet needs in this area. This action conforms to actions taken in the Assembly Subcommittee No. 1.

ISSUES FOR DISCUSSION

4260 Department of Health Care Services

1. Medi-Cal Caseload Update (DOF ISSUE 103,104, 105)

Budget Issue. The May Revision projects total expenditures in 2014-15 for Medi-Cal to be $90.6 billion ($17.4 billion General Fund) which is an increase of $17 billion ($502 million General Fund) as compared to the Governor's January budget. See tables below for details.

As of April 30, 2014, there are 10.6 million individuals enrolled in Medi-Cal and of these 566,000 are related to the mandatory Medi-Cal expansion.

Key adjustments to the Governor's January budget included in the May Revision are:

- An increase of $510 million General Fund related to the Medi-Cal mandatory expansion under the federal Affordable Care Act (ACA). This increase assumes a 60 percent increase in this caseload and an increase in the per enrollee cost for some of these individuals.
- A decrease of $17.7 million General Fund as a result of the conversion to Modified Adjusted Gross Income (MAGI) eligibility rules and changes in federal claiming.
- An increase of $187.2 million General Fund related to increases in managed care rates.

Table: January to May Revision Current Year Comparison

	January Budget	**May Revision**	
	2013-14	**2013-14**	**Difference**
Benefits	$65,641,000,000	$58,665,000,000	-$6,976,000,000
County Administration (Eligibility)	$3,622,500,000	$3,282,300,000	-$340,200,000
Fiscal Intermediaries (Claims Processing)	$414,300,000	$424,700,000	$10,400,000
Total	**$69,677,800,000**	**$62,372,100,000**	-$7,305,700,000
General Fund	$16,229,900,000	$16,646,800,000	$416,900,000
Federal Funds	$43,631,300,000	$39,521,400,000	-$4,109,900,000
Other Funds	$9,816,700,000	$6,203,800,000	-$3,612,900,000

Table: January to May Revision Budget Year Comparison

	January Budget	May Revision	
	2014-15	2014-15	Difference
Benefits	$69,725,300,000	$86,366,800,000	$16,641,500,000
County Administration (Eligibility)	$3,361,900,000	$3,724,400,000	$362,500,000
Fiscal Intermediaries (Claims Processing)	$419,300,000	$492,900,000	$73,600,000
Total	**$73,506,400,000**	**$90,584,100,000**	$17,077,700,000
General Fund	$16,899,500,000	$17,401,800,000	$502,300,000
Federal Funds	$45,752,500,000	$58,745,000,000	$12,992,500,000
Other Funds	$10,854,500,000	$14,437,300,000	$3,582,800,000

Table: Current Year and Budget Year Comparisons of ACA Related Medi-Cal Expansions

	2013-14			2014-15		
	January	May	Diff.	January	May	Diff.
Medi-Cal Caseload	9,170,500	9,358,200	2%	10,106,200	11,500,500	14%
Medi-Cal ACA Mandatory Expansion						
Average Monthly Caseload	130,046	157,789	21%	508,540	815,358	60%
General Fund	$103,754,350	$193,414,050	86%	$419,214,950	$929,905,350	122%
Medi-Cal ACA Optional Expansion						
Average Monthly Caseload	326,592	462,678	42%	769,069	1,627,276	112%

Administration's Methodology to Determine Mandatory Expansion Caseload. The Administration indicates that it based its caseload projections on enrollment data through mid-April, general caseload growth of one percent, and certain assumptions about the estimated 996,000 pending Medi-Cal applications. Some of the assumptions regarding these pending applications include:

- 15 percent would be denied coverage
- 4.4 percent overlap with the Express Lane population
- 22.84 percent would be considered part of the mandatory expansion (based upon CalHEERS non-pending aid codes)

With these assumptions, the Administration estimates that of the 996,000 pending Medi-Cal applications, 265,000 would be eligible under the mandatory expansion and 478,000 would be eligible under the optional expansion.

Additionally, the Administration finds that only 31 percent in the current year and 62 percent in the budget year of new Medi-Cal enrollees would enroll in managed care.

Administration's Methodology to Determine Mandatory Expansion Costs. The Administration revised its methodology to determine the per enrollee cost for the mandatory population. In the May Revision the Administration assumes a new, significantly higher per member per month (PMPM) cost for a large portion of individuals who are assumed to enroll in fee-for-service (FFS), it used a $202.95 PMPM for children and $369.41 PMPM for adults, compared to the weighted average $139 PMPM under managed care. The Administration contends that the reason for this new assumption is that given the overwhelming response in enrollment into Medi-Cal, it is taking longer for individuals to choose and sign up for health plans. Consequently, a PMPM based on FFS utilization is assumed. In some cases, these PMPM costs are close to three times the PMPM cost in managed care and the PMPM costs for a health population in FFS.

Table: Administration's Mandatory Expansion Per Member Per Month Costs

	2013-14	2014-15
Managed Care Adult	$139	$145.95
Managed Care Child	$97.10	$101.95
Fee-For-Service Adult	$369.41	$387.88
Fee-For-Service Child	$202.95	$213.10

LAO Finding—Administration's Mandatory Expansion Caseload Estimates Plausible. The LAO finds that the assumptions used to estimate caseload are plausible. However, since the type and scope of changes made by the ACA are largely unprecedented and the major provisions of the ACA have only been in effect for a few months, the estimates of additional enrollment associated with the mandatory expansion are subject to considerable uncertainty.

LAO Finding—Administration's Mandatory Expansion Costs Too High. The LAO finds that key assumptions about per enrollee costs appear too high. The LAO finds that it is unclear why the average costs in FFS for these new enrollees would be significantly higher—nearly three times higher in some cases—than average costs for non-disabled adults and children enrolled in managed care plans. In the LAO's view, the Administration's estimated PMPM costs for individuals in FFS are likely too high and the average PMPM for existing managed care enrollees is a more reasonable estimate of PMPM costs.

According to the LAO, when evaluating the Administration's PMPM assumptions for the mandatory expansion population, there are a couple of important factors to keep in mind. First, the mandatory expansion population is defined as individuals who, absent changes made by the ACA, would be eligible for Medi-Cal but not enrolled. In the LAO's view, it is reasonable to assume that—compared to the non-disabled parents and children that are already enrolled in the Medi-Cal—the mandatory expansion population is likely healthy and, on average, less costly. If these individuals had significant and costly health care needs, they likely would have enrolled in the program.

In addition, the LAO has concerns about using FFS costs for similar populations enrolled in FFS as a proxy for PMPM costs for mandatory expansion enrollees. The historical average FFS costs may include a disproportionately high number of costly services that likely would not apply to mandatory expansion enrollees. For example, non-disabled parents or children sometimes enroll in the program after visiting an emergency room and/or having an unexpected hospital stay--these costs are part of average FFS costs. In contrast, relatively few mandatory expansion enrollees will have FFS emergency room or hospital costs because, by definition, they are individuals who are enrolling in the program in response to factors such as enhanced outreach and streamlined enrollment process. Therefore, we would expect average mandatory expansion costs to be lower than existing average FFS costs.

LAO Recommendation—Adjust Medi-Cal Budget to Reflect Lower Costs. The LAO recommends the Legislature reduce the Medi-Cal budget to reflect lower PMPM cost assumptions for mandatory expansion enrollees. The LAO recommends the Legislature apply average PMPM costs for non-disabled parents and children that are currently enrolled in managed care—$139 for most enrollees and $97 for certain children in 2013-14—to the entire estimated mandatory expansion population. In our view, these PMPM cost assumptions are a more reasonable estimate of average PMPM costs for the mandatory expansion population than the much higher average PMPM assumptions—up to $369 dollars in some cases—used by the Administration. This would reduce the estimated Medi-Cal General Fund spending by about $64 million in 2013-14 and $230 million in 2014-15. The LAO indicates that it is working with the Administration on refining these adjustments.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this issue. Compared to the January budget, the Administration estimates that there would be a 60 percent increase in the number of individuals enrolling under the mandatory expansion and that this would result in a 122 percent increase in General Fund costs related to this population. While it appears that the caseload estimate is reasonable, the Administration has not yet provided justification for why the costs for this population has increased so significantly. The Administration does not yet have actual claims data to support using a PMPM that is close to three times the PMPM for the non-disabled adult population. Individuals enrolling under the mandatory expansion would likely be healthy and would be a less expensive population.

Although the LAO finds the assumptions regarding the potential number of duplicative pending applications reasonable, it is also possible that the number could be higher. DHCS has found between 12 percent and 19 percent depending on the entry portal. It is possible that of those that have not been verified, the duplication percent may be at the higher-end as applicants who were not receiving a response towards the end of open enrollment may have been more likely to submit duplicate applications.

Questions.

1. Please provide an overview of the adjustments to the Medi-Cal caseload and budget.

2. Please explain why the Administration finds that only 31 percent in the current year and 62 percent in the budget year of new Medi-Cal enrollees would enroll in managed care?

3. Please explain the Administration's assumptions in using the FFS PMPM for the mandatory expansion population.

2. Eliminate Major Risk Medical Insurance Program (MRMIP) (DOF ISSUE 173)

Budget Issue. The May Revise proposes to eliminate MRMIP, effective January 1, 2015, and reduce $20.846 million local assistance funding from the Major Risk Medical Insurance Fund (MRMIF) in 2014-15. The reduction provides funds to cover MRMIP expenditures from July 1, 2014 to December 31, 2014. This proposal would also amend the annual appropriation of Proposition 99 funds to the MRMIF. In addition, this proposal would require the development of a transition plan that would be submitted to the appropriate policy and fiscal legislative committees by September 1, 2014, detailing processes to be employed regarding the closure of the program.

The 2014-15 Governor's January Budget proposed the transfer of the Major Risk Medical Insurance Program (MRMIP) and associated funding to the Department of Health Care Services (DHCS) effective July 1, 2014.

Table: MRMIP Budget Summary (in thousands)

	2013-14		2014-15	
	January Budget	**May Revision**	**January Budget**	**May Revision**
State Operations	$1,272	$1,272	$1,304	$1,304
Local Assistance	$41,691	$41,691	$41,691	$20,846
Total	$42,963	$42,963	$42,995	$22,150
Ending MRMIP Fund Reserve	$36,803	$36,803	$25,587	$35,010

Background. MRMIP was established by AB 60, Chapter 1168, Statutes of 1989. MRMIP is a program developed to provide health insurance for Californians unable to obtain coverage in the individual insurance market. MRMIP services are delivered through contracts with health insurance plans, and program subscribers participate in the payment for the cost of their coverage by paying monthly premiums equal to 100 percent of the average market cost of premiums, an annual deductible, and copayments.

MRMIP has an annual benefit cap of $75,000 and a lifetime benefit cap of $750,000. MRMIP supplements subscriber contributions to cover the cost of care that is funded annually by tobacco tax funds. To be eligible for MRMIP, California residency is a requirement, Medicare and/or COBRA coverage cannot be available except in specific circumstances, and proof that coverage was denied by a private insurer in the previous 12 months must be provided. Since MRMIP is a state-only funded program, proof of citizenship is not a requirement for enrollment.

There are approximately 60 MRMIP subscribers with End Stage Renal Disease (ESRD) under age 65 who are covered by Medicare (because of their ESRD diagnosis) but who cannot get the Medicare supplemental coverage that most Medicare subscribers need. This Medicare coverage disqualifies them from obtaining coverage through Covered California because of federal "anti-duplication" requirements

and state law currently allows the Medicare supplement market to exclude them. MRMIP in effect serves as the Medicare supplement for these individuals.

The Affordable Care Act (ACA) includes a prohibition against the denial of coverage for pre-existing health conditions and a prohibition of charging individuals with pre-existing conditions a higher premium due to their condition. Therefore, the need for a high risk pool and subsidized premium for individuals with a pre-existing condition has diminished considerably. This is evident by the fact that since the ACA open enrollment began in October 2013 the monthly caseload for MRMIP has declined by 54 percent. The MRMIP enrollment on October 1, 2013 was approximately 6,500 and now the current enrollment as of April 1, 2014 is approximately 2,972 subscribers. Most individuals with pre-existing conditions can now seek comprehensive coverage through Covered California or the individual market and cannot be denied coverage or be charged above market rates due to their condition.

Administration's Proposal Has Major Policy Concerns. Currently, individuals with ESRD are covered by Medicare and can also subscribe to MRMIP for supplemental coverage (a person with ESRD can have monthly medical costs of $4,000 to $6,000). As part of the proposal to eliminate MRMIP, the Administration proposes to require Medicare Supplement Plans to offer coverage to individuals with ESRD. According to one Medicare Supplement Plan, this could lead to current rates being increased by four to five times, which would likely lead to financial hardship for these current Medicare Supplement Plan enrollees.

Additionally, it is not clear why MRMIP could not be maintained as a form of supplemental insurance for ESRD individuals who are enrolled in Medicare, as Medicare would be considered minimal essential coverage, per the federal Affordable Care Act.

MRMIP is Over-Budgeted. In addition to the policy concerns stated above, the Administration's estimates for funding necessary for the current year and budget year for MRMIP are overstated. For example:

- **Current Year Does Not Account for Decreased Enrollment.** In the current year, MRMIP is budgeted for full caseload of 7,500 enrollees per month. However, as shown in the table below, enrollment in MRMIP has substantially decreased since January.

Table: July 2013-June 2014 MRMIP Enrollment

Month	Caseload
July	6,463
August	6,536
September	6,570
October	6,492
November	6,321
December	5,678
January	4,782
February	3,591
March	3,242

April	2,972
May	2,972
June	2,972

Using these enrollment figures would reduce MRMIP expenditures by approximately $14.8 million compared to the Governor's budget.

- **Budget Year Does Not Account for Decreased Enrollment.** The May Revision proposes to transfer $20 million in Proposition 99 funds to MRMIP to cover the MRMIP costs from July through December. However, if the MRMIP caseload stays at approximately 3,000 individuals per month, the cost of the program would only be $16.5 million.

- **Major Risk Medical Insurance Fund (MRMIF) Has Substantial Reserve.** Under the Governor's proposal, the MRMIF will have a reserve of $36.8 million at the end of 2013-14 and $35 million at the end of 2014-15. While sufficient funds need to be available to close out prior year MRMIP reconciliations, it is highly unlikely that a full year's appropriation would be needed to reconcile claims. The Administration has not been able to provide an estimate of the funds necessary to complete the reconciliation process.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject the Administration's proposal to eliminate MRMIP. The MRMIP program should be maintained as a program where Medicare-ESRD individuals can purchase supplemental coverage. The MRMIP program should also be maintained as an option for non-ESRD individuals who are in MRMIP today, in order to determine the nature of this population and other options for coverage. Consequently, it is recommended to adopt placeholder trailer bill language to:

- Require DHCS to convene a stakeholder workgroup composed of stakeholders, including health care providers, county representatives, labor, consumer advocates, immigrant policy advocates, and employers of low-wage workers to develop a plan to utilize available Major Risk Medical Insurance Funds including Managed Care Administrative Fines Penalties Funds transferred pursuant to Health and Safety Code 1341.45(c)(1)(B) to continue to provide health coverage to individuals that are not eligible for other full-scope programs or subsidies.

Questions.

1. Please provide an overview of the Administration's proposal.

2. Please explain why MRMIP can no longer be an option for Medicare enrollees with ESRD.

3. Robert F. Kennedy Medical Plan

Issue. The federal Affordable Care Act (ACA) introduces new standards for employer-sponsored health plans. The implementation dates for these requirements vary based on the plan's effective date, whether the plan is subject to a collective bargaining agreement (CBA), and whether the plan is self-insured or fully insured. Some plans may be "grandfathered". These plans are exempt from some provisions, while other requirements apply on the same date as they apply to other plans. The ACA allowed fully insured plans that are pursuant to a CBA to have certain elements of their plan be "grandfathered." ACA allows multiemployer plans with CBAs to maintain "grandfathered" status with the exception of lifetime and annual limits.

One such plan is the Robert F Kennedy (RFK) Medical Plan, a self-funded, self-insured plan that is subject to a CBA between the United Farmworker's Union (UFW) and multiple agricultural employers (also known as a Taft-Hartley Plan). According to the plan and the UFW, it provides coverage to approximately 10,710 lives. Of those 5,083 are adults and 5,627 are children. The employee and all dependents are automatically covered. The employer's contribution is between $2 and $3 per hour depending on the CBA. According to the plan and the UFW, the plan provides benefits that are equivalent or richer than is required under the ACA in almost every requirement. For instance, the occupational therapy is more generous than is required and all primary and preventive care is provided with very low co-pays and deductibles. According to the plan, about 96 percent of the RFK Plan's budget goes directly to providing benefits to its beneficiaries and their dependents, meeting and exceeding the medical loss ratio requirements.

There is one requirement however, that has proven to be a significant hurdle to the continued existence of the plan, the prohibition on annual and lifetime limits. The plan has a waiver until September 1, 2014 that exempts the plan from the annual limits and currently has an annual cap around $70,000. RFK estimates that the cost of a replacement plan that would be ACA compliant by removing annual limits would result in a 35 to 80 percent increase in costs. The plan has determined that it can purchase stop loss insurance for the cost of $3.2 million to cover any costs that would exceed the current maximum and would then be in compliance with the ACA and is therefore requesting this amount.

The plan argues that there will be off-setting savings in the Medi-Cal program. This is based on an assumption that it will not be financially viable and will therefore not continue without this subsidy. In that case, the plan's consultants assume 50 percent of the plans members would be eligible for Medi-Cal. The cost of Medi-Cal to the state of California for these participants would be at least $4.7 million.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to provide $3.2 million in one-time Proposition 99 funds, which are available due to the over-budgeted MRMIP program (discussed in the item above), to DHCS to be contracted out to the RFK plan for purposes of purchasing stop loss insurance.

Questions.

1. Please provide an overview of this item.

4. Coordinated Care Initiative (CCI) – Medicare D-SNP Proposal (DOF Issue 106)

Budget Issue. In the May Revise, the Administration updates the savings related to the CCI (see following table) and proposes trailer bill language to implement its policy regarding Medicare Advantage/D-SNP plans and the Coordinated Care Initiative. Specifically, DHCS proposes:

1. In non-CCI counties, DHCS will offer Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) contracts to DSNPs for the duration of the CMC demonstration under same terms and conditions as authorized in 2014.

2. In CCI counties, DHCS will offer MIPPA contracts to DSNPs that are not also CMC plans in a CCI county for the duration of the CMC demonstration subject to the following:
    a. Such MIPPA contracts will contain the same terms and conditions as authorized in 2014; and
    b. Eligible populations will be beneficiaries excluded from CMC and/or CMC-eligible beneficiaries enrolled as of December 31, 2014.

3. In CCI counties, DHCS will offer MIPPA contracts to DSNPs for the duration of the CMC demonstration that are also CMC plans only for beneficiaries excluded from CMC.

4. As for passive enrollment into CMC, DHCS will:
    a. Passively enroll DSNP enrollees into CMC when DSNP is also a CMC Plan, as authorized under current law; and
    b. Not passively enroll any other MA enrollees into CMC if they are in a non-CMC DSNP or any other MA plan.

In addition, the proposed language contains provisions unique to Kaiser and SCAN, as follows:

- Kaiser - Exempts Kaiser enrollees from passive enrollment into CMC. The language allows Kaiser to continue to enroll new CMC-eligible members after December 31, 2014 based on a prior affiliation with the plan.
- SCAN - Authorizes DHCS to enter into a contract extension with SCAN, and specifies that individuals already enrolled in the SCAN plan will not be passively enrolled into CMC. Allows SCAN to continue to enroll new CMC-eligible members in 2015.

Background. The Centers for Medicare & Medicaid Services (CMS) requires that Dual-Eligible Special Needs Plans (D-SNPs) enter into MIPPA compliant contracts with state Medicaid agencies. Under current law, DHCS was only authorized to enter into such MIPPA contracts for calendar year 2014. Also, Cal MediConnect (CMC)-eligible enrollees in Medicare Advantage (MA) products, including D-SNPs, will be passively enrolled into CMC, effective January 2015.

Within the eight CMC counties, approximately 168,000 individuals are currently enrolled in comprehensive, integrated Medicare managed care plans, for which the state's contracts expire on December 31, 2014.

Coordinated Care Initiative 2014 May Revision Estimate Cost-Savings Analysis				
	2013-14		2014-15	
(In thousands)	TF	GF	TF	GF
SAVINGS				
Local Assistance Costs (Savings)	**$ 62,284**	**$ 11,906**	**$ 3,362,405**	**$ 475,077**
Payments to Managed Care Plans	$ 98,877	$ 49,439	$ 6,901,009	$ 3,450,504
Transfer of IHSS Costs to DHCS	$ -	$ (19,237)	$ -	$ (1,206,125)
Savings from Reduced FFS Utilization	$ (36,593)	$ (18,296)	$ (3,538,604)	$ (1,769,302)
Payment Deferrals	**$ (36,974)**	**$ (18,487)**	**$ (883,411)**	**$ (441,706)**
Defer Managed Care Payment	$ (39,437)	$ (19,718)	$ (963,695)	$ (481,848)
Delay 1 Checkwrite	$ 2,463	$ 1,231	$ 80,284	$ 40,142
Revenue	**$ (123,247)**	**$ (123,247)**	**$ (425,052)**	**$ (425,052)**
Increased MCO Tax from CCI (All Revenue)	$ -	$ -	$ (103,844)	$ (103,844)
Increased MCO Tax from non-CCI (Incremental increase from 2.35 to 3.93 percent)	$ (123,247)	$ (123,247)	$ (321,208)	$ (321,208)
Savings Sub-Total	**$ (97,937)**	**$ (129,828)**	**$ 2,053,942**	**$ (391,681)**
COSTS				
Increased DHCS Costs				
Administrative Costs	$ 9,217	$ 2,759	$ 8,086	$ 2,551
Fiscal Intermediary Costs	$ 10,207	$ 5,103	$ 37,507	$ 18,753
Increased DSS Costs				
Service Costs (increased GF due to MOE)	$ 100,212	$ 100,212	$ 118,370	$ 118,370
DSS Administrative Costs From CCI	$ 2,340	$ 1,172	$ 7,072	$ 3,542
CalHR Administrative Costs	$ 563	$ 282	$ 1,411	$ 706
	.			
DMHC Administrative Costs	$ 2,218	$ -	$ 2,186	$ -
CDA Administrative Costs	$ 627	$ -	$ 768	$ -
Costs Sub-Total	**$ 125,384**	**$ 109,528**	**$ 175,400**	**$ 143,922**
Net Impact to CA - Costs	**$ 27,447**	**$ (20,300)**	**$ 2,229,342**	**$ (247,759)**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to approve the revised CCI estimates and adopt placeholder trailer bill language to allow current D-SNP enrollees to keep their D-SNP unless it is also a CMC plan. DHCS has significantly changed course compared to its January proposal to no longer enter into contracts with D-SNPs in CCI counties. This revised approach addresses the need to balance beneficiary choice and continuity of care with the interest of promoting enrollment into CMC.

Questions.

1. Please provide an overview of proposed trailer bill language.

2. Please explain the exceptions for Kaiser and SCAN and the justification for these exceptions.

5. AB 85 – Updated County Savings Related to Health Care Reform

Budget Issue. Under the ACA, county costs for indigent health care are expected to decrease as more individuals gain access to coverage. Current law redirects these county savings to CalWORKs, providing a corresponding General Fund offset. The May Revision continues to assume a redirection of $300 million in county savings in the current year but decreases the 2014-15 redirection estimate of $900 million to $724.9 million. Compared to the Governor's budget, this revised redirection results in increased CalWORKs General Fund costs of $175.1 million. See table below for the revised budget year estimates by county.

Table: Summary of AB 85 Redirected County Savings

Article 13 Counties	Formula or 60/40		2014-15 Redirection Amount
Placer	60/40	$	3,217,487
Sacramento	60/40	$	31,528,114
Santa Barbara	60/40	$	8,032,309
Stanislaus	60/40	$	10,786,847
Yolo	60/40	$	3,479,489
Fresno	Formula	$	9,839,629
Merced	Formula	$	2,117,668
Orange	Formula	$	41,136,441
San Diego	Formula	$	44,573,489
San Luis Obispo	Formula	$	2,844,523
Santa Cruz	Formula	$	3,697,680
Tulare	Formula	$	6,885,537
Subtotal		**$**	**168,139,213**
Public Hospital Counties			
Alameda	Formula	$	44,592,649
Contra Costa	Formula	$	15,927,158
Kern	Formula	$	3,038,259
Los Angeles	Formula	$	238,230,704
Monterey	Formula	$	2,486,294
Riverside	Formula	$	4,872,321
San Bernardino	Formula	$	3,062,992
San Francisco	Formula	$	3,896,974
San Joaquin	Formula	$	3,316,785
San Mateo	Formula	$	-
Santa Clara	Formula	$	-
Ventura	Formula	$	14,900,010
Subtotal		**$**	**334,324,148**

CMSP Counties			
Alpine	60/40	$	13,150
Amador	60/40	$	620,264
Butte	60/40	$	5,950,593
Calaveras	60/40	$	913,959
Colusa	60/40	$	799,988
Del Norte	60/40	$	781,358
El Dorado	60/40	$	3,535,288
Glenn	60/40	$	787,933
Humboldt	60/40	$	6,883,182
Imperial	60/40	$	6,394,422
Inyo	60/40	$	1,100,257
Kings	60/40	$	2,832,833
Lake	60/40	$	1,022,963
Lassen	60/40	$	687,113
Madera	60/40	$	2,882,147
Marin	60/40	$	7,725,909
Mariposa	60/40	$	435,062
Mendocino	60/40	$	1,654,999
Modoc	60/40	$	469,034
Mono	60/40	$	369,309
Napa	60/40	$	3,062,967
Nevada	60/40	$	1,860,793
Plumas	60/40	$	905,192
San Benito	60/40	$	1,086,011
Shasta	60/40	$	5,361,013
Sierra	60/40	$	135,888
Siskiyou	60/40	$	1,372,034
Solano	60/40	$	6,871,127
Sonoma	60/40	$	13,183,359
Sutter	60/40	$	2,996,118
Tehama	60/40	$	1,912,299
Trinity	60/40	$	611,497
Tuolumne	60/40	$	1,455,320
Yuba	60/40	$	2,395,580
CMSP Board	60/40	$	133,361,875
Subtotal		**$**	**222,430,836**
Total 2014-15 Redirection Amount		**$**	**724,894,197**

Background. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, establishes a county fiscal true-up mechanism to share in potential savings resulting from the shifting of individuals previously covered through county indigent health programs to the Medi-Cal program under the expansion. Specifically, AB 85:

- Establishes a formula for the County Medical Services Program counties (the 34 counties that participated in this program in 2011-12) and two options for all other counties to decide how their contribution would be met. These two options are (1) a formula that measures actual county health care costs and revenues and (2) 60 percent of a county's health realignment allocation plus maintenance of effort. Under Option 1, counties will retain 20 percent of the indigent care savings; and, therefore, would have funding above what is needed to cover the cost of the services. Additionally, under Option 1, the state's share of savings is limited to the funding spent on indigent health. Savings, from all counties, are estimated to be $300 million in 2013-14. For counties that chose Option 1, the state will revise the 2013-14 estimates in May and if the savings are estimated to be lower than $300 million, money will be provided to the county for health care costs.

- Creates the County Health Care Funding Resolution Committee. This committee is made up of: 1) one person from the California State Association of Counties, 2) one person from the Department of Health Care Services (DHCS), and 3) one person from the Department of Finance. It allows the counties to petition to switch to a mechanism option described above. Additionally, the committee resolves issues related to differences in historical data being applied to calculations and the data being provided by the county and the department.

- Establishes safety-net protections for public hospital counties.

Subcommittee Staff Comment and Recommendation--Approve. The Administration and counties have been in discussion on this methodology for months. Subcommittee staff has not received any comments or letters related to these revised estimates. It is recommended to approved the updated estimate.

Questions.

1. Please provide an overview of this item.

2. Please explain the factors resulting in the decrease in budget year savings.

6. Martin Luther King (MLK) Jr. Community Hospital Trailer Bill Language

Issue. Los Angeles County and the University of California are requesting trailer bill language in order to update the financing structure for the MLK Jr. Community Hospital in Los Angeles, in light of significant changes to the overall health care system that have rendered the existing statutory financing scheme unworkable.

Background. In 2007, the Los Angeles County-operated Martin Luther King, Jr. public hospital, originally built in the aftermath of the Watts Riot to provide critically needed medical care to one of the most underserved communities in the nation, was closed by Federal regulators after failing to meet patient care standards.

Within a year, the county launched an ambitious effort, in collaboration with the State of California and the leadership of the University of California (UC), to develop a plan for a replacement hospital. The concept that was agreed to was a unique model -- a private, non-profit entity backed by the financial assistance of the County and the medical expertise of UC. In 2010, the County of Los Angeles and the UC Regents signed a coordination agreement for the establishment of the new Martin Luther King (MLK), Jr. Community Hospital.

On September 23, 2010, the Governor signed AB 2599 (Bass and Hall), Chapter 267, Statutes of 2010, sponsored by LA County and UC. This legislation authorized State payments for the new MLK, Jr. Community Hospital and allowed county financing to be utilized to meet the needs of the facility.

Reason for Request. The former California Medical Assistance Commission (CMAC) was the primary vehicle in AB 2599 for ensuring that the new MLK, Jr. Community Hospital received the necessary financial assistance, and the CMAC rate was to be tied to the anticipated cost of providing services at the new hospital.

Health care financing has changed in significant ways since the passage of AB 2599. CMAC was eliminated as of July 2, 2012, and replaced with a new diagnosis-based reimbursement system. The Affordable Care Act, which took effect January 1, 2014, created a new level of Medi-Cal matching payments

Due to these changes, the original MLK, Jr. Community Hospital financing commitment needs to be restructured. The proposed restructuring is intended to maintain all of the original commitments of the 2010 state, UC, and county agreement.

Supplemental financing to ensure the viability of the new MLK, Jr. Community Hospital will come from the County of Los Angeles. This financing will come primarily through two annual payments:

1. $50 million per year intergovernmental transfer (IGT) for the benefit of Medi-Cal patients seen at the hospital.

2. An annual $18 million payment to the hospital to support indigent patient care services.

The county financing will be used to maximize federal matching dollars for the hospital. State General Fund costs will remain the same as prescribed in AB 2599 and will continue to be linked to the projected cost of care in the facility and will be capped at a fixed percentage of cost. No University of California funding will be used.

This legislation also implements the expressed intent language of AB 2599 to remove MLK, Jr. Community Hospital from receiving private hospital Disproportionate Share Hospital (DSH) funding.

The new MLK, Jr. Community Hospital is scheduled to open to the public in May 2015. Supporters of this proposal state that legislation to implement this restructured financing must be approved in 2014 to guarantee that the financing promised by the state and county when the original agreement was reached in 2010 is available to fund patient services.

Subcommittee Staff Recommendation—Approve. This proposal has no impact to the General Fund and maintains status quo in regard to the existing agreements on funding for hospitals. It is recommended to adopt placeholder trailer bill language that to ensure that the new MLK, Jr. Community Hospital receives at a minimum the financing committed to it in 2010 in a manner that continues to guarantee a cap on the state's contribution. The proposed trailer bill language would do the following:

- The new hospital will receive supplemental Medi-Cal payments tied to the projected costs of providing both in-patient and outpatient Medi-Cal services.

- The state will continue to provide funding linked to the cost of care that is capped at the same percentages agreed to in the 2010 agreement.

- Any non-federal share (state match) that is required that exceeds the 2010 State commitment will be generated through IGTs provided by the County of Los Angeles.

- The state will seek federal approval as necessary to obtain federal matching funds to the maximum extent permitted by federal law.

Questions.

1. Please provide an overview of this item.

2. Does DHCS have concerns with the proposed trailer bill language?

3. Please confirm there is no impact to the General Fund or any hospital funding mechanism with this proposal.