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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Jeff Stone

Thursday, March 21, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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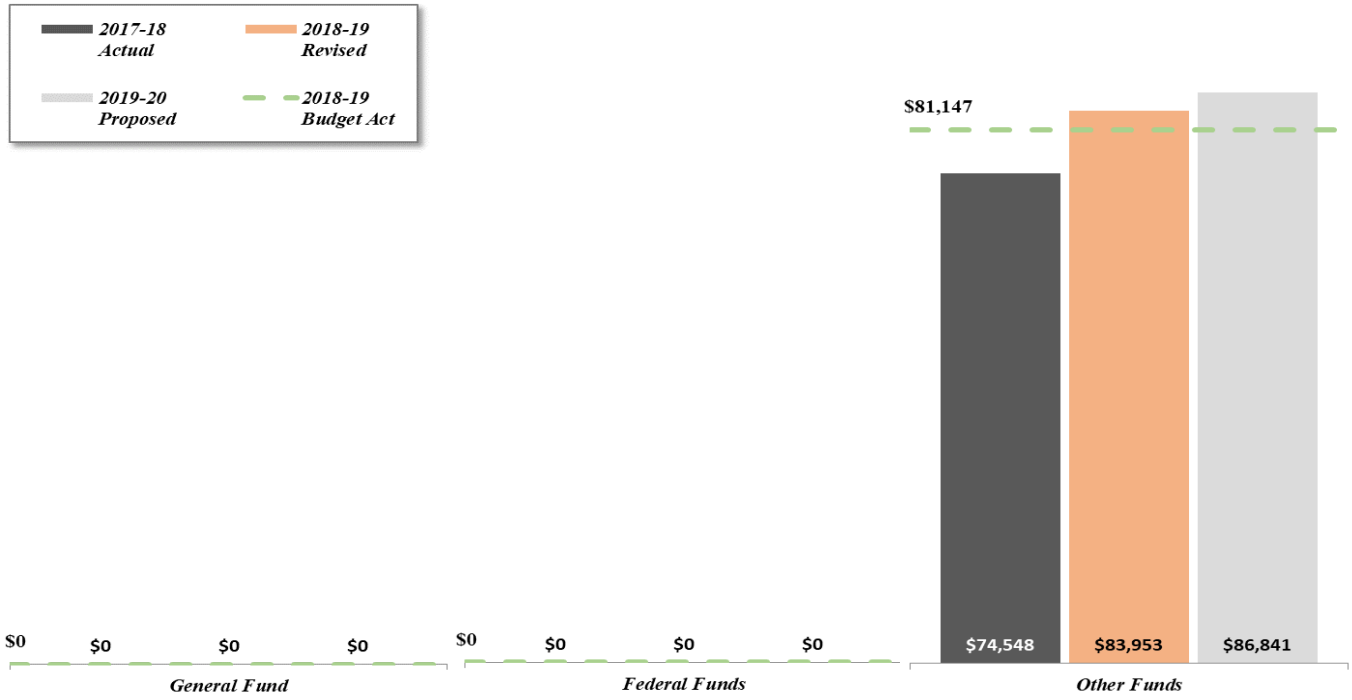
4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

Department of Managed Health Care – *Three-Year Funding Summary*
(dollars in thousands)



Department of Managed Health Care - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$0	$0	$0
Federal Funds (0890)	$0	$0	$0
Other Funds (*detail below*)	$81,147,000	$83,953,000	$86,841,000
Total Department Funding:	**$81,147,000**	**$83,953,000**	**$86,841,000**
Total Authorized Positions:	**417.6**	**417.6**	**437.6**
Other Funds Detail:			
Managed Care Fund (0933)	*$80,976,000*	*$83,782,000*	*$86,670,000*
Reimbursements (0995)	*$171,000*	*$171,000*	*$171,000*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 126 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 26 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 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 contributed to the submission of erroneous reports. The widespread inaccuracy of the data submissions made it impossible for DMHC to analyze whether plans were in compliance with timely

access standards for 2015. In response, DMHC required the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions.

In February 2018, DMHC published its timely access report for calendar year 2016. According to DMHC, although it required health plans to use an approved external vendor to perform validation and quality assurance review of data collection, much of the data for the 2016 report had already been collected under prior methodological standards. Although the submitted data contained fewer errors than the 2015 report, there were still analytical challenges due to non-standardized data collection methods and insufficient sample sizes. The data the department was able to report included the results of surveys regarding how often providers in health plan networks had appointment availability within the required timeframes.

In December 2018, DMHC published its timely access report for calendar year 2017. According to DMHC, although the data reporting suffered from some of the same individual categories of inaccuracies, the overall quality of the data improved significantly. The key findings for calendar year 2017 were as follows:

Full-Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 99 percent to a low of 63 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 70 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 52 percent

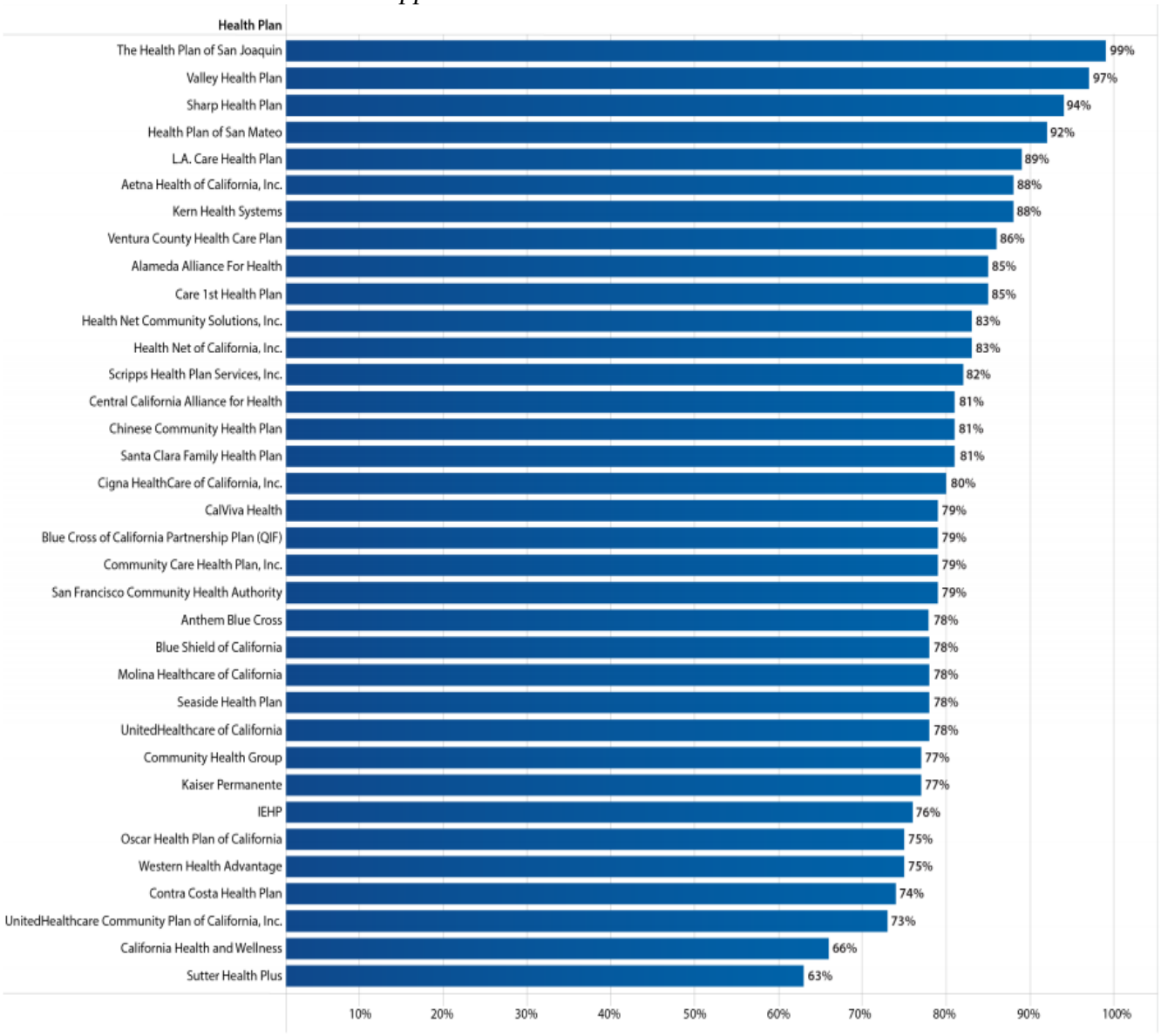
Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 83 percent to a low of 64 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87 percent to a low of 71 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 80 percent to a low of 57 percent.

Kaiser Permanente:

- The percentage of all audited providers meeting appointment wait time standards across all provider types and appointment types (urgent and non-urgent) was 92 percent.
- The percentage of all audited providers meeting non-urgent appointment standards was 91 percent.
- The percentage of all audited providers meeting urgent appointment standards was 98 percent.

Full-Service Health Plans: Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards



According to DMHC, it is working with statisticians to quantify how the percentage of providers meeting appointment time standards translates into a reliable estimate of an enrollee's ability to obtain timely appointments.

Managed Care Prescription Drug Expenditures Reporting (SB 17). SB 17 (Hernandez), Chapter 603, Statutes of 2017, was intended to provide drug cost transparency in response to the significant growth in expenditures for prescription drugs by public health care programs, commercial health plans, and the general public. These increased expenditures have been attributable to both specialty drugs newly brought to market, such as new treatments for hepatitis C, and existing drugs, often no longer under patent protection, for which a single manufacturer controls the drug's supply and substantially

increases its price. SB 17 requires health care service plans to publicly report to DMHC certain information regarding expenditures on prescription drugs on behalf of beneficiaries.

DMHC's primary responsibilities for implementation of SB 17 include the following:

Health Plan Expenditures on High Cost and High Utilization Drugs – SB 17 requires health plans that file certain rate information to report by October 1 of each year the following information for all covered prescription drugs:

- The 25 most frequently prescribed drugs.
- The 25 mostly costly drugs by total annual plan spending.
- The 25 drugs with the highest year-over-year increase in total annual plan spending.

Large Group Expenditures on Prescription Drugs – SB 17 requires health plans that file annual large group rate information to include the following information:

- The percent of premium attributable to drug costs for each category of prescription drugs (e.g. generic, brand name, and brand name/generic specialty).
- The year-over-year increase, as a percentage, in per member, per month costs for each category.
- The year-over-year increase in per member, per month costs for drug prices compared to other components of the health care premium,
- The specialty tier formulary list.
- The percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.
- Information on use of a pharmacy benefits manager (PBM), if any, including which components of prescription drug coverage are managed by the PBM.

SB 17 also requires DMHC by January 1 of each year to compile and publish this information by plan in a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. DMHC published its first SB 17 Prescription Drug Cost Transparency Report in December 2018 covering information received for calendar year 2017. The report included the following key findings:

- Health plans paid nearly $8.7 billion for prescription drugs in 2017.
- Prescription drugs accounted for 13.1 percent of total health plan premiums.
- Health plans' prescription drug costs increased by 5 percent in 2017, whereas medical expenses increased by 5.9 percent. During the same period, health plan premiums increased 4.8 percent.
- Health plans received manufacturer drug rebates of approximately $915 million or about 10.5 percent of the $8.7 billion spent on prescription drugs.
- While specialty drugs accounted for only 1.6 percent of all prescription drugs, they accounted for 51.5 percent of total annual spending on prescription drugs.
- Generic drugs accounted for 87.8 percent of all prescribed drugs but only 23.6 percent of the total annual spending on prescription drugs.
- Brand name drugs accounted for 10.6 percent of prescriptions and constituted 24.8 percent of the total annual spending on prescription drugs. The 25 most frequently prescribed drugs

represented 47.7 percent of all drugs prescribed and approximately 42.8 percent of the total annual spending on prescription drugs.

- For the 25 most frequently prescribed drugs enrollees paid 2.9 percent of the cost of specialty drugs and 56.6 percent of the cost of generics.
- Overall, plans paid 91.2 percent of the cost of the 25 most costly drugs across all three categories (generic, brand name and specialty).

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. Please provide a brief overview of the key findings from the department's Managed Care Timely Access Report for 2017.

3. Please provide a brief overview of the key findings from the department's Prescription Drug Cost Transparency Report for 2017.

Issue 2: Division of Plan Surveys Workload

Budget Issue. DMHC requests four positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $2 million annually thereafter. If approved, these resources would allow DMHC to manage increased workload from a higher number of licensed health plans and increased expenditures from higher rates for clinical consultants.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$2,077,000	$2,045,000
Total Funding Request:	**$2,077,000**	**$2,045,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2020-21.

Background. DMHC's Division of Plan Surveys within the Office of Plan Monitoring is responsible for evaluating and promoting health plan regulatory compliance and quality improvement related to health care delivery systems. The division's public health and clinical professionals evaluate each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. At least once every three years, the division conducts a routine survey of each plan that covers eight major areas of the plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

- *Quality Management* – Each plan is required to assess and improve the quality of care it provides to its enrollees.
- *Grievances and Appeals* – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.
- *Access and Availability of Services* – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.
- *Utilization Management* – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.
- *Continuity of Care* – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.
- *Access to Emergency Services and Payment* – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.
- *Prescription Drugs* – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.
- *Language Assistance* – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The division may also perform follow-up surveys to monitor correction of deficiencies identified during routine surveys, as well as non-routine surveys as needed to monitor ongoing compliance with the provisions of the Knox-Keene Act and other applicable laws and regulations. According to DMHC, follow-up surveys are performed when deficiencies identified in a routine survey preliminary report remain uncorrected at the time of the final report. The purpose of a follow-up survey is to determine and report on the status of the health plan's efforts to correct uncorrected deficiencies within 18 months of issuance of the routine survey's final report. Non-routine surveys may be performed when deficiencies remain uncorrected at the issuance of the follow-up report, or when DMHC discovers, or is alerted to, potential flaws in health plan business processes. Findings from non-routine surveys may result in a referral to DMHC's Office of Enforcement and be subject to enforcement action.

Division of Plan Surveys Monitors Compliance With Other State and Federal Requirements. In addition to monitoring compliance with provisions of the Knox-Keene Act, DMHC is also required to monitor compliance with various other state and federal requirements. For example, the Division of Plan Surveys, during its survey process, reviews plans for compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which requires health plans that offer mental health and substance use disorder services to provide those services with no more restrictive treatment limitations than required for medical or surgical services. MHPAEA reviews generally require evaluation of quantitative and non-quantitative treatment limitations for the mental health, substance use disorder and medical and surgical services to determine whether the limitations are equivalent. The division is also responsible for monitoring compliance with SB 137 (Hernandez), Chapter 649, Statutes of 2015, which requires plans to maintain accurate provider directories, and AB 72 (Bonta), Chapter 492, Statutes of 2016, which implemented a process for health plans to reimburse out-of-network providers delivering services in an in-network hospital.

According to DMHC, the division currently has 31 authorized positions, which is based on assumed workload of 28 routine surveys, five follow-up surveys, and five non-routine surveys annually. The division also contracts with clinical consultants to perform clinical and medical compliance reviews of health plan programs, policies, procedures, reports and other documents to evaluate the delivery of health care. The work performed by these consultants requires the use of highly specialized medical, dental, and other clinical expertise that is not available through the civil service system.

DMHC reports the number of licensed health plans has increased by 23 percent in the last ten years and, based on survey workload over the last two fiscal years, the division estimates it will instead be required to conduct 35 routine surveys, 25 follow-up surveys, and five non-routine surveys annually. In addition, the hourly rates for the division's clinical consultants have increased significantly, rising from $183 per hour in 2016-17 to $325 per hour for 2019-20.

DMHC requests four positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $2 million annually thereafter. This request includes $1.4 million for the increased hourly costs of its clinical consultants. The four positions are as follows:

- **Two Associate Health Care Service Plan Analysts** would serve as the primary contacts with health plans and coordinate routine and follow-up surveys, including the drafting and finalizing of reports. These analysts would also prepare and review on-site document submissions, lead the survey teams and conduct interviews with health plan staff.

- **One Attorney** would perform complex legal reviews and analyses for routine and follow-up survey findings, and develop strategies to respond to unconventional and sensitive matters. This Attorney would also provide legal support for review of health plan deficiencies.
- **One Senior Health Care Service Plan Analyst** would manage and oversee activities for routine and follow-up surveys, and provide technical assistance and guidance to associate analysts with planning, coordination and evaluation of medical surveys.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 3: Conversion of Blanket Positions to Permanent

Budget Issue. DMHC requests 16 positions funded by existing Managed Care Fund expenditure authority. If approved, these positions would allow DMHC to convert temporary help positions to permanent that more accurately reflect the department's current workload needs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$0	$0
Total Funding Request:	**0**	**$0**
Total Requested Positions:	**16.0**	**16.0**

* Positions ongoing after 2020-21.

Background. According to DMHC, 16.0 positions were eliminated pursuant to budget bill language and Department of Finance budget policies implemented during the 2012 Budget Act to improve transparency regarding actual state expenditures on salaries and wages. Although the position authority was eliminated, the budget maintained the expenditure authority associated with the eliminated positions and reallocated it to the department's budget for other operating expenses. Since the elimination of those positions, DMHC has utilized temporary help positions to complete administrative tasks to support workload including hiring employees, providing department-wide training, developing and implementing the department's strategic plan, completion of timely financial reports and other administrative tasks. As this workload been performed by temporary help since 2012, DMHC requests to convert these 16.0 temporary help positions to permanent authorized positions to accurately reflect the department's staffing needs, allowing the department to receive accurate funding for employee compensation and retirement adjustments not provided for temporary help positions.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 4: Health Care Service Plan Mergers and Acquisitions (AB 595)

Budget Issue. DMHC requests expenditure authority from the Managed Care Fund of $1 million annually. If approved, these positions would allow DMHC to analyze and assess the impact of mergers and other transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595 (Wood), Chapter 292, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$1,031,000	$1,031,000
Total Funding Request:	**$1,031,000**	**$1,031,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

Background. Prior to passage of AB 595, a health plan regulated under the Knox-Keene Act was required to obtain DMHC approval prior to merging with or acquiring another plan. However, DMHC's review of health plan mergers and acquisitions focused on organizational and administrative changes, health delivery system changes, changes to products and subscriber contracts, the effect on the health plan's financial viability, the financing for the transaction and the merger's impact on consumers. DMHC's approval of a merger is also frequently contingent on the health plan fulfilling certain commitments, called undertakings, to benefit California enrollees. DMHC's previous merger review did not include review for the impact on competition, as those considerations were outside of DMHC's authority. Although the Department of Insurance has broad authority to deny insurance company transactions that have negative impacts on competition, DMHC does not possess similar authority over health care service plan transactions.

AB 595 authorizes DMHC to disapprove a health plan merger or acquisition upon finding the merger either violates the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in the state. AB 595 also clarifies DMHC's existing authority to review mergers and secure health plan undertakings to benefit consumers, and adds requirements to ensure transparency and public participation for major mergers. AB 595 requires the following of plans and DMHC:

- Requires a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition or control by, any entity, including another health plan or health insurer, to give notice to, and secure prior approval from, DMHC.
- Requires the health plan to provide all information necessary for DMHC to approve, conditionally approve, or disapprove the transaction or agreement.
- Allows DMHC to conditionally approve the transaction or agreement, contingent on the health plan's agreement to fulfill required undertakings to benefit enrollees or provide for a stable health care delivery system. DMHC shall engage stakeholders in determining the measures for improvement included in the required undertakings.

- Requires DMHC to obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system and other relevant provisions of the Knox-Keene Act, for major transactions or agreements.
- Allows DMHC to disapprove a transaction or agreement if it fails to satisfy the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in the state. DMHC may obtain an opinion from an expert consultant to assess the competitive impact of a transaction.
- Requires DMHC, prior to approving, conditionally approving, or denying a major transaction or agreement, to hold a public meeting on the proposal in accordance with the Bagley-Keene Open Meetings Act. DMHC must consider public comments and testimony from the meeting in making its decision regarding the proposed transaction or agreement.
- Requires DMHC to prepare a statement describing the transaction or agreement if the department determines a material amount of health plan assets is subject to purchase, acquisition, or control, and to make the statement available to the public before any public meeting.
- Requires DMHC to specify fees and obtain reimbursement of reasonable costs payable by the health plans involved in the proposed transaction or agreement.

DMHC requests expenditure authority from the Managed Care Fund of $1 million annually to allow DMHC to analyze and assess the impact of mergers and other transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595. DMHC's Office of Financial Review would contract with an external consultant to perform the independent analyses of the impact of mergers or other transactions. DMHC assumes 10 transactions per year will require this independent analysis at a cost of $100,000 per analysis.

Included in the request is $31,000 for DMHC's Office of Administrative Services. These resources would allow DMHC to cover venue costs and staff travel for the public meetings required prior to approval or denial of major transactions.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

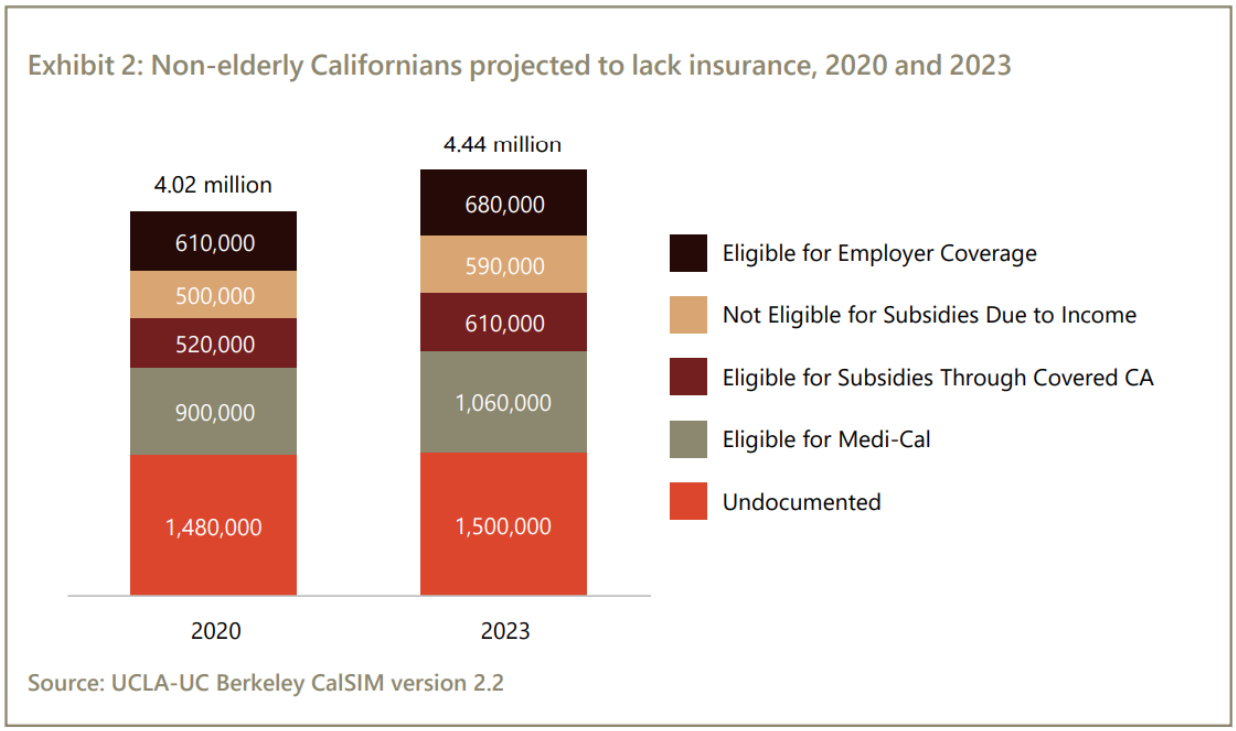
Issue 1: Overview – Expanding Health Coverage and Affordability

Background. On January 7, 2019, the Governor announced several health care proposals intended to reduce the number of Californians that remain uninsured. Although California has reduced its uninsured population more than any other state, from 17.2 percent in 2013 to 7.2 percent in 2017, millions of California residents remain without adequate health coverage. Of the categories of individuals remaining uninsured, the largest group remains undocumented residents. According to the Berkeley Labor Center, approximately 1.5 million undocumented residents are expected to be uninsured by 2020, 90 percent of whom would otherwise be eligible for coverage under the Medi-Cal program, but for their immigration status.

The next largest group of uninsured are individuals that are eligible, but not enrolled in Medi-Cal. The Berkeley Labor Center estimates there will be 900,000 individuals uninsured in this category by 2020. In addition, by 2020 there are estimated to be 520,000 uninsured individuals eligible for subsidies through the Covered California health benefit exchange but who remain uninsured, 500,000 individuals not eligible for subsidies due to higher income, and 610,000 who are eligible for employer coverage.

Presentation on the Remaining Uninsured. The subcommittee has requested a brief presentation from the Berkeley Labor Center of their research on characteristics of the remaining uninsured in California.

- **Laurel Lucia –** Director, Health Care Program, UC Berkeley Labor Center



Issue 2: Expanding Affordability in the Individual Health Insurance Market

Budget Issue. The budget proposes to increase premium subsidies to individuals with incomes between 250 and 400 percent of the federal poverty level (FPL) who are purchasing coverage on the Covered California health benefit exchange. All of these individuals currently receive premium subsidies from the federal advance premium tax credit (APTC). The budget also proposes to expand premium subsidies to individuals with incomes between 400 and 600 percent of the FPL, all of whom are currently ineligible for premium subsidies from the federal APTC. The Administration proposes to fund the increased and expanded subsidies by implementing a state-based individual mandate penalty. Similar to the recently reduced federal mandate penalty, under the state-based mandate penalty, individuals would be required to purchase minimum essential coverage or face a penalty modeled on the federal requirement prior to its reduction under the federal tax bill. The Administration has not provided estimates of the revenue it expects to receive from the state-based penalty, nor the level of premium subsidies it expects to provide to individuals purchasing coverage.

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013, more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals with incomes between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services.
- Prescription drugs.
- Emergency services.
- Rehabilitative and habilitative services and devices.
- Hospitalization.

- Laboratory services.
- Maternity and newborn care.
- Preventive and wellness services and chronic disease management.
- Mental health and substance use disorder services, including behavioral health treatment.
- Pediatric services, including oral and vision care.

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.

- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94, 87 or 73 percent of medical expenses.

- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.

- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers" https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/*

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g.

Gold or Platinum). According to Covered California, as of December 2018, approximately 1.3 million individuals covered by exchange products received an average of $445 per month in APTC subsidies. Approximately 103,000 individuals receive exchange-based coverage, but are not eligible for APTC subsidies.

Individual Mandate Penalty and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate penalty. The individual mandate penalty was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate penalty, individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures, which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan beneficiaries with incomes under 250 percent of the FPL. These cost-sharing reductions result in savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until recently, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes under 250 percent of the FPL. According to Covered California, the loss of these subsidies will result in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction takes effect for coverage in the 2019 calendar year.

The reduction of the federal mandate penalty led health plans participating in the Covered California exchange to prospectively increase premium rates in anticipation of lower enrollment and a resulting higher acuity risk pool. In August 2018, Covered California reported a preliminary overall weighted increase in premium rates of 8.7 percent if existing consumers renewed coverage in the same plans. The increase in premium rates net of APTC subsidies was six percent. Of these rate increases, plans reported adding an average of 3.5 percent to premiums, with a range of 2.5 to six percent, exclusively due to reduction of the federal mandate penalty.

Covered California Enrollment Slightly Lower for 2019. According to Covered California, at the end of the open enrollment period for 2019 coverage, the exchange finished with a total of 1,513,833 plan selections, a decrease of 7,641 or 0.5 percent compared to 2018. Of these plan selections, renewals accounted for 1,217,903 of the total, which is an increase of 84,723 or 7.5 percent compared to 2018. 295,980 consumers were newly enrolled in the exchange, which is a decrease of 92,364 or 23.8 percent compared to 2018. Covered California's analysis suggests the significant decline in new enrollments, which is a greater decline than that of states with a federally-facilitated marketplace (FFM), may be due

to the reduction of the federal individual mandate penalty to zero. This greater decline may be due to California's success in preventing reductions in enrollment in prior years compared to other states. Between 2016 and 2019, Covered California total enrollment has been between 1.5 and 1.6 million plan selections, while FFM states have declined from 9.6 million to 8.4 million plan selections, a decline of 13 percent.

AB 1810 Affordability Workgroup Recommendations. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, required Covered California to develop options for providing financial assistance to help low- and middle-income Californians with incomes up to 600 percent of the FPL access health care coverage. Covered California created the AB 1810 Affordability Workgroup composed of health care advocates, health insurance issuers, health care associations, legislative staff, and two Covered California board members. The workgroup held five meetings between October 2018 and January 2019 to discuss options for health insurance affordability including premium and cost-sharing subsidies for various income groups, establishment of a state-based individual mandate penalty, and implementing a state-based reinsurance program offset by additional federal funding available under Section 1332 of the Affordable Care Act. The workgroup and Covered California staff collaborated with economists at the University of California at Los Angeles and the University of Illinois at Chicago to model the effects of each of these affordability options, alone and in combination, on enrollment, premium affordability, and consumers' out-of-pocket costs.

The workgroup issued its final report on February 1, 2019 and included the following estimates of new total enrollment and state costs for each of the potential policy options for the 2021 calendar year.

Policy Objective	Policy Options	New Enrollment	New State Cost
Targeted improved affordability for consumers earning less than 400 percent FPL	**T1. Premium support** that lowers premium contributions for consumers earning less than 400 percent FPL	70,000	$425,000,000
	T2. Cost-sharing support that reduces out-of-pocket costs for consumers between 200-400% FPL who do not qualify for more generous federal cost-sharing subsidies	27,000	$215,000,000
Targeted improved affordability for consumers earning less than 600% FPL	**T3. Premium support** that lowers premium contributions for consumers earning between 0 and 600 percent FPL	125,000	$765,000,000
	T4. Premium support that lowers premium contributions for consumers earning between 0 and 600 percent FPL **and an individual mandate**	478,000	$891,000,000 *($482,000,000 potential offset from penalty revenue)*
Targeted improved affordability for consumers earning more than 400% FPL	**T5. Premium support** that lowers premium contributions for consumers earning between 400 and 600 percent FPL	47,000	$285,000,000
	T6. Premium support that lowers premium contributions for consumers earning more than 400 percent FPL	50,000	$324,000,000
	T7. Reinsurance that lowers gross premiums by 10 percent per year	118,000	$1,456,000,000 *($878,000,000 potential offset from 1332 reinsurance waiver)*
Targeted improved affordability for all consumers generated by reinstating the mandate penalty	**T8. Reinstate individual mandate penalty** which increases enrollment and lowers premiums by improving the risk mix in the individual market	359,000	*($526,000,000 potential penalty revenue)*

Source: Covered California. "Options to Improve Affordability in California's Individual Health Insurance Market". (February 1, 2019)

The workgroup report model indicates that implementation of a state-based individual mandate penalty would have the largest single impact on coverage, with 359,000 additional enrollments and estimated revenue to the state of $526 million. The average net premium reduction would be zero for subsidy-eligible enrollees and $24 per month for off-exchange enrollees due to the improved risk pool. Premium support that caps premiums at no more than 15 percent of income for individuals with incomes under 600 percent of the FPL would result in 125,000 new enrollments, premium reduction for subsidy-eligible enrollees of $21 per month and $14 per month for off-exchange enrollees, and result in state costs of $765 million. Reinsurance would result in 118,000 additional enrollments, a premium reduction of $70 per month or ten percent for off-exchange enrollees, and a net state cost of $578 million.

The report also modeled three options in combination: 1) premium and cost-sharing support, 2) premium and cost-sharing support with an individual mandate penalty, and 3) premium and cost-sharing support with a penalty and reinsurance.

	Option 1: Premium and Cost Sharing Support	Option 2: Premium and Cost Sharing Support with Penalty	Option 3: Premium and Cost Sharing Support, Penalty and Reinsurance
New Enrollment	**290,000**	**648,000**	**764,000**
<250% FPL	*66,000*	*120,000*	*139,000*
250-400% FPL	*153,000*	*342,000*	*358,000*
400%+ FPL	*71,000*	*187,000*	*267,000*
Individual Market Take-up Rate*	58%	67%	70%
Percent of Enrollees in Silver Coverage or Higher**	79%	77%	79%
Benefits to Existing Enrollees			
On-Exchange Number Benefitting	1,292,000	1,292,000	1,292,000
On-Exchange Average Monthly Premium Reduction	$39/m	$39/m	$39/m
Off-Exchange Number Benefitting	662,000	662,000	662,000
Off-Exchange Average Monthly Premium Reduction	$18/m	$41/m	$111/m
Spending Impacts			
New State Spending	**$2,190,000,000**	**$2,562,000,000**	**$4,201,000,000**
Premium Support	*$1,561,000,000*	*$1,886,000,000*	*$1,874,000,000*
Cost-Sharing Support	*$629,000,000*	*$676,000,000*	*$604,000,000*
Reinsurance	*None*	*None*	*$1,724,000,000*
Potential State Spending Offsets			
Penalty Revenue	None	**$441,000,000**	**$393,000,000**
Potential 1332 Funding			**$1,132,000,000**
Potential Net State Spending***	**$2,190,000,000**	**$2,121,000,000**	**$2,676,000,000**
Change in Federal Tax Credit Expenditures	$670,000,000	$975,000,000	($331,000,000)

* 51% under Affordable Care Act Baseline 2021
** 69% under Affordable Care Act Baseline 2021
*** Net State Spending assumes all offsets are applied to reduce State expenditures

Source: Covered California. "Options to Improve Affordability in California's Individual Health Insurance Market". (February 1, 2019)

Each of the three options have the same impact on subsidy-eligible enrollees, reducing premiums by $39 per month, while Option 1 reduces off-exchange premiums by $18 per month, Option 2 by $41 per month, and Option 3 by $111 per month. However, additional state costs needed per additional enrollment vary between the three options. Option 1 results in annual costs of approximately $7,552 per new enrollee, Option 2 results in annual costs of approximately $3,273 per new enrollee, and Option 3 results in annual costs of approximately $3,503 per new enrollee.

Stakeholders Propose Package of Premium and Cost-Sharing Subsidies and Mandate Penalty. Health Access California, Western Center on Law and Poverty, and a broad coalition of advocacy organizations request $2.1 billion additional General Fund dollars to establish comprehensive affordability enhancements. The recent estimates done for Covered California indicate that subsidies for premiums and cost sharing for those below 400 percent of the FPL and for premiums for those above 400 percent of the FPL combined with an individual mandate penalty, would cut in half the number of

uninsured who are not excluded due to immigration status. Getting to universal coverage with affordable access to care for those in the individual market requires spending on this scale. While Covered California outlined a buffet of options with lesser price tags, those individual options are insufficient to get California to near-universal levels of coverage comparable to European countries such as France or Germany.

Under the Governor's proposal, California would be the first state in the nation, post-Affordable Care Act, to offer additional help for those between 250 to 400 percent of the FPL while providing financial help to middle-income Californians between 400 and 600 percent of the FPL, who get no affordability help now. According to the proponents, this proposal ignores two realities: first, for those 200 to 250 percent of the FPL, the current federal affordability assistance in the form of cost sharing reductions is utterly insufficient. As a result, many consumers in this income category select bronze coverage with a $6,300 deductible, something that no one living on $24,000 to $30,000 a year can afford. Second, while most of those who are over 400 percent of the FPL are between 400 percent and 600 percent of the FPL, there are those in their late 50s and early 60s who make more than 600 percent of the FPL who need help affording premiums. Cutting off help at 600 percent of the FPL just creates a cliff at a different point on the income scale. A married couple in their early 60s living on $75,000 a year gross income is not poor, but not rich either. The Governor's proposal builds on the underlying structure of the ACA, in which the sliding scale for premiums provides greater affordability to those at the end of the income scale and with the most help for those who have the least. Californians who need more help to afford care and coverage in our high cost state would now get that support.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Panel Discussion. The subcommittee has requested the following panelists to discuss the Administration's coverage affordability proposal, as well as other options for expanding affordability in the individual health insurance market:

- **Jacob Lam, Principal Program Budget Analyst, Department of Finance**
- **Aleksander Klimek, Finance Budget Analyst, Department of Finance**
- **Katie Ravel, Director of Policy, Eligibility, and Research, Covered California**
- **Beth Capell, Policy Advocate, Health Access California**
- **Jen Flory, Policy Advocate, Western Center on Law and Poverty**

Issue 3: Full-Scope Medi-Cal Expansion to Undocumented Young Adults

Budget Issues. The budget proposes to expand full-scope Medi-Cal coverage to approximately 138,000 income-eligible young adults up to age 26, regardless of immigration status. DHCS requests expenditure authority of $257.1 million ($194 million General Fund and $63.1 million federal funds) for the expansion of coverage. In addition, DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter. If approved, these resources would allow implementation and make necessary system changes for the expansion of coverage.

Trailer Bill Language Proposals. The cost of the Governor's expansion proposal would be partially offset by redirecting county realignment funding for indigent health care to the state. DHCS is proposing two trailer bill language changes related to the expansion proposal: 1) Implementation of the expansion of coverage to undocumented young adults, and 2) increasing the percent of realignment funds redirected from certain counties from 60 percent to 75 percent.

Program Funding Request Summary – State Operations		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$237,000	$153,000
0890 – Federal Trust Fund	$387,000	$153,000
Total Funding Request:	**$624,000**	**$306,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

State Operations Budget Change Proposal for Implementation of Coverage Expansion. DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter. If approved, the requested resources would support key planning activities for the implementation of the full scope Medi-Cal coverage expansion for all income-eligible immigrants from 19 through 25 years of age, regardless of immigration status. This expanded Medi-Cal coverage will require DHCS to develop key policy and implementation instructions for counties, update application materials and develop outreach materials for applicants and transitioning populations, collaborate extensively with all DHCS program areas, including counties and consumer advocates, oversee all eligibility, enrollment, and billing system changes, and respond to beneficiary and stakeholder inquiries.

DHCS is requesting **one Associate Governmental Program Analyst** to manage changes to eligibility systems, serve as a subject matter expert on immigration, and oversee development of policy letters and regulatory development. DHCS is also requesting **one Information Technology Specialist I** position to provide technical guidance for updating eligibility systems. The requested resources also include $300,000 one-time resources for technical upgrades to the eligibility systems.

Background. Although California has reduced its uninsured population more than any other state, from 17.2 percent in 2013 to 7.2 percent in 2017, millions of California residents remain without adequate health coverage. In particular, approximately 1.5 million undocumented residents are expected to be uninsured by 2020, 90 percent of whom would otherwise be eligible for coverage under the Medi-Cal

program, but for their immigration status. The Legislature has proposed state-funded coverage for all or portions of this population several times in recent years, including a successful effort in 2015 to provide full-scope Medi-Cal coverage to income-eligible children up to age 19, regardless of immigration status.

Medi-Cal Covers One in Three Californians. Medi-Cal covers 13.2 million Californians, including more than five million children, at a total estimated cost of $98.5 billion in 2018-19 and $100.7 billion in 2019-20. Of that amount, the federal government is expected to contribute $62.7 billion in 2018-19 and $65.4 billion in 2019-20 as a share of health care-related expenditures for Medi-Cal beneficiaries. The rate at which federal matching funds are provided to states is dependent on a state's per capita income. California has traditionally received a federal match of 50 percent, the minimum percentage allowable, due to the state's high per capita income relative to other states. Certain beneficiary populations and categories of Medi-Cal expenditures are eligible for higher federal matching rates, such as children eligible for the Children's Health Insurance Program (CHIP), adults eligible for the expansion of Medi-Cal under the Affordable Care Act, family planning expenditures, and improvements to information technology systems.

Limitations on Health Care Options for Undocumented Californians. Federal Medicaid law prohibits federal matching fund payments to states for full-scope coverage of undocumented residents. However, federal law does allow payments for emergency and pregnancy (restricted-scope) services provided to undocumented residents. According to DHCS, the total cost of providing restricted-scope services was $1.6 billion in 2016-17. As of July 2018, DHCS estimates that 952,683 undocumented adults are enrolled in restricted-scope Medi-Cal. 268,811 undocumented children up to age 19 are also eligible and enrolled in state-funded full-scope Medi-Cal benefits. The state continues to be eligible for federal matching funds for emergency and pregnancy services for this population. (For more information, see *Medi-Cal Eligibility for Children Regardless of Immigration Status*, below).

Federal law also prohibits undocumented residents from participating in the Covered California health benefit exchange established after passage of the federal Affordable Care Act. Covered California provides health care service plan coverage options in the individual market for eligible citizens and legal permanent residents. Covered California participants with incomes up to 400 percent of the federal poverty level (FPL) receive federally financed premium subsidies to make coverage more affordable. Covered California also serves as an active purchaser, utilizing its selective contracting authority to negotiate with health plans to lower premiums for California health care consumers. Undocumented residents may enroll in off-exchange coverage options similar to those negotiated by the exchange, but are ineligible for federally financed premium subsidies that make such coverage affordable.

County Indigent Health Programs Provide Coverage for the Uninsured. State law requires counties to serve as the health care provider of last resort for residents age 18 and over who cannot afford care, known as medically indigent adults. The services offered and requirements for eligibility vary significantly by county. County indigent programs generally fall into two categories:

1. *County Medical Services Program (CMSP)* – 35 mostly small and rural counties contract with Advanced Medical Management to administer a standardized benefit for limited-term health coverage for uninsured low-income, indigent adults not otherwise eligible for publicly funded health care programs. An eleven member CMSP Governing Board sets program eligibility requirements, determines the scope of covered health care benefits, and sets the payment rates

paid to providers. CMSP counties include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

2. *Medically Indigent Service Program* – 23 counties manage their own medically indigent programs with different service delivery options and eligibility requirements. These counties include: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Merced, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Stanislaus, Tulare, and Ventura.

1991 Realignment Funds County Indigent Programs. County indigent health programs are generally funded by revenues received under 1991 Realignment, which shifted significant fiscal and programmatic responsibility for certain health and human services programs from the state to the counties. 1991 Realignment revenues have historically allowed county indigent health programs to provide care for the uninsured and those ineligible for other coverage. Prior to 2014, county indigent programs covered childless adults that were previously ineligible for Medi-Cal coverage, but few covered undocumented residents.

The federal Affordable Care Act authorizes states to expand their Medicaid programs to previously uninsured individuals. AB 1 X1 (Pérez) and SB 1 X1 (Hernandez), Chapters 3 and 4, Statutes of 2013, First Extraordinary Session, authorized California's optional expansion of the Medi-Cal program. The optional expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults with incomes at or below 138 percent of the federal poverty level. Optional expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits.

As a result of the expansion of coverage to previously uninsured individuals through the state's Medi-Cal program, county indigent health programs were no longer responsible for providing care for this population. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, provides for the redirection of health-related 1991 Realignment revenues from counties to offset state General Fund costs to account for this shift in responsibility and health care expenditures for the Medi-Cal expansion population. The redirection of 1991 Realignment funds offsets expenditures in the California Work Opportunity and Responsibility to Kids (CalWORKs) program that were previously funded through the state's General Fund.

AB 85 requires CMSP counties to redirect 60 percent of the realignment funds they would have previously received. That legislation also gave another group of counties the option to redirect 60 percent of realignment funds or base the redirection amount on a formula that takes into account a county's cost and revenue experience. Counties with public hospitals, except Los Angeles, base redirection amounts on the cost and revenue formula. Los Angeles County adheres to a county-specific formula.

Administration Proposes to Increase AB 85 Redirection from 60 to 75 Percent. DHCS is proposing trailer bill language to amend the redirection percentages implemented in AB 85 for certain counties. For CMSP counties, as well as the counties that chose to implement a 60 percent redirection amount, the proposed trailer bill language would instead redirect 75 percent of 1991 Realignment funds from those

counties. According to the Administration, this additional redirection would result in approximately $63 million of additional offset General Fund costs in the CalWORKs program. According to the Administration, the increased redirection amount is meant to account for the reduced burden on county indigent programs achieved by enrolling undocumented young adults in full-scope Medi-Cal coverage.

Certain County Indigent Health Programs Offer Non-Emergency Care for Undocumented. After implementation of the Medi-Cal expansion, undocumented residents are the largest proportion of the remaining uninsured for whom county indigent health programs are responsible to provide care. While all programs offer emergency care covered by Medi-Cal to undocumented residents, some counties have recently expanded the scope of coverage to include non-emergency, limited primary care benefits.

CMSP Counties: Eligibility Expansion and Primary Care Benefit. Beginning in 2016, the CMSP Governing Board approved an expansion of eligibility requirements for its 35-county indigent health program from 200 percent to 300 percent of the FPL. In addition, the board approved the Primary Care Benefit program, a two-year pilot to provide CMSP participants, including undocumented residents, with certain non-emergency benefits for a renewable, six-month enrollment period. These benefits include:

1. Up to three office visits for primary care, specialty care, or physical therapy,
2. Preventative health screenings and lab tests,
3. Prescription drugs with a five dollar co-pay and up to $1,500 in benefits, and
4. Services provided by contracting community health centers, clinics, and other providers.

Beginning September 2018, the CMSP Governing Board authorized the Primary Care Benefit program to be permanently incorporated into the CMSP standard benefit package in its indigent health program.

Los Angeles County: My Health LA. Los Angeles County implemented My Health LA in 2014 to provide primary and specialty care services to more than 144,319 uninsured county residents. The program provides primary preventive, specialty care, hospital inpatient, urgent and emergency care through county public hospitals, clinics and other providers. In addition, the program provides prescription drugs, mental health/substance use treatment, lab tests, and other health care services.

According to an analysis by Health Access California, the following counties also provide some non-emergency coverage for undocumented residents through their county indigent programs: Fresno, Sacramento, Contra Costa, Monterey, and Santa Clara.

Source: Health Access California. "Profiles of Progress: California Counties Taking Steps to a More Inclusive and Smarter Safety-Net". (May 2016)

Full-Scope Medi-Cal Eligibility for Children Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expanded eligibility for full-scope Medi-Cal to all income-eligible children under age 19, regardless of immigration status. Undocumented children were previously only eligible for restricted-scope Medi-Cal coverage, which receives a federal match depending on the child's eligibility category, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimated that 250,000 undocumented children under age 19 would become eligible under the expansion. As of January 2019, a total of 268,811 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

1. *Previous Restricted-Scope Medi-Cal Beneficiaries:* As of January 2019, 120,614 undocumented children previously enrolled in restricted-scope Medi-Cal coverage have transitioned into full-scope Medi-Cal coverage.

2. *Not Previously Enrolled:* As of January 2019, 148,197 undocumented children who were previously eligible, but not enrolled in, restricted scope Medi-Cal have enrolled in full-scope benefits.

Full-Scope Medi-Cal Coverage for Children Regardless of Immigration Status, by County (Jan. 2019)							
County	**Covered Children**	**County**	**Covered Children**	**County**	**Covered Children**	**County**	**Covered Children**
Alameda	11,472	Kings	1,105	Placer	744	Sierra	*
Alpine	*	Lake	559	Plumas	*	Siskiyou	99
Amador	62	Lassen	*	Riverside	14,284	Solano	2,088
Butte	565	Los Angeles	97,628	Sacramento	7,838	Sonoma	2,194
Calaveras	69	Madera	1,320	San Benito	356	Stanislaus	4,447
Colusa	193	Marin	1,752	San Bernardino	11,572	Sutter	487
Contra Costa	6,416	Mariposa	*	San Diego	13,254	Tehama	404
Del Norte	*	Mendocino	730	San Francisco	4,904	Trinity	*
El Dorado	372	Merced	2,970	San Joaquin	5,038	Tulare	4,415
Fresno	6,387	Modoc	34	San Luis Obispo	1,040	Tuolumne	67
Glenn	234	Mono	101	San Mateo	6,479	Ventura	5,211
Humboldt	348	Monterey	4,886	Santa Barbara	4,250	Yolo	1,020
Imperial	732	Napa	703	Santa Clara	10,278	Yuba	370
Inyo	63	Nevada	208	Santa Cruz	1,441	**Statewide**	**268,811**
Kern	7,544	Orange	19,398	Shasta	462		

***** = Value suppressed due to low enrollment totals.

Proposals to Expand Medi-Cal Eligibility to Remaining Uninsured Populations. Legislators and stakeholders have expressed interest in expanding Medi-Cal coverage to undocumented families and individuals not currently eligible due to immigration status, including adults up to age 26, adults ages 26 to 64 and seniors age 65 and older. Prior to approval of the 2018 Budget Act, the Assembly adopted a proposed expansion of full-scope Medi-Cal to undocumented young adults up to age 26, while the Senate adopted a proposed expansion of full-scope Medi-Cal to undocumented seniors over age 65. The 2018 Budget Act ultimately included neither proposal. In addition, SB 29 (Lara and Durazo) and AB 4 (Arambula, Bonta, and Chiu) were introduced in the current legislative session to provide full-scope Medi-Cal coverage to all adults regardless of immigration status. These bills are awaiting their first committee hearings.

The California Immigrant Policy Center, Health Access California, and a coalition of 80 organizations request resources to fund expansion of full-scope Medi-Cal services to otherwise eligible adults regardless of immigration status. The Administration estimates expansion of full-scope Medi-Cal to undocumented individuals age 26 to 64 would enroll 1,043,614 individuals and result in costs of $2 billion ($1.5 billion General Fund and $507.6 million federal funds) in the Medi-Cal program. The Administration also estimates expansion of full-scope Medi-Cal to undocumented seniors 65 years of

age and older would enroll 28,379 undocumented seniors and result in costs of $115.3 million ($94.5 million General Fund and $20.9 million federal funds) in the Medi-Cal program. These costs do not reflect expenditures for In-Home Supportive Services (IHSS). The Administration indicates it is in the process of preparing fiscal estimates of the IHSS costs for these populations.

According to the coalition, California's robust implementation of the Affordable Care Act (ACA) has brought the uninsured rate to a historic low of 6.8 percent. In 2015, California showed great leadership by investing in access to full-scope Medi-Cal for all income eligible children under the age of 19, regardless of immigration status, which has provided comprehensive care to over 200,000 undocumented children. Through these efforts, California now provides near-universal coverage for children. However, their parents and other undocumented adult Californians still face exclusions to health care access. Of the nearly three million uninsured Californians, 58 percent are undocumented adults who are locked out of health care access simply because of their immigration status. Any effort to achieve universal health coverage in California must include immigrant communities who shape our state and who call California home.

Counties Concerned About Impacts of AB 85 Redirection Proposal. Several counties have submitted opposition to the Administration's proposed increase in the redirection of 1991 Realignment funds to offset the costs of the expansion of Medi-Cal coverage to undocumented young adults. According to the County of Santa Barbara, part of the funding mechanism is based on an inaccurate financial premise and will have dire consequences on the essential core public health services provided by Santa Barbara County, Stanislaus County, Yolo County, Sacramento County, and Placer County Public Health Departments. The Governor's proposed budget inaccurately assumes that county costs will decrease because of this proposed Medi-Cal expansion to cover more indigents. In actuality, any savings would be nominal and in no way offset the redirection of realignment as proposed. Specific consequences to public health programs if this change is implemented include reductions in support of communicable disease control and epidemiology, vaccination services, contact investigations and surveillance, public health nursing interventions, public health laboratory testing and epidemiologic investigations, and public health outreach initiatives to promote healthy lifestyles.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Panel Discussion. The subcommittee requests the following panelists to discuss the Administration's proposed expansion, resource request, trailer bill language proposals, stakeholder proposals for additional expansion of eligibility, and concerns about the redirection of county realignment funds:

- **Jennifer Kent,** Director, Department of Health Care Services
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Laura Ayala,** Staff Finance Budget Analyst, Department of Finance
- **Ronald Coleman**, Director of Policy and Legislative Advocacy, Health Access California
- **Deepen Gagneja,** Senior Legislative Advocate, CA Immigrant Policy Center
- **Dr. Peter Beilenson**, Director, Sacramento County Health Services Department

Issue 4: Stakeholder Proposals: Expansion of Medi-Cal Eligibility and Enrollment

Background. Medi-Cal covers 13.2 million Californians, including more than five million children, at a total estimated cost of $98.5 billion in 2018-19 and $100.7 billion in 2019-20. Of that amount, the federal government is expected to contribute $62.7 billion in 2018-19 and $65.4 billion in 2019-20 as a share of health care-related expenditures for Medi-Cal beneficiaries. The rate at which federal matching funds are provided to states is dependent on a state's per capita income. California has traditionally received a federal match of 50 percent, the minimum percentage allowable, due to the state's high per capita income relative to other states. Certain beneficiary populations and categories of Medi-Cal expenditures are eligible for higher federal matching rates, such as children eligible for the Children's Health Insurance Program (CHIP), adults eligible for the expansion of Medi-Cal under the Affordable Care Act (ACA), family planning expenditures, and improvements to information technology systems.

Affordable Care Act Expanded Medi-Cal Coverage to 3.9 million Newly Eligible Californians. The ACA authorizes states to expand their Medicaid programs to previously uninsured individuals. AB 1 X1 (Pérez) and SB 1 X1 (Hernandez), Chapters 3 and 4, Statutes of 2013, First Extraordinary Session, authorized California's optional expansion of the Medi-Cal program. The optional expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Optional expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits.

For states that expanded Medicaid, the ACA authorized federal matching funds of 100 percent for services provided to this population until January 1, 2017. States received a federal match of 95 percent for calendar year 2017, and will receive a federal match of 94 percent for calendar year 2018, 93 percent for calendar year 2019, and 90 percent for calendar year 2020 and beyond. Medi-Cal assumed a five percent General Fund share for the optional expansion population beginning January 1, 2017, a six percent General Fund share beginning January 1, 2018, a seven percent General Fund share beginning January 1, 2019, and will assume a ten percent share beginning January 1, 2020 and ongoing. In addition, the share of capitation payments for abortion-related services offered by Medi-Cal managed care has been borne by the state's General Fund since 2014, as federal funding is not available for this purpose.

The budget includes $17.3 billion ($1.5 billion General Fund and $15.7 billion federal funds) in 2018-19 and $20.1 billion ($2.2 billion General Fund and $17.8 billion federal funds) in 2019-20 for coverage of the optional expansion population. The department estimates optional expansion enrollment of approximately 3.8 million beneficiaries in 2018-19 and 2019-20.

Medi-Cal Eligibility for Children Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expanded 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 estimated 250,000 undocumented children under age 19 would become eligible under the expansion. As of January 2019, a total of 268,811 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

1. *Restricted-Scope Medi-Cal Beneficiaries* 120,614 undocumented children previously enrolled in restricted-scope Medi-Cal coverage have transitioned into full-scope Medi-Cal coverage.
2. *Not Previously Enrolled* DHCS estimated 130,924 undocumented children that were eligible for, but not enrolled in, restricted-scope Medi-Cal would be eligible for full-scope coverage under the expansion of eligibility. As of January 2019, 148,197 children in this category have enrolled in full-scope benefits, or 113.2 percent of the department's estimate of eligible children.

Proposals to Expand Medi-Cal Eligibility and Promote Medi-Cal Enrollment. Stakeholders have expressed interest in expanding Medi-Cal coverage to individuals not currently eligible because certain income limits for those eligible due to age or disability differ from those of other populations. In addition, stakeholders have expressed interest in expanding various outreach and assistance efforts to enroll individuals that are currently eligible, but not enrolled. These proposals are as follows:

Aged and Disabled Program Eligibility. AB 2877 (Thomson), Chapter 93, Statutes of 2000, established the Aged and Disabled program, which extends full-scope Medi-Cal coverage to individuals with income under 100 percent of the federal poverty level (FPL) and who are over age 65 or are disabled. The statute also provided for an income disregard of $230 for an individual or $310 for a couple, raising the effective level of eligibility to those with income higher than 100 percent of the FPL, currently about 123 percent of the FPL. This income disregard has not been updated since the program was implemented. Prior to AB 2877, aged and disabled individuals could qualify for the Medically Needy program, which imposes a monthly share of cost, which must be paid prior to receiving Medi-Cal benefits. Today, aged and disabled individuals whose incomes exceed 100 percent of the FPL plus the income disregard are still eligible under the Medically Needy program and must pay a monthly share of cost, which is the difference between eligible income and the Maintenance Need Income Level, a fixed dollar amount in statute intended to provide for food, rent and utilities. This level is $600 for an individual and $934 for a couple.

The Western Center on Law and Poverty (WCLP), Disability Rights California, Justice in Aging, and a coalition of 64 organizations request resources to raise the income eligibility for Medi-Cal's Aged and Disabled program to 138 percent of the federal poverty level. This proposal would bring the Aged and Disabled program into alignment with other income-based Medi-Cal eligibility programs.

According to the coalition, when the aged and disabled program was established, the income standard was equivalent to 133 percent FPL, the same level as most other adults enrolled in Medi-Cal. However, the disregards lose real value every year, because they are specific dollar amounts rather than percentages of FPL. Today, these unchanged dollar amounts place the resulting income standard at 123 percent FPL. When a senior has even a small increase in their income that puts them over 123 percent FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost.

Express Lane Eligibility for Women, Infants, and Children (WIC) Program Participants. SB 1 X1 required the state to participate in a federal option to simplify the Medi-Cal enrollment process for those receiving benefits in the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh. As of the 2015 Budget Act, DHCS estimated approximately 209,000 individuals would take up Medi-Cal coverage through Express Lane Eligibility related to CalFresh participation. In addition to CalFresh, federal guidance allows states to establish Express Lane programs within agencies capable of

making a finding regarding one or more programmatic eligibility requirements, using information the Express Lane agencies already collect. One of the allowable programs under this federal guidance is the Women, Infants, and Children (WIC) program, which is administered in California by the Department of Public Health and provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level.

A coalition of six children's advocacy organizations requests General Fund resources of approximately $5 million to establish an Express Lane program for children and a presumptive eligibility program for pregnant women participating in the WIC program, effective April 2020. Approximately $100,000 would fund needed administrative expenses to establish the program, while $4 million would fund health care services for the additional children and $700,000 for pregnant women enrolled in Medi-Cal as a result of the program. The coalition estimates full-year costs for implementation of the proposal would be $26 million General Fund. According to the coalition, the WIC eligibility system currently checks participants' Medi-Cal enrollment by linking to the Medi-Cal Eligibility Data System. About 90,000 WIC children and 13,000 WIC pregnant women do not have Medi-Cal, despite eligibility. Federal Express Lane Eligibility authority allows WIC income eligibility findings to be used to determine Medicaid enrollment for children. State statute authorizes a WIC automated enrollment gateway but requires a budget appropriation. Express enrollment for pregnant women would require a federal waiver. However, with a state plan amendment, WIC pregnant women could be determined presumptively eligible for Medi-Cal while a full application is completed.

Funding for Medi-Cal Enrollment Assistance and Outreach. Beginning in January 2014 DHCS received a $12.5 million contribution from the California Endowment for purposes of implementing an enrollment and outreach program to supplement county efforts to enroll eligible but not enrolled individuals into the Medi-Cal program. Among other program requirements, grants were provided for efforts that place special emphasis on one or more of the following populations:

1) Persons with mental health disorder needs
2) Persons with substance use disorder needs
3) Persons who are homeless
4) Young men of color
5) Persons who are in county jail, state, prison, on state parole, on county probation, or under post release community supervision
6) Families of mixed-immigration status
7) Persons with limited English proficiency

According to DHCS, the cumulative progress of Enrollment and Outreach (O&E) is as follows:

	Totals
Amount Invoiced	$22,388,499
Number of AB 82 individuals reached by O&E efforts	1,801,991
Number of AB 82 individuals assisted with enrollment into Medi-Cal	202,461
Number of approved Medi-Cal applications resulting from Medi-Cal O&E efforts	87,678
Number of AB 82 beneficiaries that retained Medi-Cal coverage as a result of the O&E efforts	30,683

Source: DHCS - O&E Quarterly Progress Report: Outreach, Enrollment, and Retention - Cumulative Totals

The California Pan-Ethnic Health Network, Maternal and Child Health Access, and Community Health Councils request $15 million General Fund per year for two years to reinstate and continue outreach, enrollment, retention, and utilization assistance in Medi-Cal. The funds would be allocated to counties on the basis of a funding formula and administered by counties, as occurred under AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

According to the coalition, for the first time in years, California is seeing a substantial decline in enrollment in health care coverage both in Medi-Cal and Covered California. For a number of compounding reasons, such as fear of immigration consequences generated by the federal Administration, unaffordable premium costs, and the end of the individual mandate penalty, the communities most in need are declining to enroll in, retain, or use life-saving coverage. Now more than ever, it is time for the state to reinvest in outreach, enrollment, and utilization assistance for low-income families and individuals eligible for Medi-Cal, the Medi-Cal Access Program, or Covered California.

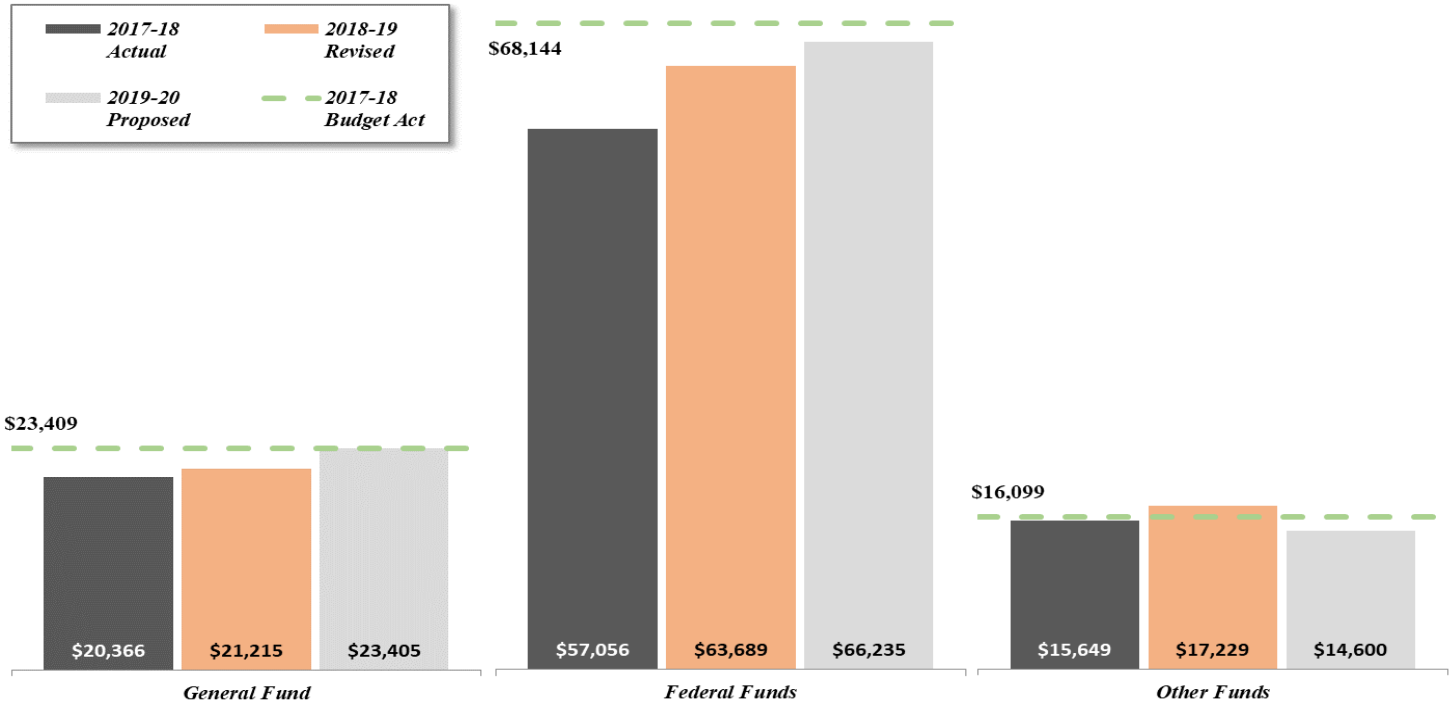
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested advocates to briefly present these proposals and respond to questions from subcommittee members.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services – *Three-Year Funding Summary*
(dollars in millions)



Department of Health Care Services - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$23,408,652,000	$21,215,355,000	$23,405,017,000
Federal Funds	$68,143,762,000	$63,689,469,000	$66,234,871,000
Other Funds	$16,098,932,000	$17,228,907,000	$14,600,085,000
Total Department Funding:	**$107,651,346,000**	**$102,133,731,000**	**$104,239,973,000**
Total Authorized Positions:	**3434.5**	**3434.5**	**3557.8**
Other Funds Detail:			
Breast Cancer Control Account (0009)	*$11,692,000*	*$11,790,000*	*$11,965,000*
Childhood Lead Poisoning Prev Fund (0080)	*$867,000*	*$867,000*	*$867,000*
DUI Program Licensing Trust Fund (0139)	*$1,212,000*	*$1,269,000*	*$1,270,000*
Hospital Svc. Account, Prop 99 (0232)	*$73,335,000*	*$73,335,000*	*$125,979,000*
Physician Svcs. Account, Prop 99 (0233)	*$22,496,000*	*$22,496,000*	*$39,526,000*
Unallocated Account, Prop 99 (0236)	*$46,804,000*	*$46,834,000*	*$74,491,000*

Narc Treatment Prog Lic Trust Fund (0243)	*$1,757,000*	*$1,801,000*	*$1,802,000*
Perinatal Insurance Fund (0309)	*$12,105,000*	*$16,396,000*	*$20,113,000*
Audit Repayment Trust Fund (0816)	*$67,000*	*$67,000*	*$67,000*
Medi-Cal Inpt Payment Adj Fund (0834)	*$152,040,000*	*$166,513,000*	*$144,465,000*
Special Deposit Fund (0942)	*$67,040,000*	*$59,305,000*	*$74,553,000*
Reimbursements (0995)	*$1,599,713,000*	*$1,209,167,000*	*$1,625,642,000*
County Health Init Matching Fund (3055)	*$176,000*	*$176,000*	*$176,000*
Childrens Med Services Rebate Fund (3079)	*$16,259,000*	*$11,000,000*	*$8,300,000*
Mental Health Services Fund (3085)	*$1,841,437,000*	*$2,023,841,000*	*$2,024,179,000*
Nondesig Public Hosp Supp Fund (3096)	*$0*	*$525,000*	*$0*
Priv Hospital Supplemental Fund (3097)	*$19,500,000*	*$19,500,000*	*$19,500,000*
Mental Heath Facility Lic Fund (3099)	*$375,000*	*$375,000*	*$375,000*
Residential/Outpatient Prog Lic Fund (3113)	*$6,903,000*	*$7,120,000*	*$7,122,000*
Childrens Health/Human Svcs Fund (3156)	*$21,286,000*	*$286,000*	*$0*
Hosp Qual Assurance Revenue Fund (3158)	*$4,872,901,000*	*$6,278,091,000*	*$4,361,024,000*
SNF Quality & Accountability Fund (3167)	*($1,899,000)*	*($2,194,000)*	*($2,833,000)*
Emerg Air Trans/Children's Fund (3168)	*$8,525,000*	*$7,576,000*	*$8,090,000*
Public Hosp Invest, Improve, Inc Fund (3172)	*$762,447,000*	*$843,924,000*	*$666,000,000*
LongTerm Care Qual Assurance Fund (3213)	*$460,098,000*	*$899,759,000*	*$503,268,000*
Health and Human Svcs Spec Fund (3293)	*$2,520,163,000*	*$2,526,905,000*	*$806,432,000*
Healthcare Treatment Fund, Prop 56 (3305)	*$1,259,038,000*	*$935,138,000*	*$1,053,518,000*
Health Plan Fines/Penalties Fund (3311)	*$8,700,000*	*$10,595,000*	*$9,096,000*
Medi-Cal Emerg Med Transport Fund (3323)	*$61,887,000*	*$63,121,000*	*$69,959,000*
Medi-Cal Drug Rebate Fund (3331)	*$0*	*$0*	*$1,440,526,000*
Whole Person Care Pilot Spec Fund (8107)	*$437,421,000*	*$419,861,000*	*$323,365,000*
Global Payment Program Spec Fund (8108)	*$1,246,043,000*	*$1,213,940,000*	*$1,026,722,000*
Desig Public Hosp GME Spec Fund (8113)	*$568,544,000*	*$359,528,000*	*$154,526,000*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2017-18**	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$203,063,000	$246,958,000	$237,675,000	($9,283,000)
Federal Funds[1]	$327,832,000	$467,752,000	$448,476,000	($19,276,000)
Special Funds/Reimb	$41,887,000	$60,973,000	$57,914,000	($3,059,000)
Total Expenditures	**$572,782,000**	**$775,683,000**	**$744,065,000**	**($31,618,000)**
Total Auth. Positions	**3502.9**	**3434.5**	**3557.8**	**123.3**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$20,366,160,000	$21,215,355,000	$23,405,017,000	$2,189,662,000
Federal Funds[1]	$57,055,664,000	$63,689,469,000	$66,234,871,000	$2,545,402,000
Special Funds/Reimb	$15,648,623,000	$17,228,907,000	$14,600,085,000	($2,628,822,000)
Total Expenditures	**$93,070,447,000**	**$102,133,731,000**	**$104,239,973,000**	**$2,106,242,000**
[1]*Federal Funds include Funds 0890, 7502, and 7503*				

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 13.2 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 2018 Medi-Cal Estimate - Overview

Budget Issue. The November 2018 Medi-Cal Local Assistance Estimate includes $98.5 billion ($20.7 billion General Fund, $62.7 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2018-19, and $100.7 billion ($22.9 billion General Fund, $65.4 billion federal funds, and $12.5 billion special funds and reimbursements) for expenditures in 2019-20.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$19,695,653,000	$21,851,207,000	$2,155,554,000
Federal Funds	$58,756,149,000	$61,717,409,000	$2,961,260,000
Special Funds/Reimbursements	$15,079,839,000	$12,458,842,000	($2,620,997,000)
Total Expenditures	**$93,531,641,000**	**$96,027,458,000**	**$2,495,817,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$808,388,000	$906,788,000	$98,400,000
Federal Funds	$3,793,253,000	$3,410,136,000	($383,117,000)
Special Funds and Reimbursements	$4,997,000	$4,589,000	($408,000)
Total Expenditures	**$4,606,638,000**	**$4,321,513,000**	**($285,125,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$175,298,000	$119,024,000	($56,274,000)
Federal Funds	$192,408,000	$231,883,000	$39,475,000
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$367,706,000**	**$350,907,000**	**($16,799,000)**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$20,679,339,000	$22,877,019,000	$2,197,680,000
Federal Funds	$62,741,810,000	$65,359,428,000	$2,617,618,000
Special Funds and Reimbursements	$15,084,836,000	$12,463,431,000	($2,621,405,000)
Total Expenditures	**$98,505,985,000**	**$100,699,878,000**	**$2,193,893,000**

Caseload. In 2018-19, the budget assumes annual Medi-Cal caseload of 13.2 million, a decrease of 1.2 percent compared to assumptions in the 2018 Budget Act. The department estimates 81.9 percent of

Medi-Cal beneficiaries, or 10.8 million, will receive services through the managed care delivery system while 18.1 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

In 2019-20, the budget assumes annual Medi-Cal caseload of 13.2 million, a 0.4 percent increase compared to the revised caseload estimate for 2018-19. The department estimates 81.8 percent of Medi-Cal beneficiaries, or 10.8 million, will receive services through the managed care delivery system while 18.2 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2018 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2018-19 General Fund Savings - The budget includes decreased General Fund expenditures in the Medi-Cal program of $2.3 billion in 2018-19 compared to the 2018 Budget Act. These savings are primarily attributable to the following factors:

- Successful resolution of federal Centers for Medicare and Medicaid Services (CMS) deferrals and a lower amount of projected deferrals – ($418 million savings)
- Long-Term Care Quality Assurance Fund transfers from providers who failed to pay the Quality Assurance Fee, which offsets General Fund expenditures in Medi-Cal – ($307 million savings)
- Hospital Quality Assurance Fee payments increased due to prior year adjustments and changes in timing – ($428 million savings)
- Drug rebate projections increased based on more recent data and rebate timing shifts – ($390 million savings)
- Base managed care projections decreased based on reduced caseload projections – ($248 million savings)

Medi-Cal Optional Expansion – The budget includes $17.3 billion ($1.5 billion General Fund and $15.7 billion federal funds) in 2018-19 and $20.1 billion ($2.2 billion General Fund and $17.8 billion federal funds) in 2019-20 for the optional expansion of Medi-Cal eligibility to childless adults up to 138 percent of the federal poverty level pursuant to the federal Affordable Care Act. The state assumed a six percent share of cost for the optional expansion population in calendar year 2018, a seven percent share in calendar year 2019, and will assume a ten percent share in calendar year 2020 and beyond.

Proposition 56 Supplemental Payments - The budget allocates $2.1 billion ($710.5 million Proposition 56 funds and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 funds and $1.4 billion federal funds) in 2019-20 for supplemental provider payments for services provided by physicians, dentists, women's health providers, intermediate care facilities for individuals with developmental disabilities, AIDS Waiver providers, home health providers, pediatric day health centers, and free-standing pediatric subacute facilities. The budget also includes three new investments with Proposition 56 revenues:

- Value-Based Payment Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to establish a Value-Based Payment Program through Medi-Cal managed care plans that will provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations.

- Developmental and Trauma Screenings – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to support the provision of developmental screenings for all children in Medi-Cal ages zero to 21 and trauma screenings for all adults and children in Medi-Cal. These payments will be in addition to the amounts paid generally for an office visit in fee-for-service delivery models or capitation paid in managed care delivery models.
- Family Planning – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) to provide additional fiscal support for family planning services in the Medi-Cal program.

Including these new proposals, the budget includes a total of $3.2 billion ($1.1 billion Proposition 56 funds and $2.1 billion federal funds) in 2019-20 for all supplemental payments related to Proposition 56 tobacco tax revenues.

Full-Scope Medi-Cal Expansion to Undocumented Young Adults - The budget includes $257.1 million ($194 million General Fund and $63.1 million federal funds) to expand full-scope Medi-Cal benefits to individuals age 19 to 25 who would otherwise be eligible for Medi-Cal, regardless of immigration status. DHCS estimates 138,000 undocumented young adults would receive full-scope Medi-Cal coverage under the expansion. DHCS is also proposing trailer bill language to increase redirection of county realignment funds from County Medical Services Program and other non-formula based counties under AB 85 (Committee on Budget), Chapter 24, Statutes of 2013. According to the Administration, this redirection would provide approximately $63 million of offsetting savings for the expansion of coverage.

Whole Person Care Housing Services - The budget includes $100 million General Fund in 2019-20 to provide counties and local entities with funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on people with mental illness. These funds would be available for expenditure through June 30, 2025.

Drug Rebates Fund - The budget proposes to create a new special fund, the Medi-Cal Drug Rebates Fund, beginning July 1, 2019. The newly established fund would fund health care services for Medi-Cal beneficiaries and would enhance management of drug rebate accounting and transparency. DHCS expects to deposit $1.4 billion of rebate revenues into the new special fund in 2019-20, all of which would offset General Fund expenditures in the Medi-Cal program.

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 2018-19 and 2019-20 fiscal years.

Issue 3: County Administration Estimate

Budget Issue. The budget includes $2 billion ($1 billion General Fund and $1 billion federal funds) in 2018-19 and $2.1 billion ($1 billion General Fund and $1 billion federal funds) in 2019-20 for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocation for county administration in 2018-19 is unchanged from the amount included in the 2018 Budget Act, while the allocation in 2019-20 reflects an increase of $53 million ($26.5 million General Fund and $26.5 million federal funds) compared to the revised 2018-19 estimate. The increase in the 2019-20 allocation is due to an adjustment that reflects an increase in the California Consumer Price Index.

County Administration Base* Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$1,007,289,500	$1,033,781,000	$26,491,500
0890 – Federal Trust Fund**	$1,007,289,500	$1,033,781,000	$26,491,500
Total Expenditures	**$2,014,579,000**	**$2,067,562,000**	**$52,983,000**

*As of the 2018 Budget Act, the County Administration Base includes ACA expenditures, no longer reflected separately.
** Federal fund adjustments for ACA and CHIP beneficiaries are budgeted separately. In this display, funding reflects a 50 percent federal match.

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.

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 to account for the increase in workload. As of the 2018 Budget Act, these additional amounts are included in the base allocation for county administration.

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, was meant to reflect changes in county operations as a result of implementation of the ACA. In 2014-15, the Legislature approved positions and contract funding to begin working on the new

methodology. According to DHCS, the approved staff were 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 a contractor to perform time/motion studies and make other estimates of county costs to assist in the development of the new methodology.

Cost-of-Doing-Business-Adjustment. DHCS reports it was unable to secure a vendor to develop the new budgeting methodology required by SB 28. The 2018 Budget Act included $54.8 million ($18.5 General Fund and $36.3 million federal funds) for a cost-of-doing-business adjustment for county eligibility workload. The adjustment is intended as an interim solution as the Administration and its county partners evaluate next steps for implementation of a budgeting methodology. The adjustment was calculated based on adjusting the existing level of funding by the California Consumer Price Index, which was estimated to be 2.8 percent in 2018-19. The Administration reported at the time that a similar increase would be applied in 2019-20 and 2020-21 as the county eligibility systems move to a single Statewide Automated Welfare System. The adjustment to the county eligibility base for 2019-20 reflects an estimated increase in the California Consumer Price Index of 2.63 percent.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item 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.

Issue 4: Medi-Cal Optional Benefits

Background. Federal Medicaid law requires certain benefits to be included in a state's Medicaid plan for providing services to its beneficiaries. In addition to the required benefits, states are authorized to include certain optional benefits for Medicaid beneficiaries. Both mandatory and optional benefits are eligible for federal matching funds. According to the federal Centers for Medicare and Medicaid Services, the mandatory and optional benefits in federal Medicaid laws and regulations are as follows:

Mandatory Benefits	Optional Benefits
Inpatient hospital services	Prescription Drugs
Outpatient hospital services	Clinic services
EPSDT	Physical therapy
Nursing Facility Services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diag./screening/preventive/rehab. services
FQHC services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental Services
Nurse Midwife services	Dentures
Certified Pediatric/Family NP services	Prosthetics
Freestanding Birth Center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling (pregnant women)	Other practitioner services
	Private duty nursing services
	Personal Care
	Hospice
	Case management
	Services for Individuals 65 or Older in an IMD
	Services in an ICF-DD
	State Plan HCBS - 1915(i)
	Self-Directed Pers. Assistance Services- 1915(j)
	Community First Choice Option- 1915(k)
	TB Related Services
	Inpatient psychiatric services-individuals under 21
	Other services approved by the Secretary
	Health Homes (for Chronic Conditions)- 1945

Elimination of Medi-Cal Optional Benefits. In 2009, facing a significant General Fund deficit, the budget included several reductions in reimbursement and benefits in the Medi-Cal program. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, eliminated several optional Medi-Cal benefits, including adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Recent budget and legislative actions have restored acupuncture services, full adult dental services, and optical benefits effective January 2020 upon inclusion by the Legislature in the budget process.

Costs to Restore Remaining Optional Benefits. According to DHCS, the costs to restore each of the previously discontinued optional benefits in 2019-20 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$3,814,000	$6,126,000	$9,940,000	$3,085,000
Chiropractic	$477,000	$4,714,000	$5,191,000	$1,371,000
Incontinence Creams/Washes	$7,019,000	$8,984,000	$16,003,000	$5,105,000
Optician/Optical Lab*	$16,939,000	$58,645,000	$75,584,000	$22,024,000
Podiatry	$2,105,000	$11,721,000	$13,826,000	$3,397,000
Speech Therapy	$243,000	$2,159,000	$2,402,000	$676,000
Grand Total	**$30,597,000**	**$92,349,000**	**$122,946,000**	**$35,658,000**

***** The 2017 Budget Act restored Optician/Optical Lab benefits January 2020 upon inclusion in the budget process.

Budget Does Not Include Restoration of Optical Benefits Approved in 2017. The 2017 Budget Act included restoration of full adult dental services effective January 1, 2018, and optical services effective January 1, 2020. The restored funding for optical services was accompanied by trailer bill language conditioning the restoration of the benefit on the Legislature "including funding for these services in the state budget process". However, the budget does not include funding for restoring the optical benefit effective January 1, 2020. According to the Administration, while funding was included in totals for the 2019-20 fiscal year at the time of the final 2017 Budget Act, the funding was removed from base totals in the subsequent fiscal year and is currently no longer reflected for 2019-20. It is unclear what action the Legislature would be required to take to fulfill the statutory requirement of including funding for optical services in the state budget process.

Various stakeholders have proposed restoration of previously discontinued optional benefits, addition of new benefits, and modification of existing benefits in the Medi-Cal program. These proposals are as follows:

Restoration of Remaining Optional Benefits – The Western Center on Law and Poverty (WCLP) and a coalition of other groups request $47.4 million ($13.6 million General Fund and $33.7 million federal funds) to restore the remaining optional benefits not previously restored. This request is in addition to the expected restoration of optical benefits in January 2020, as currently prescribed in statute adopted in the 2017 Budget Act. According to WCLP, access to these services prevents deterioration of health and the need to utilize costlier emergency services. For example, podiatry services are particularly critical

for many diabetics who often need more expensive services from complications if they don't get the podiatric services, including amputations. Access to podiatrists can prevent complications for patients and provide savings in addition to improved quality of life. Restoring audiology, podiatry, speech therapy, and incontinence creams and washes benefits would only cost the state about $13 million in General Fund dollars but would greatly improve health outcomes for many low-income Californians. In a time of recovery and surplus, it is paramount that the state's most vulnerable residents have access to these medically necessary services.

The California Podiatric Medical Association (CPMA) requests specifically to reinstate treatment performed by podiatrists in the Medi-Cal system and eliminate the unnecessary authorizations, billing, and service policies that apply to them, but not physicians, within the Medi-Cal system. According to CPMA, the elimination of the podiatry benefit removed Medicaid coverage by a type of provider (podiatrist), but not the services themselves, which may be provided by a physician or surgeon. Currently, podiatrists perform physician services and have full medical staff admitting and surgical privileges in hospitals and surgery centers. However, they are prohibited from providing podiatric services to patients in the Medi-Cal system unless certain conditions are met or the treatment is provided in a specific setting. This limitation on podiatry has led to delayed treatment of diabetic foot care, traumatic foot, and ankle injuries and has resulted in reduced access, higher costs, and a 31 percent rise in lower limb amputations between 2010 and 2016.

Asthma Education and Environmental Remediation Benefit – The California Pan-Ethnic Health Network (CPEHN), Children Now, and Regional Asthma Management and Prevention (RAMP) request total expenditure authority of $15 million ($7.5 million General Fund and $7.5 million federal funds) to provide access to medically necessary asthma education and home environmental trigger remediation for Medi-Cal beneficiaries with poorly controlled asthma. Specifically, these organizations request DHCS to allow qualified professionals that fall outside of the state's clinical licensure system to provide these services as long as a licensed practitioner has initially recommended the services. According to the proponents, ample research indicates asthma education, including home environmental assessments, frequently provides a return on investment due to decreased utilization of more costly health care services such as emergency department visits and hospitalizations Increasing access to asthma education and home environmental asthma trigger assessments will help fulfill California's Quadruple Aim of strengthening quality of care, improving health outcomes, reducing health care costs and advancing health equity.

Extension of Medi-Cal Eligibility for Post-Partum Women Suffering from Mental Health Disorders– The American College of Obstetricians and Gynecologists (ACOG) requests resources to expand Medi-Cal benefits for a postpartum woman from 60 days to one year if that woman is diagnosed with a maternal mental health disorder. According to ACOG, maternal mental health is of increasing concern because of the high prevalence of depression and anxiety during the perinatal period and the resulting long-term implications of delayed, inconsistent, or absent treatment. Maternal mental health conditions influence the well-being of mothers, children, families, and communities. Low-income women and women of racial and ethnic minorities are disproportionately affected by maternal mental health disorders, as they face unique barriers to diagnosis and treatment. While many of these women may already be enrolled in Medi-Cal, others, who do not meet Medi-Cal's income eligibility, are not.

Under current law, the income eligibility requirements for pregnancy-related Medi-Cal increases from 138 percent of the federal poverty level (FPL) to 213 percent of the FPL for women who are pregnant. Pregnant women whose income is above 213 percent of the FPL up to and including 322 percent of the FPL may qualify for assistance through the Medi-Cal Access Program (MCAP). While MCAP is comprehensive coverage, it does require a small fee (1.5 percent of annual family income) to participate. These programs enable more low-income women who may not otherwise qualify for Medi-Cal to receive medically necessary treatment to ensure the health of their pregnancy and baby.

These benefits end after 60 days from the birth of the child. Unless the new mom enrolls in a Covered California program, which requires her to pay a premium, any treatment she would be receiving would no longer be covered. She would either need to obtain commercial insurance or explore community resources that offer appropriate mental health services. This disruption in coverage could break the continuity of care and potentially halt treatment altogether. This is unhealthy for the mother and the baby.

Audiology Benefit Liaison Staff – The California Academy of Audiologists (CAA) requests funding and establishment of a position within DHCS to serve as a liaison between department program staff and audiologists providing services to Medi-Cal and California Children's Services (CCS) program beneficiaries. According to CAA, California audiologists have been forced to withdraw from the CCS program due to a number of problems, including insufficient reimbursement allowances and rates, delays in reimbursement requiring providers to pay out of pocket, and significant delay in CCS authorization for cochlear implants, which can be used for early intervention for children with hearing loss. The significant delay in obtaining early intervention puts these children at risk of language delay or aberrant language development.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. Please provide the Administration's rationale for not including funding for optical benefits restored as part of the 2017 Budget Act effective January 1, 2020.

Issue 5: Managed Care Enrollment Tax

Budget Issue. SB 2 X2 (Hernandez), Chapter 2, Statutes of 2016, Second Extraordinary Session, authorized a three-year tax on enrollment of health care service plans operating in California. The revenue from this tax serves as the non-federal share of increased capitation payments to managed care organizations providing services to Medi-Cal beneficiaries, as well as other expenditures in the Medi-Cal program. Because the revenue provides the non-federal share for these expenditures, overall General Fund spending in the program is reduced. The budget includes a total General Fund offset related to the managed care organization (MCO) enrollment tax of $1.9 billion in 2018-19 and $583.4 million in 2019-20. Although the MCO enrollment tax expires on July 1, 2019, there is a three-month lag in collections of the tax, which leads to the additional General Fund offset in 2019-20. SB 2 X2 also contained tax reform components that exempted payers of the MCO enrollment tax from liability for the state's gross premiums tax and from the business and corporations tax.

The budget does not include a proposal to reauthorize the MCO enrollment tax. As a result, expiration of the tax as scheduled on July 1, 2019, will result in a reduction in tax revenue available to offset General Fund expenditures in the Medi-Cal program of approximately $1.3 billion.

Federal Requirements for Health Care Related Taxes. Section 433.68 of Title 42 of the Code of Federal Regulations (42 CFR 433.68) authorizes state Medicaid programs to receive federal financial participation for expenditures using health care-related taxes, as long as certain conditions are met. The MCO enrollment tax qualifies as a health care-related tax. Taxes must be:

1) Broad-based – For a health care related tax to be considered broad based, it must be imposed on all non-federal and non-public providers in the state or jurisdiction imposing the tax.
2) Uniformly imposed – For a health care related tax to be considered uniform, it must be applied at the same rate for all affected providers.
3) No hold-harmless provisions – A taxpayer cannot be held harmless for the amount of the tax. A taxpayer is considered to be held harmless if there is a correlation between their Medicaid payments and the tax amount, all or any portion of the Medicaid payment varies based only on the tax amount, or the state or other taxing jurisdiction provides for any direct or indirect payment or other offset for all or any portion of the tax amount.

States may apply for waivers to both the broad-based and uniform requirements.

For a waiver of the broad-based requirements, a state must demonstrate that the tax is "generally redistributive" by calculating the proportion of tax revenue applicable to Medicaid under a broad-based tax (P1) and comparing it to the same proportion under the proposed tax (P2). A waiver may be approved if the ratio of P1/P2 is at least 0.95, and the excluded providers are in a list of providers defined in the regulation.

For a waiver of the uniform requirements, a state must measure the ratio of the slope of a linear regression equation of a broad-based and uniform tax (B1) compared to the proposed tax (B2). The ratio of B1/B2 must be at least 0.95, and the excluded providers are in a list of providers defined in the regulation. The MCO enrollment tax applied for a waiver of the uniform requirement, and its structure was designed to comply with the required B1/B2 ratio.

Offsets of General Fund Expenditures with the MCO Enrollment Tax. The MCO enrollment tax provides General Fund savings of between $1.2 billion and $1.9 billion annually over the three years of the tax. The flow of funds that allows this tax revenue to be used for costs that would have otherwise been borne by the General Fund are as follows:

1) Tax revenue is received from health care service plans based on the tiered tax structure in SB 2 X2. This revenue is deposited into the Health and Human Services Special Fund (Fund 3293). The 2018 Budget Act assumed total revenue of $2.3 billion in 2016-17 and $2.4 billion in 2017-18. The 2019 January budget assumes total revenue of $2.6 billion in 2018-19.
2) Tax revenue is used to offset General Fund expenditures for capitation rate increases to cover the MCO enrollment taxes paid by Medi-Cal managed care plans. The 2017 Budget Act assumed the General Fund expenditures offset for this purpose were $521.7 million in 2016-17. The 2018 Budget Act assumed a General Fund expenditure offset of $809.8 million in 2017-18. The 2019 January budget assumes a General Fund expenditure offset of $660.3 million in 2018-19 and $223 million in 2019-20.
3) The remaining tax revenue is used to offset other expenditures that would have been funded by the General Fund. The 2017 Budget Act assumed General Fund savings of $1.2 billion in 2016-17. The 2018 Budget Act assumed $1.6 billion General Fund savings in 2017-18. The 2019 January budget assumes $1.9 billion General Fund savings in 2018-19 and $583.4 million in 2019-20.

History of Provider-Related Taxes on Managed Care. California imposes three provider-related taxes: a fee on certain general acute-care hospitals (Hospital Quality Assurance Fee or HQAF), a fee on free-standing skilled nursing facilities (AB 1629 Quality Assurance Fee), and a tax on enrollment in health care service plans in the state of California (MCO Enrollment Tax). Provider-related taxes on managed care organizations were first authorized in 2003.

2003 - Quality Improvement Fee. AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, authorized the state's first provider fee on Medi-Cal managed care organizations. The fee was implemented in July 2005 as a quality improvement fee of 5.5 percent of a plan's revenue. The 2005 Governor's Budget assumed net General Fund savings of $37.7 million as a result of the fee. The fee was allowed to expire in October 2009, as the federal government disallowed the fee because it was not sufficiently broad-based and, therefore, in violation of the relevant Medicaid regulations.

2009 - Gross Premiums Tax. AB 1422 (Bass), Chapter 157, Statutes of 2009, replaced the previous quality improvement fee with an extension of the state's existing gross premiums tax of 2.35 percent to Medi-Cal managed care plans. The tax had previously only been levied on insurance products, but taxation of Medi-Cal managed care plans under this existing tax regime was sufficient to comply with federal Medicaid regulations and guidance that the tax be broad-based. AB 1422 provided that revenue from the tax would serve as the non-federal share for expenditures in both the Medi-Cal program and the state's program for the federal Children's Health Insurance Program, known as the Healthy Families Program. The 2010 Budget Act assumed the gross premiums tax would provide $99.8 million to Medi-Cal and $82 million to Healthy Families in the 2009-10 fiscal year. The gross premiums tax was extended by SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, and

again by AB 21 X1 (Blumenfield), Chapter 11, Statutes of 2011, First Extraordinary Session, until June 30, 2012.

2012 - Managed Care Organization Tax. The gross premiums tax expired on July 1, 2012, as the Legislature was unable to approve trailer bill language to continue the tax after its expiration. This left the Medi-Cal and Healthy Families Programs with a significant deficiency in their budgets. SB 78 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2013, extended the gross premiums tax at its previous rate of 2.35 percent until June 30, 2013. SB 78 then authorized a tax of 3.9375 percent, equal to the state's portion of the sales and use tax, on the operating revenue of Medi-Cal managed care organizations, known as the MCO tax. The tax was authorized for three years, until June 30, 2016. The 2013 Budget Act assumed General Fund savings of $304.6 million for the Medi-Cal program from the MCO tax. Over subsequent years, additional populations began to enroll in Medi-Cal managed care, particularly related to the optional expansion of Medi-Cal authorized by the federal Affordable Care Act. As a result, General Fund savings from the MCO tax grew significantly because the tax was a percentage of overall expenditures on Medi-Cal managed care. The 2016 Budget Act assumed $971.2 million of annual General Fund savings in the 2015-16 fiscal year, the last year of operation of the sales-tax-related structure of the MCO tax.

Managed Care Enrollment Tax. In 2014, the federal government released guidance indicating that the structure of the state's MCO tax did not comply with federal Medicaid regulations. The state was instructed to make any necessary statutory changes to bring the tax into compliance by the end of the next scheduled legislative session, or the end of 2016. SB 2 X2, authorized the current tax on enrollment of managed care plans statewide, along with certain tax reform provisions. SB 2 X2 created a tiered tax on the enrollment of health care service plans based on their enrollment as reported to the Department of Managed Health Care for the 12 month period of October 1, 2014 through September 30, 2015, known as the "base year". There are three sets of tiers : 1) Medi-Cal enrollees, 2) Alternate Health Care Service Plan (AHCSP) enrollees (such as Kaiser), and 3) all other enrollees. Each tier, based on the number of member months, has a different tax rate per enrollee. DHCS used the following taxing tier structure to determine the MCO enrollment tax for 2018-19:

Medi-Cal			
Enrollees (Member Months)	Rate	Average Enrollment/Entity	Tax Revenue
0-2,000,000	$45.00	39,161,294	$1,762,259,000
2,000,001-4,000,000	$21.00	21,180,988	$444,801,000
Over 4,000,000	$1.00	48,831,000	$48,831,000

Non-Medi-Cal (including AHCSP)			
Enrollees (Member Months)	Rate	Average Enrollment/Entity	Tax Revenue
0-4,000,000	$8.50	25,757,753	$218,941,000
4,000,001-8,000,000	$3.50	16,832,337	$58,913,000
Over 8,000,000	$1.00	20,244,000	$30,244,000

Prospects for Federal Approval of a Reauthorized MCO Enrollment Tax. DHCS reports that, while CMS expressed concerns about the structure of the current MCO enrollment tax, no change in federal regulations was implemented in response to those concerns. In addition, CMS approved a similar tax on managed care organizations in Michigan in December 2018. Similar to California's MCO enrollment tax, Michigan's Insurer Provider Assessment taxes managed care plans in a tiered structure and the state reduced or eliminated other state taxes to reduce the overall tax liability on plans. These developments suggest CMS is likely to approve a reauthorization of a California MCO enrollment tax with similar features.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. Why did the Administration elect not to propose reauthorization of the MCO enrollment tax?

3. Is the Administration aware of any federal or other barriers to reauthorization of the MCO enrollment tax?

Issue 6: Cybersecurity Program Augmentation

Budget Issue. DHCS requests three positions and expenditure authority of $1.2 million ($591,000 General Fund and $591,000 federal funds) in 2019-20 and $1.2 million ($578,000 General Fund and $577,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address cybersecurity risks identified by independent security assessments conducted by the California Military Department and the Office of Health Information Integrity. Included in the resource request is $575,000 ($288,000 General Fund and $287,000 federal funds) annually for the ongoing costs of additional enterprise security infrastructure tools.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$591,000	$578,000
0890 – Federal Trust Fund	$591,000	$577,000
Total Funding Request:	**$1,182,000**	**$1,155,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, cyberattacks have been on the rise every year and the department has seen a dramatic increase in the sophistication and volume of attacks. International cybercriminal organizations and nation states have access to state-of-the-art tools and experts that work continuously to attack organizations with large amounts of data. Currently, DHCS averages between one and four million attacks per month against its firewall, and these are only the attacks that get past the state data center's firewall and their own sophisticated intrusion prevention system. Should an attack be successful and get past the firewall, there is a significant chance it could result in a data breach of protected health information. As of June 2018, there have not been any significant breaches of the DHCS firewall. However, industry breaches at major organizations have shown they can go undetected for months or even years.

Security Assessments of DHCS Systems. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department.

As required by AB 670, the California Military Department's CND Team performed an independent security assessment (ISA) of DHCS in 2017. The assessment criteria was based upon agreed standards set forth by the California Information Security Office. The ISA identified areas with low maturity in cybersecurity. The CND report dated January 10, 2018, identified 14 findings requiring remediation. DHCS will be able to partially remediate some of these findings using existing resources, however additional permanent staff and software tools are required for complete and ongoing remediation. CND will re-assess DHCS every two years, so temporary remediation is not sufficient.

The California Office of Health Information Integrity (CalOHII) has statutory authority over all Health Insurance Portability and Accountability Act (HIPAA) impacted state entities within the executive branch and implements statewide policy according to the requirements of the HIPPA Implementation Act of 2001 (Health and Safety Code Section 130300, et seq.). CalOHII completed a compliance review of DHCS in 2017 based upon its requirements under the Statewide Health Information Policy Manual (SHIPM).

The CalOHII compliance assessment dated April 7, 2017, identified 26 areas of non-compliance with SHIPM. The assessment included 16 high-risk, eight medium-risk, and two low-risk areas of non-compliance. DHCS has identified three of the CalOHII findings (two high-risk, one medium-risk) as requiring additional resources to remediate. Similar to the CND findings, complete and ongoing remediation requires additional permanent staff and software tools.

DHCS requests three positions and expenditure authority of $1.2 million ($591,000 General Fund and $591,000 federal funds) in 2019-20 and $1.2 million ($578,000 General Fund and $577,000 federal funds) annually thereafter. If approved, these resources are intended to address 17 of 40 total findings between the two assessments which are resource constrained, with work prioritized by risk level. The other 23 findings are being remediated using existing DHCS staff and tools.

Included in the resource request is $575,000 ($288,000 General Fund and $287,000 federal funds) annually for the ongoing costs of additional enterprise security infrastructure tools. These tools include a firewall rules analyzer ($50,000), an application audit log analytics monitoring tool ($475,000), and a web application firewall ($50,000). The requested staffing resources are as follows:

- **One Information Technology Specialist II - Configuration Management, Patching and Hardening -** This position would lead the effort to improve secure configuration and patching of all IT assets, including secure management of end point configurations, patching, hardening, access controls, validating least administrative privilege, IT asset management, encryption, malicious code protection, port hardening, credentials, accounts, sensitive data leakage, and phishing prevention.

- **One Information Technology Specialist II - IT Application Security -** This position would lead the effort to improve application level security for over 40 DHCS critical IT applications including: 1) performing vulnerability and penetration tests of IT applications, 2) managing web application firewalls, 3) managing audit trail monitoring, 4) configuring and validating secure and compliant IT applications, 5) monitoring IT applications for anomalous activity, 6) network zone security, and 7) managing a centralized IT application inventory.

- **One Information Technology Specialist II - Technical Risk Management -** This position would lead the effort to improve conduct of continuous, thorough, enterprise level risk assessments of common controls, IT application controls, policies, procedures, and training. This position would manage a centralized enterprise-level process to track, mitigate and resolve all identified deficiencies, including risk reporting.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 7: Electronic Health Record Incentive Program Audits

Budget Issue. DHCS requests expenditure authority of $294,000 ($29,000 General Fund and $265,000 federal funds) in 2019-20, 2020-21, and 2021-22. If approved, these resources would allow DHCS to support program and audit close outs associated with the Medi-Cal Electronic Health record Program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$29,000	$29,000
0890 – Federal Trust Fund	$265,000	$265,000
Total Funding Request:	**$294,000**	**$294,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and Resources requested until 2021-22.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes approximately $4.5 billion for California for both the Medicare and Medi-Cal Electronic Health Records (EHR) incentive programs. Of the $4.5 billion for California, it is estimated that approximately $2 billion in incentive payments will be made through the Medi-Cal EHR Incentive Program to qualified Medi-Cal health care providers who adopt, implement, or upgrade and meaningfully use electronic health records in accordance with federal requirements. DHCS' Office of Health Information Technology (OHIT) manages and administers the incentive payments to eligible Medi-Cal providers and hospitals.

Since the implementation of the Medi-Cal EHR Incentive Program, OHIT has authorized more than 48,000 incentive payments to over 25,000 providers and over 300 hospitals. This has resulted in more than $1.5 billion in federal incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program for an estimated total of approximately $2 billion distributed over the course of the program.

The Medi-Cal EHR Incentive Program is currently scheduled to operate through December 31, 2021. However, according to DHCS, the program and audit close outs would extend beyond 2021 based on recent federal guidance. The 2016 Budget Act included three-year, limited-term expenditure authority of $403,000 ($41,000 General Fund and $362,000 federal funds) for the Medi-Cal EHR Incentive Program to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre- and post-payment audits and investigations for program eligible managed care and fee-for-service providers. These resources support **two Health Program Auditor IV (HPA IV)** positions in the Audits and Investigations unit to perform pre-payment and post-payment audits of applicants for EHR incentive payments. These audits include review of first-year applications and follow-up review for verification of provider meaningful use of the technology.

DHCS requests expenditure authority of $294,000 ($29,000 General Fund and $265,000 federal funds) for an additional three years. These resources would continue to support the two HPA IV positions and their audit workload to allow close-out of the Medi-Cal EHR Incentive Program consistent with federal guidance.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 8: Every Woman Counts Program Staffing

Budget Issue. DHCS requests conversion of one expiring, limited-term position to permanent and expenditure authority of $175,000 from the Breast Cancer Control Account annually. If approved, this position and resources would allow DHCS to continue ongoing data management, programming, and data analysis requirements for the Every Woman Counts program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0009 – Breast Cancer Control Acct, Breast Cancer Fund	$175,000	$175,000
Total Funding Request:	**$175,000**	**$175,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

Background. The Every Woman Counts (EWC) program, established in 1991, provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP). EWC serves as the California site of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which is funded through federal grant funds, and the state and federal Breast Cancer Control Program.

According to DHCS, Detecting Early Cancer (DETEC) is a web-based data collection system where providers enter client level data reported to the Centers for Disease Control and Prevention (CDC) and NBCCEDP. The NBCCEDP grant requires grantees to submit the program's data deliverables twice a year and, starting in 2018-19, EWC will be required to submit additional clinic-based data on patient navigation, program evaluation, and evidence-based interventions.

The 2016 Budget Act included federal fund expenditure authority of $399,000 for three years to perform programming, data analysis, and data management functions for the EWC program. These resources supported three positions, including **one Information Technology Specialist I (ITS I)** position in the program's Benefits Division. DHCS requests conversion of this position to permanent and expenditure authority of $175,000 from the Breast Cancer Control Account annually.

This position has been responsible for data collection for federal grant reporting, claims data import and processing, conducting record linkages, monitoring and troubleshooting DETEC data import, data cleaning and monitoring, and creating and exporting databases and tables. In addition, according to DHCS, a contract with San Diego State University Research Foundation (SDSURF) will expire on June 30, 2018. The contractor was responsible for oversight of the Regional Contractors Management Information System (RCMIS) data system used to collect and manage the scope of work deliverables of EWC's regionally contracted Health Educators and Nurses. Currently, monthly data files are shared with SDSURF and on July 1, 2018, this activity will cease. The Clinical Coordination and Health Education for EWC Regions (CHEER) data system is being developed by a contractor to replace RCMIS. According to DHCS, the existing ITS I designed the specifications and system logics for the CHEER system, is responsible for overseeing development of the system by the contractor, and would be responsible for system management once implemented.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 9: Office of Legislative and Governmental Affairs Staffing

Budget Issue. DHCS requests two positions and expenditure authority of $247,000 ($124,000 General Fund and $123,000 federal funds) annually. If approved, these resources would allow DHCS to support workload in the Office of Legislative and Governmental Affairs, which responds to external inquiries and prepares fiscal and programmatic analyses of pending legislation or budget proposals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$124,000	$124,000
0890 – Federal Trust Fund	$123,000	$123,000
Total Funding Request:	**$247,000**	**$247,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, the Office of Legislative and Governmental Affairs (LGA) provides guidance to the California Health and Human Services Agency (CHHSA), the Department of Finance, the Governor's Office, and to other department divisions. LGA also coordinates the provision of technical assistance to legislative staff on legislative policy and budget issues, and serves as the direct contact point for legislative offices, Department of Finance and the Governor's Office regarding constituent and legislative inquiries. LGA's staff assignments include researching, reading and drafting complex documents, coordinating and attending inter- and intra-departmental and external meetings, coordinating stakeholder input and communications, and preparing briefings for legislators and their staff.

In response to increased workload, DHCS reports it redirected two limited-term Associate Governmental Program Analyst (AGPA) positions to LGA in 2017-18 to augment the four existing legislative coordinators. LGA reports the number of bill analyses it coordinates increased 29 percent in 2017 and 22 percent in 2018. LGA prepares evaluations of the fiscal impact for each bill affecting the department, which are shared with the Senate and Assembly Appropriations Committees and the Department of Finance. After legislation is approved and sent to the Governor, LGA completes an Enrolled Bill Report to advise the Governor's Office of DHCS' position on the bill.

DHCS requests establishment of **two AGPA positions** to replace the limited-term resources utilized to redirect the two existing positions in 2017-18. According to DHCS, the current workload level for LGA is ongoing and these permanent positions and resources are required to support the high volume of legislative and constituent inquiries.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 10: Whole Child Model Evaluation Contract Funding

Budget Issue. DHCS requests expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021. If approved, these resources would allow DHCS to secure a contractor to perform an independent evaluation of the Whole Child Model implementation. An identical level of one-time resources was previously approved, but unspent, in the 2018 Budget Act.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	[($800,000)]	$800,000
0890 – Federal Trust Fund	[($800,000)]	$800,000
Total Funding Request:	**[($1,600,000)]**	**$1,600,000**
Total Requested Positions:	**0.0**	**0.0**

* Unspent expenditure authority approved in 2018-19 will revert to the General Fund and Federal Trust Fund.

Background. SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorizes DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. Services previously provided to CCS beneficiaries on a fee-for-service basis will be delivered by Medi-Cal managed care plans. After stakeholder discussions, DHCS will implement the Whole Child Model program in 21 counties with 5 health plans to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

The 21 counties and 5 health plans that will participate in the Whole Child Model are as follows:

- Participating Counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, San Mateo, Orange, Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity, and Yolo
- Participating Health Plans: CenCal Health, Central California Alliance for Health, Health Plan of San Mateo, CalOptima, Partnership Health Plan of California

Six COHS counties implemented the Whole Child Model on July 1, 2018. Partnership Health Plan, operating in 14 counties, implemented the Whole Child Model on January 1, 2019. CalOptima, operating in Orange County, is scheduled to implement the Whole Child Model no sooner than July 1, 2019. The budget includes $28.5 million ($12.8 million General Fund and $15.7 million federal funds) in 2018-19 and $791,000 ($365,000 General Fund and $426,000 federal funds) in 2019-20 for implementation of the Whole Child Model.

SB 586 requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the

patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home.

The 2018 Budget Act included $1.6 million for DHCS to secure a contractor to perform this evaluation. The resources were included in a budget change proposal related to California's Section 1115 Waiver: Medi-Cal 2020. According to DHCS, due to the delay of Whole Child Model implementation from 2017 to 2018, the finalization of the evaluation design and associated metrics was postponed and the previously allocated funding will remain unspent.

DHCS requests expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021. If approved, these resources would allow DHCS to conduct the program evaluation of the Whole Child Model required pursuant to SB 586.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 11: CA Dental Medicaid Management Information System Contract Management Staffing

Budget Issue. DHCS requests four positions and expenditure authority of $700,000 ($175,000 General Fund and $526,000 federal funds) annually. If approved, these resources would allow DHCS to support the transition to two new vendors for the California Dental Medicaid Management Information System.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$175,000	$175,000
0890 – Federal Trust Fund	$526,000	$526,000
Total Funding Request:	**$700,000**	**$700,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2020-21.

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. DHCS provides dental services to Medi-Cal beneficiaries through two primary delivery systems: 1) dental managed care (DMC) and 2) fee-for-service. For DMC beneficiaries, the department contracts with six DMC plans that provide dental care to approximately 960,000 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.

For fee-for-service beneficiaries, the department contracts with fiscal intermediary (FI) and administrative services organization (ASO) vendors to manage the delivery of dental care to Medi-Cal beneficiaries and oversee administrative processes such as claims processing, provider enrollment, and beneficiary outreach. Beginning in 2004, Delta Dental provided both FI and ASO services under a multi-year contract with DHCS for the administration of the Denti-Cal program and delivery of benefits. However, in 2012, the federal Centers for Medicare and Medicaid Services (CMS) determined the contract with Delta Dental did not meet federal regulatory criteria and conditions as a Medicaid Management Information System (MMIS). CMS asked DHCS to modify the contracting delivery model or risk losing the enhanced 75 percent federal match for MMIS activities. According to DHCS, the main concerns identified by CMS were:

- Non-compliance with MMIS requirements,
- Non-enforcement of Knox-Keene licensure requirements, and
- Use of a hybrid model of MMIS and administration within one contract with underwriting risk sharing.

In 2016, DHCS awarded two separate contracts for the FI and ASO responsibilities in the Denti-Cal program. DXC Technology Services was awarded the FI contract, which includes responsibility for operation of the California Dental Medicaid Management Information System (CD-MMIS), including claims processing, quality management operations, and system enhancements. Delta Dental was awarded the ASO contract, which includes responsibility for claims and treatment authorization request processing, telephone service center operations, provider enrollment, and beneficiary outreach. The

contract takeover process began in January 2017, with the two vendors assuming operational responsibilities in February 2018.

The 2016 Budget Act included three-year expenditure authority of $2.1 million ($514,000 General Fund and $1.5 million federal funds) to support the equivalent of seven three-year limited-term positions and contractual services to address workload related to the turnover and takeover of the Medi-Cal Dental FI contract into two separate FI and ASO services contracts. The limited-term expenditure authority supported four positions in the Enterprise Innovation and Technology Services (EITS) division, two positions in the Medi-Cal Dental Services Division (MDSD), and one position in the Office of Legal Services (OLS).

DHCS requests establishment of four positions and expenditure authority of $700,000 ($175,000 General Fund and $526,000 federal funds) annually to continue to support the transition to two new vendors. The department is requesting permanent establishment and funding, previously supported by the limited-term resources, for the following positions:

EITS

- **Two Information Technology Specialist I** positions would assess vendor deliverables and work products, review and approve invoices, apply principles of the Software Development Life Cycle to change instrument processes in the contracts, attend weekly project and operational status meeting with contractors, ensure contractors are on schedule with implementation of operational tasks, and prepare written status reports as required.

MDSD

- **One Associate Governmental Program Analyst** will review, assess, analyze, track and report on the new contract requirements, as well as conduct quality assessments, monitor contractor performance, interpret and research terms and conditions of the contracts, analyze and identify contract impact of legislative changes on the contracts, and serve as liaison between the state and the contractors.

OLS

- **One Attorney III** position will review and approve all contract amendments and change orders, provide legal analyses, serve as point of contact for all litigation issues, advise on disputes related to the contracts, monitor compliance with CMS guidance and state contracting rules, and respond to legal inquiries and correspondence from outside entities.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 12: Childhood Lead Poisoning Prevention (SB 1041)

Budget Issue. DHCS requests one position and expenditure authority of $144,000 ($72,000 General Fund and $72,000 federal funds) annually. If approved, these resources would allow DHCS to provide Medi-Cal data to the Department of Public Health for additional blood lead level reporting pursuant to SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$72,000	$72,000
0890 – Federal Trust Fund	$72,000	$72,000
Total Funding Request:	**$144,000**	**$144,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

Background. The Childhood Lead Poisoning Prevention (CLPP) program was established in 1986 at the Department of Public Health to take steps necessary to reduce the incidence of childhood lead exposure in California. The program focuses on young children considered at increased risk for lead exposure, particularly those receiving publicly-funded services such as Medi-Cal and WIC, or those living in older housing stock with lead-based paint or lead-contaminated dust and soil. Children at high risk of exposure are required to be blood tested for lead and children with high blood lead levels are eligible for CLPP services.

There are 43 local CLPP programs in 40 counties and three cities that provide services to eligible children under a contract with the state. The state CLPP program provides services to eligible children in the remaining 18 counties. These services include outreach to populations at high risk of lead exposure, educational and other services for children with high blood lead levels, full public health nursing and environmental services to children with lead poisoning, and follow-up to ensure sources of lead exposure are removed. The state CLPP program also provides information on laboratory reported lead tests to local CLPP programs; and statewide surveillance, data analysis, oversight, outreach and technical assistance for all counties.

SB 1041 Requires Additional Reporting on Blood Lead Testing for Children in Medi-Cal. SB 1041 requires the Childhood Lead Poisoning Prevention Program (CLPP) within the Department of Public Health to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for use in its biennial lead poisoning case management public reporting. While the CLPP data systems contain information about lead screening, the Management Information System/Decision Support System (MIS/DSS) and Medi-Cal Eligibility Data System (MEDS) databases at DHCS contain the most complete information about Medi-Cal participation and billing of services.

DHCS requests **one Research Data Specialist II** position and expenditure authority of $144,000 ($72,000 General Fund and $72,000 federal funds) annually. This position would support the data analytics necessary to provide CLPP with analysis and other support of Medi-Cal client-level data to

prepare the report required by SB 1041. This position would also be responsible for developing a methodology to identify children enrolled in Medi-Cal who are at the required ages for blood lead level testing or in an age range requiring catch-up testing.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 13: Strengthening Fiscal Estimates and Cash Flow Monitoring

Budget Issue. DHCS requests 25 positions and expenditure authority of $3.8 million ($1.8 million General Fund and $2 million federal funds) in 2019-20 and $3.6 million ($1.7 million General Fund and $1.9 million federal funds) annually thereafter. If approved, these resources would allow DHCS to improve the accuracy of the Medi-Cal and Family Health Local Assistance Estimates and provide additional oversight and monitoring of the department's cash flow.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,814,000	$1,706,000
0890 – Federal Trust Fund	$1,998,000	$1,881,000
Total Funding Request:	**$3,812,000**	**$3,587,000**
Total Requested Positions:	**25.0**	**25.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, the Medi-Cal budget makes up a significant portion of the state's annual General Fund expenditures, estimated to be $98.5 billion ($20.7 billion General Fund, $62.7 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2018-19, and $100.7 billion ($22.9 billion General Fund, $65.4 billion federal funds, and $12.5 billion special funds and reimbursements) for expenditures in 2019-20. The Medi-Cal budget is on a cash basis, rather than an accrual basis, of accounting, which means the timing of transactions can significantly disrupt fiscal year budgetary estimates. Currently, DHCS' fiscal functions are performed by the Administration Division's Financial Management Branch, which manages budgets and accounting, and the Fiscal Forecasting Division, which develops the Medi-Cal and Family Health Local Assistance Estimates.

Welfare and Institutions Code section 14100.5 requires DHCS to submit an estimate of Medi-Cal expenditures twice a year: once in November for release with the Governor's Budget, and once in April for release with the May Revision. At the same time, DHCS prepares a twice-yearly Family Health Estimate for several non-federal programs. These two estimates are highly detailed and forecast expenditures, caseload, and the impact of regulatory and state and federal policy changes in these programs. The estimates include base program estimates, plus over 300 policy changes that itemize specific programs or changes to base expenditures. The estimates are subject to the analysis of the Department of Finance, the Legislative Analyst's Office, the Legislature, and other stakeholders. The Fiscal Forecasting Division is the primary division responsible for preparing the estimates, based on input from all other DHCS divisions.

During 2017 and 2018, DHCS found variances in excess of $500 million General Fund between the estimates and actual expenditures. Monthly General Fund cash flow projections significantly fluctuated in 2016-17 and 2017-18. DHCS, in partnership with the Department of Finance, initiated a comprehensive, ongoing effort to identify the major programs and factors contributing to the fluctuations in cash flow and Medi-Cal Estimate variances, and the solutions and associated resources needed to improve the accuracy of the Estimates and implement a monthly cash reconciliation process.

DHCS requests 25 positions and expenditure authority of $3.8 million ($1.8 million General Fund and $2 million federal funds) in 2019-20 and $3.6 million ($1.7 million General Fund and $1.9 million federal funds) annually thereafter to improve the accuracy of the Medi-Cal and Family Health Local Assistance Estimates and provide additional oversight and monitoring of the department's cash flow. These positions would be distributed among eight department divisions, as follows:

Executive – Director's Office – One position

- **One Chief Financial Officer** would provide heightened, consolidated, deputy-level leadership of DHCS' fiscal operations, including Budgets, Accounting, and Fiscal Forecasting.

Administration – Accounting Section – Four positions

- **One Accounting Administrator I** position would centralize accounting responsibilities for monitoring and managing the department's cash flow.
- **Three Associate Accounting Analysts** would assist with reconciling cash balances with projected and actual expenditures.

Capitated Rates Development Division – Two positions

- **One Associate Governmental Program Analyst** would assist with compiling and providing monthly managed care payment rate updates to internal DHCS programs.
- **One Research Data Specialist** would research differences between projected and actual expenditures for the managed care program.

Fiscal Forecasting Division: Oversight and Monitoring Cash – Four positions

- **One Staff Services Manager II** position would lead a unit of five total staff dedicated to the development and tracking of monthly cash management reporting.
- **Two Research Data Specialist I** positions and **one Research Data Analyst I** position would develop monthly cash management reports, assist in researching differences between estimated cash flows and actual expenditures, and coordinate cash management within DHCS.

Fiscal Forecasting Division: Strengthening Local Assistance Estimates – Six positions

- **Two Health Program Specialist I** positions would perform detailed analyses of proposed policy changes in the local assistance estimates, perform data verification and engage more frequently and closely with program staff.
- **Three Research Data Specialist II** positions and **one Research Data Specialist I** position would coordinate the impact of changes in statewide eligibles for specialty mental health services and apply consistent cash-basis methodology, manage changes in estimation methods for the Medi-Cal dental program, research and develop changes to overall estimate methodology, provide timely estimate-specific data, expand the Medi-Cal data knowledge base of existing staff, and build innovative analytical datasets to aid in evaluating trends and future projections.

Managed Care Operations Division – Two positions

- **One Research Data Specialist II** position would conduct complicated fiscal research and analysis using advanced research methodologies and statistical procedures, and would be responsible for cash management, reconciliation, and reporting activities.

- **One Information Technology Specialist II** position would oversee and monitor all project management activities related to the Medi-Cal managed care program fiscal efforts, and would serve as a liaison between several divisions for system updates and refinements.

Office of HIPAA Compliance – Two positions

- **One Information Technology Specialist I** position would serve as a software developer to continue development efforts within the department's capitation payment system, implementing change requests from program areas to streamline payments, modernize outdated system modules, transition to electronic delivery of invoices, and assist with development of the managed care portion of the system.
- **One Information Technology Specialist I** position would serve as a systems analyst to initiate knowledge transfer from vendor staff, build documentation in various parts of the system, lead implementation of onboarding of new managed care plans, assist existing managed care plans with inquiries about system-related transactions, and perform systems analysis and quality assurance testing for future releases in a new system.

Pharmacy Benefit Division – One position

- **One Health Program Specialist I** position would work with divisions impacted by Medi-Cal drug rebates, oversee and manage all related efforts to address the tracking and monitoring of the drug rebate program, and develop and document processes within and across divisions to provide information for monthly cash reconciliation.

Third Party Liability Recovery Division – Three positions

- **Two Research Data Analyst II** positions would independently analyze collection activity for all quality assurance fee programs, maintain and create statistical reports to update management on program status, recommend changes to enhance program collections, initiate and track withhold transfers on debt collected, and keep stakeholders informed of program collection activities.
- **One Associate Governmental Program Analyst** would independently analyze fee collection activity and review changes in Medi-Cal and Medicare laws and regulations that could impact fee recovery programs.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. Please describe the steps DHCS is taking to better manage its cash flow and estimates to avoid the substantial General Fund variances typical of recent fiscal years.

Issue 14: Medi-Cal Drug Rebate Fund

Budget Issue and Trailer Bill Language Proposal. DHCS requests trailer bill language to establish the Medi-Cal Drug Rebate Fund to deposit the proceeds of rebates on prescription drugs purchased on behalf of Medi-Cal beneficiaries. If approved, DHCS estimates $1.4 billion would be deposited in the fund in 2019-20, which would offset General Fund expenditures in the Medi-Cal program.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$-	($1,440,526,000)
3331 – Medi-Cal Drug Rebate Fund*	$-	$1,440,526,000
Total Funding Request:	**$-**	**$-**

* Fund proposed to be created by trailer bill language.

Background. The federal Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, which requires drug manufacturers to pay rebates to state Medicaid programs for drugs dispensed to Medicaid beneficiaries. These rebates are shared between states and the federal government according to the relevant federal matching rate for the beneficiaries to whom the drugs were dispensed. In addition to the federal rebate program, California law requires DHCS to enter into contracts with drug manufacturers to provide supplemental rebates for drugs dispensed to Medi-Cal beneficiaries in the fee-for-service delivery system or enrolled in county organized health systems (COHS). These rebates are in addition to those received through the federal rebate program. In 2010, the federal Affordable Care Act further extended eligibility for the federal rebate program to drugs dispensed to beneficiaries enrolled in non-COHS Medi-Cal managed care plans.

Currently, when rebates are first received, the funding split between the General Fund and federal funds is unknown and the initial funding is credited back assuming a 50 percent federal match until reconciled with actual claims data. The timing of these later adjustments have varied, and have shifted from one fiscal year to another. For example, federal reimbursement was never remitted for drug rebates on claims between April 2015 and June 2016. For this period and the period between January and March 2017, DHCS remitted several one-time repayments to the federal government related to the higher federal matching rate for Affordable Care act beneficiaries after reconciliation of actual claims data. The 2017 Budget Act reflected a federal repayment of $487.3 million in 2016-17. The 2018-19 January budget included an additional federal repayment of $303.1 million in 2017-18 and offsetting savings of $280.7 million in 2018-19. The 2019-20 January budget includes additional rebates of $390 million for 2018-19. This uncertainty of when drug rebates are received and adjusted poses challenges for the department's overall fiscal management.

DHCS proposes to establish the Medi-Cal Drug Rebate Fund to manage the impact on the department's General Fund cash flow due to the uncertain timing of drug rebates and funding adjustments. The fund would allow for a specific amount to be budgeted and transferred to offset General Fund expenditures in the Medi-Cal program. If additional rebates are received, the department would be able to validate the rebates and have increased flexibility on the timing of the impact to the General Fund, reducing volatility in Medi-Cal General Fund expenditures.

Specifically, the proposed trailer bill language would:

- Create the Medi-Cal Drug Rebate Fund in the State Treasury to hold the state share of federal and state supplemental drug rebates collected by DHCS, including all interest and dividends earned.
- Continuously appropriate the funds, without regard to fiscal year, for expenditures in the Medi-Cal program.
- Authorize the State Controller to use the funds for cash flow loans to the GF, as specified.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. The budget allocates all rebate proceeds to offset General Fund expenditures in Medi-Cal. How does DHCS propose to use this fund in the future to manage the volatility of rebate collections?

Issue 15: Medi-Cal Checkwrite Contingency Payments

Trailer Bill Language Proposal. DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. If approved, this statutory authority would allow DHCS to maintain continuity of access to Medi-Cal healthcare services for beneficiaries and payments to providers in the event of a disruption in the Medi-Cal Checkwrite service.

Background. DHCS contracts with a fiscal intermediary (FI) to maintain and operate the California Medicaid Management Information System (CA-MMIS), which is utilized to process approximately 200 million claims annually for payment of medical services provided to Medi-Cal members. Under the CA-MMIS contract, the FI adjudicates both Medi-Cal and non-Medi-Cal claims for the state and delivers other services to program providers, beneficiaries, and federal and state users of the system. The department's CA-MMIS Division is responsible for oversight, management, monitoring, and administration of existing FI vendor responsible for providing information technology system maintenance and operations and business operations services, as well as the design, development and implementation of a new system to modernize CA-MMIS.

CA-MMIS processes payments to providers of medical care to Medi-Cal certified eligible beneficiaries, via the Medi-Cal Checkwrite. The FI provides other related services including, but not limited to, the operation of a telephone service center and provider relations functions; system operations, updates and enhancements; processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. According to DHCS, in 2017-18, the total amount paid by the Medi-Cal Checkwrite was $17,942,540.22 and averaged $345,048,851 weekly.

In October 2012, the FI contractor began design and development of a new CA-MMIS replacement system, "Health Enterprise" (HE). In October 2015, the FI announced it would not complete the replacement system and entered into negotiations with DHCS on terms and conditions of a settlement to terminate its contractual obligation. In April 2016, DHCS and the FI signed a settlement agreement to terminate design and development of the replacement system and compensate DHCS for costs incurred under the FI contract. According to DHCS, the CA-MMIS Division developed a new Modernization Approach to replace the legacy CA-MMIS system using a modular procurement approach coupled with agile design and development techniques to incrementally deliver new functionality to CA-MMIS across multiple fiscal years. This consists of iteratively implementing CA-MMIS business functionality in the form of "digital services" as they are developed. Each new digital service will replace CA-MMIS business functionality.

The FI contract requires development of an automated contingency payment process to ensure payments to providers will continue uninterrupted in the event of a Medi-Cal Checkwrite disruption. Such a disruption could be caused during implementation of new system functionality, emergencies, or other unplanned interruptions. DHCS reports it has not recently experienced a Checkwrite delay, but notes it relies on aging information technology systems and views the contingency payment process as a responsible precaution. The contingency payment process developed by the FI would calculate contingency payment amounts based on the provider's payment history for the prior twelve months, validate the provider is in good standing, and allow DHCS to determine which providers receive

contingency payments for which service dates. Once the Medi-Cal Checkwrite disruption ends, DHCS would reconcile the contingency payments against actual adjudicated claims for the contingency payment period and adjust future payments accordingly.

DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. DHCS reports that, although it has the technical ability to calculate contingency payments to providers when there is a disruption to the Medi-Cal Checkwrite process, the State Controller's Office requires statutory authority to process such contingency payments. Therefore, DHCS is seeking statutory authority to make contingency payments to providers for claims if there is a disruption to the Medi-Cal Checkwrite process upon approval of the Department of Finance.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 16: Health Homes Program Funding Extension

Trailer Bill Language Proposal. DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023. If approved, this language would allow DHCS to continue implementation and funding for the Health Homes Program, which began July 1, 2018.

Background. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Medicaid Health Home Program (HHP) Services benefit, which provides enhanced care coordination benefits for members with chronic conditions with the goal reducing state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for Medi-Cal's most vulnerable beneficiaries. Established under Section 2703 of the federal Affordable Care Act, states that adopt the HHP benefit receive a 90 percent federal match for program services for two years. After two years, the federal match converts to the 50 percent federal matching rate.

AB 361 specifies that DHCS may only implement the HHP if prior and ongoing projections show no additional General Fund monies will be used to fund the program's administration, evaluation, and services. DHCS may use General Fund monies to operate the program if ongoing General Fund costs for the Medi-Cal program do not result in a net increase. In January 2013, the California Endowment (TCE) Board of Directors approved a $25 million commitment in each of the first two years to provide the 10 percent non-federal match for program services and related state operations activities.

SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015 established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for HHP implementation. The TCE funding of $50 million for the first two years of implementation was deposited into this account.

SB 75 also appropriated $50 million from the account for the purposes of administering the HHP. The appropriation was made available for encumbrance or expenditure until June 30, 2020.

After significant stakeholder engagement, DHCS began implementing HHP in 14 counties beginning July 1, 2018. Counties will implement HHP in four groups and each group will implement its program in two phases. Phase 1 will implement HHP services for members with certain chronic conditions and substance use disorders. Phase 2 will implement HHP services for members with certain serious mental illness conditions. AB 361 also requires DHCS, within two years of implementation, to provide an evaluation of the program to the fiscal and policy committees of the Legislature. As of September 2018, the implementation schedule for the program is as follows:

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	San Francisco	July 1, 2018	January 1, 2019
Group 2	Riverside San Bernardino	January 1, 2019	July 1, 2019
Group 3	Alameda Fresno Imperial Kern Los Angeles Sacramento San Diego San Mateo Santa Clara Tulare	July 1, 2019	January 1, 2020
Group 4	Orange	January 1, 2020	July 1, 2020

DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023. As implementation of the program will continue through July 1, 2020, this language would allow DHCS to continue implementation and funding from the original TCE contribution for an additional three years.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. How does DHCS plan to continue funding of this program after 2023, given the statutory requirement to utilize non-General Fund sources?

Issue 17: Family Health Estimate Overview

Budget Issue. The November 2018 Family Health Local Assistance Estimate includes $251.3 million ($206.8 million General Fund, $5.1 million federal funds, and $39.4 million special funds and reimbursements) for expenditures in 2018-19, and $257 million ($215.2 million General Fund, $5.1 million federal funds, and $36.7 million special funds and reimbursements) for expenditures in 2019-20.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$78,356,000	$80,318,000	$1,962,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,962,000]
Total CCS Expenditures	**$83,809,000**	**$85,771,000**	**$1,962,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$3,000	$-	($3,000)
Total CHDP Expenditures	**$3,000**	**$-**	**($3,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$112,315,000	$118,146,000	$5,831,000
Special Funds and Reimbursements	$11,462,000	$8,762,000	($2,700,000)
Total GHPP Expenditures	**$123,777,000**	**$126,908,000**	**$3,131,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$16,105,000	$16,737,000	$632,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$43,737,000**	**$44,369,000**	**$632,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$206,779,000	$215,201,000	$8,422,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$39,419,000	$36,719,000	($2,700,000)
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,964,000]
Total Family Health Expenditures	**$251,326,000**	**$257,048,000**	**$5,722,000**

Background. The Family Health Estimate forecasts the current and budget year local assistance expenditures for four state-only funded programs that provide services for low-income children and adults with special health care needs who do not qualify for enrollment in the Medi-Cal program.

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 176,591 in 2018-19, a decrease of 708 or 0.4 percent, compared to the 2018 Budget Act. The budget estimates Medi-Cal CCS caseload of 178,371 in 2019-20, an increase of 1,780 or one percent, compared to the revised 2018-19 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 15,131 in 2018-19, a decrease of 312 or 2.1 percent, compared to the 2018 Budget Act. The budget estimates state-only CCS caseload of 15,131 in 2019-20, unchanged compared to the revised 2018-19 estimate.
- **Child Health and Disability Prevention (CHDP):** The CHDP program, established in 1973, provides complete health assessments and immunizations for children at or under 18 years of age whose family income is at or below 200 percent of the federal poverty level and who are not enrolled in Medi-Cal. This program also administers the Early and Periodic Screening, Diagnosis, and Treatment benefit for fee-for-service Medi-Cal beneficiaries.
  Caseload Estimate: The budget estimates state-only CHDP caseload of 22 in 2018-19, unchanged compared to the 2018 Budget Act. The budget estimates state-only CHDP caseload of zero in 2019-20, a decrease of 22 or 100 percent compared to the revised 2018-19 estimate. According to DHCS, recent significant reductions in CHDP caseload are primarily due to eligibility of all children, regardless of immigration status, for full-scope Medi-Cal pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 988 in 2018-19, a decrease of 23 or 2.3 percent, compared to the 2018 Budget Act. The budget estimates Medi-Cal GHPP caseload of 1,009 in 2019-20, an increase of 21 or 2.1 percent, compared to the revised 2018-19 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 783 in 2018-19, an increase of 62 or 8.6 percent, compared to the 2018 Budget Act. The budget estimates state-only GHPP caseload of 785 in 2019-20, an increase of two or 0.3 percent, compared to the revised 2018-19 estimate.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 26,963 in 2018-19, an increase of 543 or 2.1 percent, compared to the 2018 Budget Act. The budget estimates EWC caseload of 26,963 in 2019-20, unchanged compared to the revised 2018-19 estimate.

Elimination of Treatment Limits in Breast and Cervical Cancer Treatment Program. The 2018 Budget Act included trailer bill language and General Fund expenditure authority of $8.4 million annually to eliminate treatment limitations in the Breast and Cervical Cancer Treatment Program (BCCTP). The state-funded BCCTP previously limited the period of coverage to 18 months for breast cancer and 24 months for cervical cancer, with no similar treatment limitations for BCCTP coverage for Medi-Cal beneficiaries.

According to DHCS, during the six months between July 2018 and January 2019, 608 beneficiaries that would have lost coverage under the previous treatment limitations were allowed to continue receiving treatment under the BCCTP program. For the 2018 Budget Act, DHCS had estimated 777 beneficiaries would benefit from lifting the treatment limitations during the 2018-19 fiscal year.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2019-20 fiscal year.