

AGENDA**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR****MONDAY, APRIL 8, 2019****2:30 PM, STATE CAPITOL, ROOM 437**
(Please note room change)

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LIST OF PANELISTS IN ORDER OF PRESENTATION**4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)
8860 DEPARTMENT OF FINANCE**

ISSUE 1: AFFORDABILITY AND INDIVIDUAL MANDATE PROPOSALS**PANELISTS**

- **Katie Ravel**, Director of Policy, Eligibility, and Research, Covered California
- **Jacob Lam**, Principal Program Budget analyst, Department of Finance
- **Alek Klimek**, Finance Budget Analyst, Department of Finance
- **Beth Capell**, Policy Advocate, Health Access California
- **Jen Flory**, Policy Advocate, Western Center on Law & Poverty
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**4260 DEPARTMENT OF HEALTH CARE SERVICES**

ISSUE 2: MEDI-CAL ASSETS TESTS OVERSIGHT**PANELISTS**

- **Jen Flory**, Western Center on Law and Poverty
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services

Public Comment**ISSUE 3: MEDI-CAL ELIGIBILITY EXPANSION TO UNDOCUMENTED CALIFORNIANS****PANEL 1**

- **Deepen Gagneja**, Senior Legislative Advocate, California Immigrant Policy Center
- **Ronald Coleman**, Director of Policy & Legislative Advocacy, Health Access California

PANEL 2

- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 4: AB 85 REALIGNMENT PROPOSAL AND TRAILER BILL****PANELISTS**

- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Peter Beilenson, MD**, Health Services Director, Sacramento County
- **Jenny Nguyen**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 5: MEMBERS/STAKEHOLDER/ADVOCATE PROPOSAL: MEDI-CAL ELIGIBILITY EXPANSION FOR AGED AND DISABLED POPULATION****PANELISTS**

- **Assemblymember Jim Wood**
- **Linda Nguy**, Policy Advocate, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: STAKEHOLDER/ADVOCATE PROPOSALS: HEALTH NAVIGATORS FOR ENROLLMENT**PANELISTS**

- **Linda Tenerowicz**, Policy Advocate, California Pan-Ethnic Health Network
- **Maria Romero-Mora**, Director of Programs, California Coverage & Health Initiatives
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services

Public Comment**ISSUE 7: STAKEHOLDER/ADVOCATE PROPOSAL: WIC EXPRESS LANE ELIGIBILITY****PANELISTS**

- **Kristen Golden Testa**, California Health Director, The Children's Partnership
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 8: MEDI-CAL DRUG PURCHASING CARVE OUT EXECUTIVE ORDER****PANEL 1**

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Jenny Nguyen**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 2

- **Dr. Kahn**, Chief Medical Officer, Molina Healthcare California
- **Brian Rasmussen**, Pharmacy Director, One Community Health
- **Beth Capell**, Policy Advocate, Health Access California

Public Comment

ITEMS TO BE HEARD

**4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)
8860 DEPARTMENT OF FINANCE****ISSUE 1: AFFORDABILITY AND INDIVIDUAL MANDATE PROPOSALS****PANELISTS**

- **Katie Ravel**, Director of Policy, Eligibility, and Research, Covered California
- **Jacob Lam**, Principal Program Budget analyst, Department of Finance
- **Alek Klimek**, Finance Budget Analyst, Department of Finance
- **Beth Capell**, Policy Advocate, Health Access California
- **Jen Flory**, Policy Advocate, Western Center on Law & Poverty
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL*****Governor's Affordability Proposal***

The budget proposes to create the Affordable Care Access (ACA) Plus Program by increasing 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). This proposal also would 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. The ACA Plus Program is proposed to sunset December 31, 2022.

Governor's Individual Mandate Proposal

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. These penalties would automatically be reduced by any amount of penalty reinstated by the federal government.

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. Department of Finance (DOF) states that these estimates will be included in the May Revise. DOF also explains that the Administration intends for these two proposals to result in a General Fund neutral program over a three-year period of time. In other words, each year the subsidies are to be adjusted to reflect actual penalty revenue from recent prior years.

Stakeholder Proposal

Health Access California, Western Center on Law and Poverty, and a broad coalition of advocacy organizations request \$2.1-2.5 billion additional General Fund dollars to provide subsidies to individuals below 250 percent FPL, to significantly reduce cost-sharing for low- and moderate-income Californians, and to cut the number of uninsured in the individual market in half.

BACKGROUND

Affordability Options

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 estimates of new total enrollment and state costs for each of the potential policy options for the 2021 calendar year.

The workgroup report model indicates that:

1. 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.
2. 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.
3. 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.

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.

Individual Mandate Penalty and Cost-Sharing Reductions

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.

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.

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. 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.

Stakeholder Concerns

According to advocates, 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 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 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. Advocates state that 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.

Additional concerns raised:

Sunset on Subsidies -- the Administration's proposal includes a sunset on the proposed subsidies, yet no sunset on the mandate penalty. The Administration states that they believe that future federal action likely will serve as a natural sunset on the mandate penalty, whereas the subsidies, and the revenue source for them, will need to be re-evaluated in a few years.

Federal vs. State Filing Threshold -- the Administration's initial estimate of mandate penalty revenue, approximately \$500 million, was based on the federal filing threshold which is lower than California's state filing threshold, and therefore the revenue estimate is too high. The Administration acknowledges this, stating that the state's higher filing threshold would result in approximately 25 percent fewer people paying the penalty, and their revised estimates will reflect this fact.

Individual Annual Tax Reconciliations -- consistent with the federal subsidies, this proposal requires a reconciliation process in order to return funds to the state when an individual's income has risen during the year, resulting in a change to the individual's eligibility for subsidies. Stakeholders point out that this is an administratively costly process that ultimately would result in insignificant savings for the state, and very significant hassle, and at times cost, for individuals. The Administration indicates a willingness to consider other models, such as that used in Massachusetts which eliminated this reconciliation process in their program.

Health Care Sharing Ministries -- consistent with the ACA, if an individual has coverage through a health care sharing ministry, an unregulated insurance product, the individual is considered covered and therefore exempt from the mandate penalty. Some stakeholders believe that this is not a good form of health care coverage and it may serve Californians well to exclude this as eligible coverage in California's law. The Administration states that their goal was to mirror the ACA as much as possible in order

to avoid confusion for individuals who may find it difficult to track which types of coverage qualify for an exemption from the state penalty vs. the federal penalty, should the federal penalty be reinstated at some point in the future.

Proposed Trailer Bill Language

The administration proposed trailer bill would:

1. Create an individual mandate for California residents to obtain comprehensive health care coverage or pay a shared responsibility penalty as originally outlined under the federal Affordable Care Act, beginning January 1, 2020.
2. Create the ACA Plus program which would provide advanced premium assistance subsidies to families earning between 250 and 600 percent of the Federal Poverty Level (between \$62,750 and \$150,000 for a family of four) through Covered California, beginning January 1, 2020.
3. Design the ACA Plus program to be in line with anticipated penalty revenues, subject to an annual General Fund appropriation.
4. Provide Covered California flexibility to work within an annual budget appropriation and other program parameters to establish annual eligibility levels for advanced premium assistance subsidies.
5. Sunset the ACA Plus program December 31, 2022.
6. Provide exemptions for short coverage gaps and individuals with low incomes, unaffordable coverage, and other hardships, consistent with federal law and guidance.
7. Authorize data sharing between the Franchise Tax Board and Covered California to target outreach to uninsured individuals to help them learn about coverage options.

Proposed Budget Bill Language

The Administration proposes the following budget bill language to establish the specific subsidy amounts as determined annually:

4800-101-0001—For support of California Health Benefit Exchange [###]

Schedule:

(1) [####]-Affordable Care Access Plus [###]

Provisions:

1. The amount appropriated in this item is to support the Affordable Care Access Plus Program, which, pursuant to title 25 of the Government Code and the Program Design, shall provide advanced premium assistance subsidies during the 2020 coverage year to individuals with projected and actual household incomes between 250 and 600 percent of the Federal Poverty Level.
2. Of the amount available in this item, [\$\$\$] shall be used to provide advanced premium assistance subsidies to individuals with household incomes between 250 and 400 percent of the Federal Poverty Level.
3. Of the amount available in this item, [\$\$\$] shall be used to provide advanced premium assistance subsidies to individuals with household incomes between 400 and 600 percent of the Federal Poverty Level.
4. The Director of Finance may authorize the transfer of authority between the amounts specified in provision 2 and 3 of this item to effectively administer the program funded in this item pursuant to the Program Design.
5. The Director of Finance may authorize an increase in this appropriation and the amounts specified in provisions 2 and 3 to pay all premium assistance subsidies authorized for the 2020 coverage year pursuant to the Program Design. Any augmentation under this provision shall be authorized no sooner than 10 days after notification in writing of the necessity therefor to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.
6. Notwithstanding any other provision of law, funds appropriated for the 2020 coverage year pursuant to this item may be encumbered until December 31, 2021.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. Covered California provide a summary of their affordability report and answer questions specific to Covered California;
2. Department of Finance present the Governor's proposal and answer questions about the proposal;
3. Health Access and Western Center on Law & Poverty to share their concerns with the Governor's proposal and present their own alternative proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

4260 DEPARTMENT OF HEALTH CARE SERVICES**ISSUE 2: MEDI-CAL ASSETS TESTS OVERSIGHT****PANELISTS**

- **Jen Flory**, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services

Public Comment**OVERSIGHT ISSUE**

The Affordable Care Act (ACA) eliminated the assets test for most of the Medi-Cal population including children, parents and caretaker relatives, and most other adults under age 65. Once an adult turns age 65 or becomes Medicare eligible, however, their eligibility is determined under a more restricted set of rules, which requires that they have minimal assets to retain Medi-Cal eligibility. Although important assets such as a primary residence or retirement accounts are excluded from the assets test, programs serving these populations restrict the remaining assets to \$2,000 for an individual and \$3,000 for a couple. These limits have not changed since 1989.

The Medi-Cal asset test requirement prevents seniors from having enough resources at hand to weather a financial emergency such as an eviction or loss of transportation. When faced with the choice of having Medi-Cal or having additional savings, most seniors rationally spend down their savings as the cost of their health care is more than they have saved. This puts them at risk of further instability or homelessness when financial crises happen. With little cash on hand, few seniors can replace broken home heating, pay for a major vehicle repair, or pay first and last months' rent when needing a new apartment.

BACKGROUND

The ACA and other state legislation in public programs has demonstrated a shift from requiring low-income people to deplete all resources prior to receiving help. For example, the CalFresh program virtually eliminated the assets test for households earning less than 200% of the federal poverty level.

Twelve states, plus Washington D.C., raised their assets test, some significantly, in some or all of their Medicaid programs serving seniors and persons with disabilities. Arizona eliminated its assets test completely to simplify eligibility determinations after finding administrative savings largely offset any increase in enrollment. Seven states, plus D.C.

have no assets test at all for some or all of their Medicare Savings Programs, programs where Medi-Cal pays for an individual's Medicare premiums and co-payments.

Since 1989, the Medi-Cal program has added certain exclusions to the assets test, such as the balance of most retirement accounts, and raised the assets limit for the Medicare Savings Programs. Advocates believe that the asset limit should be significantly raised for all applicable programs so seniors can more adequately take care of themselves and their families when unexpected expenses occur.

Sponsored by Western Center on Law & Poverty and Justice in Aging, Assemblymember Wendy Carrillo is authoring AB 683 to update, simplify and reduce the burden of the Medi-Cal assets tests. Specifically, AB 683 proposes to:

1. Update the assets limits for programs serving seniors to \$10,000 for an individual and an additional \$5,000 for each additional household member, with annual indexing;
2. Expand and simplify the list of items to be excluded from the assets test for those Medi-Cal programs still subject to the assets test; and
3. Eliminate the assets test entirely for the Medicare Savings Programs, programs where Medi-Cal pays for an individual's Medicare premiums and co-payments.

DHCS indicates that if California were to eliminate any of the remaining Medi-Cal assets tests, the federal government would cease providing federal financial participation for the entire population covered by the applicable program. However, the following federal guidance appears to allow elimination of assets tests:

“In addition, states may use the flexibility authorized under Section 1902(r)(2) to set an overall asset limit at any level above the federal floor, or to disregard all assets. States have the option of using these flexibilities only for MSPs, or they may apply them to other categories of Medicaid as well. Some states have already taken these steps.”

www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. Western Center on Law & Poverty to provide an overview of this issue including the changes to the assets tests that they are advocating for through AB 683, and respond to questions by the Subcommittee;
2. DHCS to explain their understanding of federal Medicaid law and federal guidance in relation to eliminating assets tests, and respond to questions by the Subcommittee.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 3: MEDI-CAL ELIGIBILITY EXPANSION TO UNDOCUMENTED CALIFORNIANS**PANEL 1**

- **Deepen Gagneja**, Senior Legislative Advocate, California Immigrant Policy Center
- **Ronald Coleman**, Director of Policy & Legislative Advocacy, Health Access California

PANEL 2

- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSALS****Stakeholders' Proposal**

The California Immigrant Policy Center, Health Access California, and a coalition of approximately 80 organizations request resources to fund an expansion of full-scope Medi-Cal services to otherwise eligible adults regardless of immigration status.

Governor's Budget Proposal

The Governor 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 \$257.7 million (\$194.3 million General Fund and \$63.4 million federal funds) in Medi-Cal for the expansion of coverage in 2019-20. This proposal also creates new costs in the In-Home Supportive Services (IHSS) program estimated to be \$2.2 million General fund in 2019-20, growing to approximately \$40 million at full implementation. The budget proposal includes both a Budget Change Proposal (BCP) and trailer bill, as follows:

Budget Change Proposal

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.

DHCS explains that they did not request an increase in state operations resources with the passage of SB 75 (Chapter 18, Statutes of 2015), which provides full scope Medi-Cal to otherwise eligible children under the age of 19, regardless of citizenship or immigration status. SB 75 was implemented in May of 2016 and DHCS regrets overlooking the need for additional state-level resources for implementation and ongoing operation of the expansion.

Trailer Bill

To implement this proposal, the administration proposes trailer bill that would:

1. Provide full-scope Medi-Cal to otherwise eligible applicants and beneficiaries, ages 19 through 25, regardless of citizenship or immigration status.
2. Require coverage to begin no sooner than July 1, 2019.
3. Require the Department of Health Care Services to claim federal funds to the extent the Department determines they are available.
4. Require eligible individuals to enroll in a managed care plan, where available.
5. Transition beneficiaries, ages 19 through 25 who are receiving restricted-scope Medi-Cal, to full-scope Medi-Cal when the Department implements this proposal.

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 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.

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.

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.

According to the coalition of stakeholders and advocates, 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. Advocates assert that any effort to achieve universal health coverage in California must include immigrant communities who shape our state and who call California home.

CWDA Concerns/Request

County welfare offices administer Medi-Cal application and eligibility-determination functions for the state, and receive funding for this purpose. Naturally, county workload increases as a result of any Medi-Cal eligibility expansion such as the one proposed here. The Governor's January budget includes a \$53 million increase in county funding for 2019-20 over the 2018-19 budget, in part to reflect the increased workload and costs anticipated to result from this proposal. However, the County Welfare Directors Association (CWDA) has indicated to the Subcommittee that they have concerns with the amount of increased funding and are in discussions with DHCS regarding their request for an additional \$11.5 million. The requested increase would be as follows:

- \$10 million one-time for one-time work to process new full-scope eligibles whose eligibility does not convert automatically from restricted scope Medi-Cal, cases that typically require a substantial amount of manual work; this number could drop to reflect a potential decrease in projected caseload included in the May Revise.
- \$1.5 million one-time for automation; this is consistent with the amount counties spent for SB 75 systems modifications that were necessary to implement the expansion to undocumented children.

Stakeholder Request for Amendments

The California State Association of Counties (CSAC) and the California Association of Public Health Systems (CAPH) request amendments to the Administration's proposed trailer bill that they believe would provide continuity of care protections for individuals transitioning from county-based care to Medi-Cal as a result of this proposal. These amendments mirror language that was included in the bill that implemented the ACA Medi-Cal expansion. The Administration points out that for the ACA Medi-Cal expansion, most individuals were transitioning to Medi-Cal from Low-Income Health Programs (LIHPs) and DHCS had LIHP data on providers and benefits. DHCS structured the Medi-Cal expansion around this data. On the contrary, with this proposed expansion, this population may receive some health services from counties, but they are by in large uninsured, and therefore DHCS has no data on the health care they currently receive.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests:

1. Panel 1 present their proposal.
2. DHCS present the Governor's proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 4: AB 85 REALIGNMENT PROPOSAL AND TRAILER BILL**PANELISTS**

- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Peter Beilenson, MD**, Health Services Director, Sacramento County
- **Jenny Nguyen**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL**

DHCS is proposing trailer bill language to amend the redirection percentages implemented in AB 85 (Committee on Budget, Chapter 24, Statutes of 2013) for certain counties in order to account for the reduced burden on county indigent programs achieved by enrolling undocumented young adults in full-scope Medi-Cal coverage. 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.

BACKGROUND

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 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. The counties that chose the 60/40 formula include: Placer, Sacramento, Santa Barbara, Stanislaus, and Yolo.

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.

County Concerns

Several of the 60/40 counties have submitted opposition to the Administration's proposed increase primarily due to the fact that these 60/40 counties, that are most affected by this proposal, use these funds for public health purposes and therefore would have to make cuts to public health services.

Santa Barbara County

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.

Sacramento County

Sacramento County explains that the proposal would result in approximately a 50 percent cut to their budget for both public health and indigent care (i.e., health care for Sacramento County's undocumented population). Specifically, this proposal would result in a \$7.5 million cut to Sacramento County, of which currently \$5 million supports health

care for undocumented individuals, while the other approximate \$2.5 million supports public health services and programs. Sacramento County makes the point that the funding cut for health services would be approximately 50 percent, yet the new coverage being provided by the state is only for young adults, 19-25 years old, who make up only 2.5 percent of the undocumented population. Moreover, young adults are a generally healthy population, and therefore this 2.5 percent is less expensive than the rest of the population. Sacramento County states that they would be open to returning 2.5 percent of their funding to the state.

Regarding public health funding, Sacramento County states that there has been a 300 percent increase in syphilis cases (including congenital syphilis) in the past four years in Sacramento County. Yet, the loss of this funding will result in the closure of the recently launched STD clinic at the Sacramento County Health Center. These cuts also are expected to reduce the number of communicable disease investigations in the County, which will end the practice of tracking partners of patients with STDs. This reduction also will severely curtail the County's ability to investigate disease outbreaks and tuberculosis cases. Finally, the County states that this will result in cuts to the County's California Children's Services (CCS) program and the local African American Perinatal Health Program.

Yolo County

When AB 85 was negotiated, Yolo County chose to use the 60/40 realignment formula, and therefore are listed as such in the statute. However, in 2018, Yolo County became a full CMSP (County Medical Services Provider) member; the CMSP Board provides indigent care for all CMSP counties. Therefore, Yolo County is requesting technical amendments to the trailer bill to reflect the fact that the County is no longer a 60/40 county and is a CMSP county.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. DHCS to present this proposal and respond to questions.
2. Sacramento County to provide the concerns and perspective of the 4 60/40 counties and what the impacts of this proposal will be on those counties.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 5: MEMBER/STAKEHOLDER/ADVOCATE PROPOSAL: MEDI-CAL ELIGIBILITY EXPANSION FOR AGED AND DISABLED POPULATION**PANELISTS**

- **Assemblymember Jim Wood**
- **Linda Nguy**, Policy Advocate, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

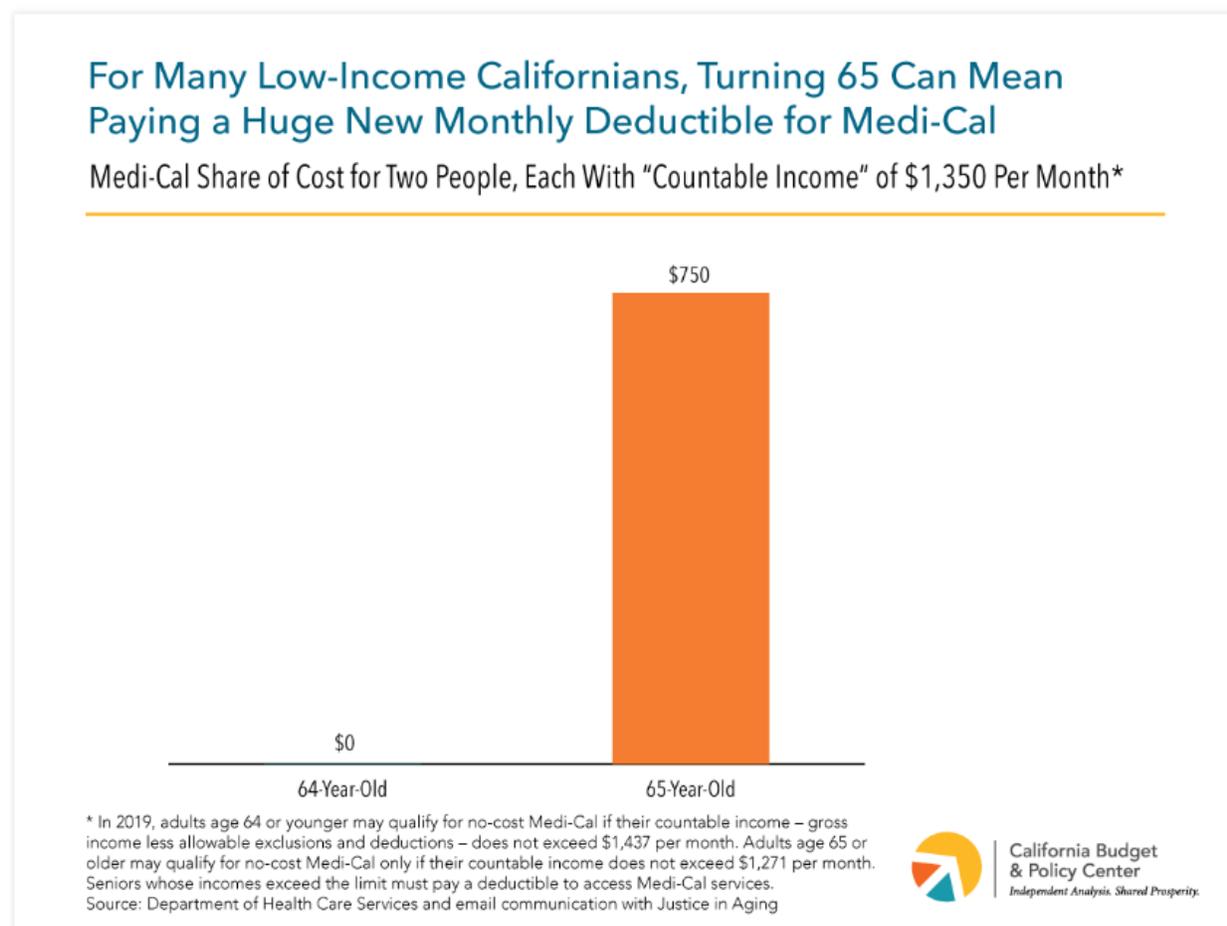
Public Comment**PROPOSAL**

Assemblymember Jim Wood, Western Center on Law & Poverty, 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. The Department of Finance is currently working on developing a cost estimate for this proposal.

BACKGROUND

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.

According to the coalition supporting this proposal, 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. This low eligibility threshold, coupled with the high share of cost means that, unlike all the adult beneficiaries covered under the Affordable Care Act who qualify for free Medi-Cal up to 138% FPL, seniors and people with disabilities must pay more than half their income before they can access Medi-Cal coverage.



STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. Assemblymember Wood and Western Center on Law & Poverty to present this proposal.
2. DHCS to provide any technical feedback or concerns with the proposal other than increased Medi-Cal costs.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 6: STAKEHOLDER/ADVOCATE PROPOSALS: HEALTH NAVIGATORS FOR ENROLLMENT**PANELISTS**

- **Linda Tenerowicz**, Policy Advocate, California Pan-Ethnic Health Network
- **Maria Romero-Mora**, Director of Programs, California Coverage & Health Initiatives
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services

Public Comment**PROPOSALS***CPEHN Proposal*

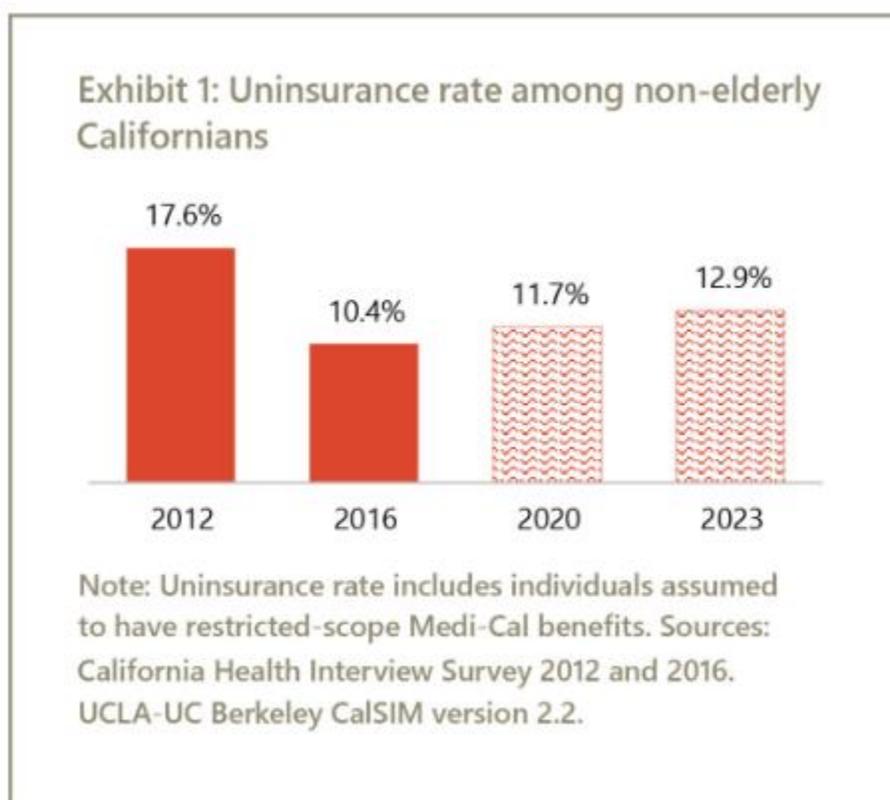
The California Pan-Ethnic Health Network (CPEHN), Maternal and Child Health Access, Community Health Councils, and approximately 45 other organizations request \$15 million General Fund per year for two years (\$30 million General Fund, \$30 million Federal Fund, total funding of \$60 million) to reinstate 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). CPEHN is also proposing trailer bill which: 1) expands the populations which may be targeted by outreach, enrollment assistance, and navigation efforts to include persons with disabilities, aged persons, young women of color, immigrants, and low wage workers and their families; 2) setting a deadline of September 1, 2019 for disbursement of the funds; and 3) requiring counties to consult stakeholders regarding partnerships with community-based organizations.

CCHI Proposal

California Coverage & Health Initiatives (CCHI), Children's Health Initiative Napa County, Vision y Compromiso, United Ways of California and the Children's Defense Fund also request \$15 million General Fund per year for two years (\$30 million General Fund, \$30 million Federal Fund, total funding of \$60 million) to reinstate and continue outreach, enrollment, retention, and utilization assistance in Medi-Cal. However, unlike the proposal above, CCHI proposes a different funding methodology that is less like AB 82 which the proposal above attempts to mirror. Please see more detail on the next page.

BACKGROUND

Since the implementation of the ACA, Californians uninsured rate dropped dramatically, from approximately 17.6 percent to approximately 7.2 percent of individuals. Now, 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, which can be attributed to 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 UC Berkeley Labor Center projects that the uninsured rate could grow to 11.7 percent in 2020, or approximately 4.02 million people, and to 12.9 percent in 2023, or 4.4 million people.



Source: UC Berkeley Labor Center Report: *California's Health Coverage Gains to Erode Without Further State Action*

In January 2014, in response to the implementation of the ACA Medi-Cal expansion, 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. AB 82 funding ended June 30, 2018. 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

CPEHN Proposal Methodology

CPEHN proposes to implement this funding mirroring the process used in AB 82. CPEHN explains that:

“The State Department of Health Care Services (DHCS) previously administered the AB 82 program and distributed funds to counties and, for small rural counties, to the County Medical Services Program (CMSP) Board, as described here: AB 82 Outreach and Enrollment Program and here: CMSP Small County Fact Sheets. The counties and the CMSP Board then made grants available to community based organizations (CBOs) to do outreach work. The list of grantees is here: Statewide Network of OE Grantees and here CMSP Grantees List (pp. 1-2).

Grant distribution through DHCS to counties and the CMSP Board were an essential component of the AB 82 program methodology and should be retained with the reinstated funding. County oversight is imperative in preserving subject matter expertise on the complex rules and procedures for health program eligibility. The counties are the sole local agents with the authority to make Medi-Cal eligibility determinations, and they have an important role to play in identifying and responding to the different needs of target populations at the local level. County involvement also helps ensure that competent organizations receive funds to provide high quality service to the community, while holding their local grantees accountable and preventing financial conflicts of interest among grantee organizations.”

CCHI Proposal Methodology

CCHI proposes that DHCS would allocate the funds to CCHI which would allocate the funds to community based organizations to do the work. CCHI provides the following justification for proposing to funnel the funds through CCHI:

“CCHI’s Community-Based Organizations (CBOs) are frequently located in the hardest to reach communities, whether urban or rural, throughout the state. Our members are located in inner cities and rural areas. We are located in counties with 95% of California’s population and over 90% of its Medi-Cal population. The staff of our member Community-Based Organizations are Latinos and other People of Color, who literally live and work in those communities that most need outreach, enrollment support, retention, and utilization services. These CBOs, all non-profit and local government organizations, will strengthen their infrastructure, hire and train additional community-oriented staff to handle the uninsured and the newly insured. Not all of them, since the resource requirements substantially exceed the sum of the complementary requests from CCHI and CPEHN. These member CBOs will strengthen their already strong links to county enrollment departments, and tighten their bonds to the 650 other CBOs in their networks.”

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. CPEHN and CCHI present these two proposals.
2. DHCS to provide any technical feedback or known implementation challenges associated with either proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 7: STAKEHOLDER/ADVOCATE PROPOSAL: WIC EXPRESS LANE ELIGIBILITY**PANELISTS**

- **Kristen Golden Testa**, California Health Director, The Children's Partnership
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL**

The Children's Partnership, and a coalition of six children's advocacy organizations (Children Now, March of Dimes, Children's Defense Fund, California Coverage & Health Initiatives, and United Ways of California) request 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 Women, Infants, and Children (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.

BACKGROUND

The coalition states that 202,000 children in California remain uninsured, half of whom are eligible for Medi-Cal. Furthermore, 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.

SB 1 X1 (Hernández, Chapters 3 and 4, Statutes of 2013) 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 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.

The coalition proposes the following process for the WIC Express Lane Eligibility: If in the WIC application process, an applicant indicates they do not have a “source of healthcare,” the applicant could be asked for consent to initiate express enrollment for Medi-Cal using the WIC eligibility findings. If additional information is needed, county Medi-Cal workers can obtain it in follow-up, so as not to add extra work for WIC staff.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

1. The Children’s Partnership to present the proposal.
2. DHCS and DOF to provide technical assistance on the costs of this proposal and any other known implementation challenges.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 8: MEDI-CAL DRUG PURCHASING CARVE OUT EXECUTIVE ORDER**PANEL 1**

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director Health Care Programs, Department of Health Care Services
- **Jenny Nguyen**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 2

- **Dr. Kahn**, Chief Medical Officer, Molina Healthcare California
- **Brian Rasmussen**, Pharmacy Director, One Community Health
- **Beth Capell**, Policy Advocate, Health Access California

Public Comment**ISSUE**

On January 7, 2019, the Governor issued Executive Order (EO) N-01-19, ordering state departments to implement several directives intended to reduce the cost of prescription drugs for both public and private purchasers. The Governor's EO includes:

1. *Transition of Medi-Cal Prescription Drug Benefits to Fee-For-Service.* The Executive Order directs the Department of Health Care Services (DHCS) to take all necessary steps to transition all pharmacy services currently provided by Medi-Cal managed care plans into the Medi-Cal fee-for-service delivery system. The transition, which would be completed by January 2021, is intended to create additional negotiating leverage on behalf of the state's 13.2 million Medi-Cal beneficiaries. According to the Administration, this transition would standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings beginning in the 2021-22 fiscal year. There are no savings or transition costs for this purpose reflected in the Governor's January budget for the 2019- 20 fiscal year.
2. *Statewide Review of Drug Purchasing Initiatives.* The Executive Order directs DHCS, in consultation with the California Pharmaceutical Collaborative (CPC), to review all state purchasing initiatives and consider additional options to maximize the state's bargaining power, including the Medi-Cal program. The review, which

may include recommended changes to state law or other procurement or reimbursement processes, will be completed by July 12, 2019.

3. *Prioritization of Drugs and Implementation of Bulk Purchasing Arrangements.* The Executive Order directs the Department of General Services (DGS), in collaboration with the CPC, to develop a prioritized list of prescription drugs for future bulk purchasing initiatives or for renegotiation of existing purchasing arrangements with manufacturers. The prioritization would be based on the level of competition for the drug in the marketplace and consideration of the 25 highest-cost drugs. The department will provide a written report to the Governor's Office by March 15, 2019.

This issue is primarily for the purpose of focusing on the proposed managed care carve out for drug purchasing in Medi-Cal. The Governor's proposed 2019-20 budget contains no costs or savings estimate related to this EO, nor any proposed trailer bill.

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. However, managed care drug utilization is not eligible for state supplemental rebates.

The Governor's January budget includes General Fund savings from drug rebates of approximately \$1.6 billion in 2018-19 and \$1.4 billion in 2019-20 through the federal rebate program, state supplemental rebate program, from managed care beneficiaries, and beneficiaries in the Family Planning Access, Care, and Treatment (Family PACT) program and Breast and Cervical Cancer Treatment Program (BCCTP).

The federal Veterans Health Care Act of 1992 established the 340B Drug Pricing Program (340B Program), which requires drug manufacturers that participate in Medicaid to offer significantly reduced prices to certain safety net health care providers, known as covered entities. According to the federal Health Resources and Services Agency (HRSA), which

oversees the 340B Program, these discounts enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Health care organizations eligible to be covered entities are defined in federal statute and include HRSA-supported health centers and look-alikes (e.g. federally qualified health centers), Ryan White clinics and state AIDS Drug Assistance programs (ADAP), Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

In general, federal law prohibits states from receiving federal drug rebates for Medicaid beneficiaries if the drugs dispensed were already discounted as part of the 340B Program. 340B covered entities are also required to provide drugs purchased under the 340B program to Medi-Cal beneficiaries in the fee-for-service delivery system at the 340B price. It is unclear the extent to which Medi-Cal managed care plans, in an effort to maintain an adequate network of pharmacy providers, reimburse 340B entities at a higher rate than the 340B price. However, it is likely 340B entities receive a significant amount of revenue from the incremental difference between costs and managed care reimbursement, as this feature is the primary method utilized by the 340B program to assist safety net clinics and providers to stretch scarce funding resources to care for underserved populations.

Stakeholder Concerns

Stakeholders have expressed two major concerns with the Medi-Cal drug carve-out proposal: 1) the future ability of managed care plans to manage patient care given the potential loss of real-time prescription drug data; and 2) the potential loss of 340B revenue for 340B providers (primarily clinics and hospitals).

Managing Patient Care

Medi-Cal managed care plans have raised concerns around how the carve-out would affect their ability to manage patient care. They explain that clinical patient management is only possible given the real-time data they receive from contracted pharmacies, contracts that would no longer exist under the carve-out. The plans state that under the carve-out, all treatment authorizations would be processed through DHCS, via the existing fee-for-service treatment authorization request (TAR) process. The plans allege that even the existing carve-out for certain high cost drugs often leads to diminished quality of health care for the patients due to the lack of information and data available to the plan. DHCS believes that this carve out can be implemented in a way that plans continue to receive real-time prescription drug data, thereby allowing plans to continue to use that data to manage patient care in all of the ways that they do now.

340B Drug Program Revenue

DHCS proposed significant reforms to the 340B Drug Program over the past few years, proposals that have been met with substantial opposition from clinics and hospitals which have contended that the proposed reforms would result in a significant loss of revenue for these providers. At this point, while not knowing with certainty how the EO would affect the 340B Drug Program, clinics and hospitals are concerned again that they are at risk of losing 340B revenue. DHCS states that the way the 340B program operates now lacks transparency on how providers use their 340B revenue, and would be open to discussions on ways to replace the funding with more transparency.

In addition to the concerns above, Western Center on Law & Poverty expressed concerns and recommends that the carve-out ensure that:

1. Individuals are able to continue to access prescription drugs in a timely manner with continuity of care protections. Specifically, the carve-out should: a) recognize the prior authorization process an enrollee has undergone and provide continuity of care protections for 12 months; b) eliminate the 6 drugs per month soft cap; and c) process prior authorization requests for drugs in the greater of 24 hours or one business day, the same standard applied to Medi-Cal managed care plans.
2. Due process protections remain in place. All enrollees in a Knox-Keene licensed managed care plan are eligible for an Independent Medical Review (IMR) and a State Fair Hearing, and these consumer protections should remain in place.
3. A future report on access to pharmacy services for Medi-Cal enrollees is required. This report should include processing time for TARs, approval and denial rate of TARs, request for IMR and State Fair Hearing, and results of those decisions.

Health Access California supports the Executive Order and provided the following recommendations on further addressing drug costs in the Medi-Cal program:

- Negotiating by drug category, taking into account clinical effectiveness, rather than manufacturer by manufacturer.
 - The state should build up its formulary by class of drugs to treat particular conditions, such as hypertension, diabetes, and asthma, rather than negotiating manufacturer by manufacturer.
- Impose a single state formulary for all Medi-Cal managed care plans:
 - Creating a single state formulary for Medi-Cal managed care plans would maximize the bargaining power of the State of California rather than lending our bargaining power to health plans to pocket the savings and improve their bottom line.

- This is a concept similar to requiring the federal government to negotiate for Medicare Part D instead of having health plans and insurers to bargain individually.
- Include inflation-adjusted rebates or hold flat for the life of the patent the amount paid for brand-name drugs and sole-source drugs in order to avoid price spikes².
 - Price hikes for brand name drugs (and sole source drugs) are often highest just before competition comes on the market.
 - Rebates are usually negotiated as a percentage of the price charged by the manufacturer, rather than assuring that a flat amount is paid. If the rebate is 30% of the price and the price goes up, the rebate increases but so does the amount paid by the Medi-Cal program.
- Consider participating in multi-state purchasing efforts and drug effectiveness reviews.
 - There are a number of multi-state purchasing efforts in which multiple states bargain simultaneously. This should at least be explored.
 - Similarly, California should consider participating in drug effectiveness reviews to assure that new prescription drugs actually improve health or slow the rate of decline rather than simply costing more than older drugs.
- Base rebates on drug effectiveness reviews.
 - Not all new drugs are more effective than existing drugs.
 - Some new drugs have side-effects that cause other costs to the Medicaid programs, such as hospitalizations and emergency room visits.
 - Assessing the effectiveness of a drug prior to determining what price the State is willing to pay, as is done by most European nations. It seems a basic step in considering adding new drugs to the Medicaid formulary.
 - In some instances, such as Sovaldi which cures Hepatitis C, the effectiveness of a new drug compared to existing treatment regimens, which for Hepatitis C involved managing but not curing the condition, the effectiveness was clear. It was the cost that was an outrage.
- Ban or severely limit gifts from drug companies to physicians who participate in the Medi-Cal program, including in Medi-Cal managed care plans.
 - Federal law, the Sunshine Law, requires disclosure of drug company gifts to doctors, including meals, trips, and entertainment.
 - Such gifts are part of drug company marketing to increase sales of particular drugs by encouraging physicians to prescribe particular drugs.
 - Amending the Medi-Cal contracts to ban physicians and other prescribers in the Medi-Cal program from receiving such gifts would help to improve the cost effectiveness of the Medi-Cal drug formulary by encouraging compliance with the approved formulary.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests:

1. DHCS present the Medi-Cal prescription carve out portion of the Governor's EO and describe the process in which DHCS intends to receive and incorporate stakeholder input on this new policy.
2. Stakeholders present concerns and recommendations regarding implementation of the EO.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

This agenda and other publications are available on the Assembly Budget Committee's website at: <https://abgt.assembly.ca.gov/sub1hearingagendas>. You may contact the Committee at (916) 319-2099. This agenda was prepared by Andrea Margolis.