AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, FEBRUARY 23, 2015

1:30 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW

PANEL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs
  Department of Health Care Services

PROPOSED BUDGET

Department of Health Care Services (DHCS) Budget

For Fiscal Year 2015-16, the Governor's Budget proposes $98 billion for the support of the Department of Health Care Services (DHCS) programs (primarily Medi-Cal). Of this amount, $588.5 million is budgeted for state operations, while the remaining $97.4 billion is for local assistance. The proposed budget reflects a 10.9 percent increase over the current year budget.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Thousands)

Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	CY to BY Change	% Change
General Fund	**$16,692,207**	**$18,167,875**	**$19,041,233**	**$873,358**	**4.8%**
Federal Fund	32,814,407	56,192,246	61,364,918	5,172,672	9.2
Special Funds/ Reimbursements	8,636,020	14,019,575	17,642,975	3,623,400	25.8
Total Expenditures	**$58,142,634**	**$88,379,696**	**$98,049,126**	**$9,669,430**	**10.9%**
Positions	3,337.6	3,678.2	3,720.6	42.4	1.2%

BACKGROUND

DHCS's mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's 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.*** The Medi-Cal program 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 12 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services (CMS).*** CMS coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening 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, and it includes: 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 through the Family Planning Access Care and Treatment Program ("Family PACT"), cancer screening services to low-income under- or uninsured women, through the Every Woman Counts Program, and prostate cancer treatment services to low-income, uninsured men, through the Prostate Cancer Treatment Program ("IMPACT").

DHCS Expansion

Over the past several years, DHCS has undergone a substantial transformation into a much larger department. DHCS has undertaken a massive increase in authority and responsibility in terms of both programs that have been transferred from other departments to DHCS as well as significant new Medi-Cal initiatives, including the following:

- ***Health Care Reform Implementation***. DHCS is responsible for an array of activities, responsibilities, and functions related to the full implementation of the Affordable Care Act, the most significant of which is the expansion of the Medi-al Program.

- ***Healthy Families Transition***. In 2012 the Governor proposed and the Legislature approved of the transition of all children in the Healthy Families Program to Medi-Cal. Approximately 760,000 children transitioned from Healthy Families to Medi-Cal in 2013.

- ***Coordinated Care Initiative (CCI)***. In 2012, the Governor proposed and the Legislature approved of the CCI to integrate care for "dual eligibles" (in Medicare and Medi-Cal), involving the creation of a new, more coordinated way to provide care to this population.

- **Seniors & Persons with Disabilities**. In 2011-12, DHCS transitioned 350,000 seniors and persons with disabilities into managed care, from fee-for-service Medi-Cal.

- ***Rural Managed Care***. In 2012, the Governor proposed and the Legislature approved of providing DHCS authority to seek out and establish contracts with managed care organizations to serve Medi-Cal beneficiaries in California's still-fee-for-service, primarily rural counties. DHCS selected Anthem Blue Cross, California Health and Wellness Plan, and Partnership Health Plan of California to serve these rural counties.

- ***Community Mental Health Care***. The 2011-12 budget package moved Medi-Cal mental health programs, and the 2012-13 budget package moved several non-Medi-Cal community mental health programs, from the former Department of Mental Health to DHCS.

- ***Substance Use Disorder Treatment Services***. The 2011-12 budget package moved Drug Medi-Cal from the Department of Alcohol and Drug Programs (DADP) to DHCS, and the 2013 budget approved of the transition of the remaining non-Medi-Cal DADP programs to DHCS.

- ***Direct Services from the Department of Public Health (DPH)***. The 2012 budget approved of the Governor's proposal to move the Every Woman Counts, Family Planning Access Care and Treatment, and Prostate Cancer Treatment Programs from DPH to DHCS.

- ***Managed Risk Medical Insurance Board Programs***. The 2014 Budget Act approves of the elimination of MRMIB, and the transition of remaining MRMIB programs, including the Major Risk Medical Insurance Program (MRMIP) and Access for Mothers and Infants (AIM) to DHCS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the department, its various programs and functions, its basic organization, and the proposed budget for the department.

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: MEDI-CAL ESTIMATE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $95.4 billion ($18.6 billion General Fund). The proposed 2015-16 Medi-Cal local assistance budget is approximately 11 percent greater than the estimated 2014-15 budget.

Medi-Cal Funding Summary *(Dollars In Millions)*	2014-15 Estimate	2015-16 Proposed	CY to BY $ Change	% Change
General Fund	**$17,839.7**	**$18,610.5**	**$770.8**	**4.3%**
Federal Funds	$56,977.5	$61,637.1	$4,659.7	8.2%
Other Funds	$10,930.5	$15,164.7	$4,234.2	38.7%
Total Local Assistance	**$85,747.8**	**$95,412.4**	**$9,664.6**	**11.3%**
Medical Care Services	$81,242.0	$91,331.8	$10,089.8	12.4%
County Administration	$3,981.5	$3,617.3	($364.2)	-9.1%
Fiscal Intermediary	$524.2	$463.3	($60.9)	-11.6%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 49-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, historically at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match for the federal funds.

Medicaid is the single largest health care program in the United States. In California, the estimated average monthly enrollment is eight million or roughly one seventh of the national total program enrollment. Approximately 33 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to nearly all non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level. This expansion is estimated to increase Medi-Cal enrollment by 1.4 million Californians by 2019.

Significant Medi-Cal Estimate Adjustments

The November 2014 Estimate for the current year (2014-15) is $4.6 billion Total Funds less than the 2014 Budget Act, with an increase in General Fund of $559.6 million. The 2015-16 budget proposes Total Fund costs that are $9.7 billion ($800 million General Fund) greater than the 2014-15 estimate. Descriptions of the most significant adjustments to the Medi-Cal estimate include the following:

- **Affordable Care Act (ACA) Implementation**
  There are numerous ACA-related adjustments to the Medi-Cal estimate and other implementation issues that are discussed under issue #3 of this agenda.

- **Managed Care Organization (MCO) Tax**
  MCO tax revenue is estimated to be $97.7 million less General Fund than the Budget Act, as a result of changes to the CCI, ACA and other caseloads. The 2015-16 budget estimates an increase in General Fund benefit from the tax of $330.3 million, assuming a new, revised tax that conforms with federal guidance is passed. The administration's MCO Tax proposal will be discussed in more detail at a later Sub 1 hearing.

- **Behavioral Health Treatment (BHT)**
  The estimate assumes increased costs due to the implementation of BHT (which includes Applied Behavioral Analysis, "ABA") of $89 million General Fund in 2014-15 and increasing another $62 million in 2015-16. DHCS began implementing coverage of BHT for children under age 21, effective July 1, 2014, in response to federal guidance and SB 870 (Chapter 40, 2014 budget trailer bill) which requires that the services be implemented to the extent it is required by federal law. DHCS estimates that approximately 500 children are now receiving BHT through Medi-Cal managed care plans, and another 1,200 are being screened and evaluated for eligibility for BHT. 7,500 children already were receiving these services through Regional Centers, which are required to be the provider of last resort; therefore, these children must now receive the services through their health plans, and DHCS is working on how to conduct this transition in a way that ensures continuity of care for these children. DHCS also is still working on development of rates and a rate methodology for these services, and hopes to have a rate proposal, and therefore an updated cost estimate, in time for the May Revise. The LAO expects that the cost estimate included in the budget is likely to decrease with additional data and analysis as part of May Revise.

- **Managed Care Rates**
  Rates for the four major types of managed care plans increase by $337.9 million in 2014-15 and by $456.2 million in 2015-16. Of the 2015-16 increase, $281.2 million is a placeholder for an estimated 3.57% increase in rates. The following costs have been built into the rates: ACA mandatory expansion, Hepatitis C treatments, mental health expansion, blood factor carve-out, and AB 97 rate reductions.

- **Coordinated Care Initiative (CCI)**
  General Fund costs increased $97.3 million in 2014-15 from the Budget Act and $6.4 million in 2015-16. These increased costs are a result of the delayed start in Orange County and the removal of Alameda County from the CCI.

- **Dental Services**
  The estimate includes increased General Fund costs of $38 million (excluding dental restoration) reflecting: updated 2014-15 rates, select adult dental benefits and implementing the $1,800 soft cap. Please also see issue #10 in this agenda for a longer discussion on dental services.

- **Designated Public Hospitals Reimbursement**
  The estimate assumes $87.1 million less than the Budget Act for reimbursements from Designated Public Hospitals, due to a shift in collection of Year 4 payments from 2014-15 to 2015-16. The 2015-16 payments are expected to increase by $30.9 million over 2014-15. These payments result from the fact that the state's public hospital financing architecture excludes General Fund, yet they are being paid General Fund in the form of capitation payments for seniors and people with disabilities.

- **Residential Treatment Services**
  Due to a delay in Waiver approval, the 2014-15 estimate excludes expanding Residential Treatment Services to non-perinatal beneficiaries, for a savings of $36.9 million General Fund. DHCS expects the Waiver to be approved in 2015-16 and therefore the 2015-16 estimate includes an increase of $19.6 million General Fund.

- **AB 1629 Long Term Care Quality Assurance Fee**
  The AB 1629 (skilled nursing facility) Quality Assurance Fee and Accountability Supplemental Payment (QASP) program sunsets on July 31, 2015. The Governor's budget includes a proposal to reauthorize the fee, provides a 3.62 percent rate increase and the same level of General Fund contribution to the QASP fund as in 2014-15. This proposal will be addressed in full at the Subcommittee's hearing on March 9th, 2015.

- **Designated State Health Programs**
  The state's current 1115 Waiver expires on October 31, 2015, and DHCS is in the process of developing the state's application for a new 1115 Waiver. The current Waiver allows DHCS to claim federal financial participation using Certified Public Expenditures of approved Designated State Health Programs and Designated Public Hospitals, funding that is expected to be disallowed under a new Waiver. Therefore, the estimate assumes a $46.2 million increase in General Fund savings from this process in 2014-15, and a decrease of General Fund savings of $220.55 million in 2015-16.

Medi-Cal Caseload

DHCS estimates baseline caseload to be approximately 12.2 million average monthly enrollees in 2015-16 as compared to 11.9 million in 2014-15, a two percent increase.

	2013-14	2014-15	2015-16	13-14 to 14-15 Change	14-15 to 15-16 Change
Medi-Cal Caseload	9,505,800	11,972,700	12,221,500	25.95%	2.08%

Reflecting implementation of the ACA, the 2015-16 budget assumes the optional and mandatory expansions remain flat at 2 million and 1 million enrollees, respectively.

Legislative Analyst

In their analysis of the health budget, the LAO includes a lengthy discussion and analysis of DHCS's methodology for estimating caseload in the Medi-Cal program. Specifically, the LAO raises concerns and questions about the department's projection that the senior caseload experiences a spike in 2014-15. Further, the LAO expresses skepticism about DHCS's projection for modest increases in the families' caseload, given that they would expect participation by families to decrease as the economy improves and expands. Finally, the LAO describes significant uncertainty in the caseload projections specifically related to the mandatory ACA expansion. The LAO recommends the Legislature: 1) require the administration to resume monthly caseload reports; 2) query the administration about future treatment of the mandatory expansion; and 3) encourage the administration to refocus on the base caseload trends, separate and apart from the impacts of the ACA.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes proposed for 2014-15 and 2015-16, and to respond to the following:

1. Please respond to the recommendations made by the LAO regarding caseload methodology.

Staff Recommendation: This item should be held open pending updates and changes at May Revise.

ISSUE 3: COUNTY ELIGIBILITY ADMINISTRATION COLA TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

The Governor's budget includes a budget trailer bill proposal to eliminate the statute that expresses legislative intent to provide counties with an annual cost-of-living (COLA) adjustment. There is no fiscal impact associated with this proposal.

BACKGROUND

COLAs

DHCS reimburses counties for the costs they incur by performing administrative activities associated with the Medi-Cal eligibility process. Existing Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with a COLA annually. Nevertheless, the COLA has been suspended for the past five fiscal years: 2009-10, 2010-11, 2011-12, 2012-13, and 2014-15.

The administration indicates that it is the administration's policy and practice to end all automatic annual COLAs, consistent with Government Code Section 11019.10. Consistent with this policy, AB 8 X4, (Evans), Chapter 8, Statutes of 2009-10, Fourth Extraordinary Session, eliminates the automatic annual COLA for the State Supplemental Payment (SSP) program and for the CalWORKS program. Finally, the administration points out that it has proposed to provide the counties with substantial increases in funding to address the substantial increase in ACA-driven workload, this year and over the past couple of years; hence, counties are being funded at a level higher than if they were just provided a COLA.

New Reimbursement Methodology

Currently, counties are budgeted for their activities based on claimed expenditures from previous years, and there is no county share of cost for administrative activities in the Medi-Cal program. DHCS states that, therefore, historically, there has been no incentive for counties to maximize efficiency or to control their administrative costs. SB 28 (Hernandez & Steinberg) Chapter 442, Statutes of 2013, requires DHCS, in consultation with stakeholders, to create a new methodology for budgeting and allocating funds for county administration for the Medi-Cal program, and for this new methodology to be implemented in 2015-16. According to DHCS, the new methodology will seek to use a performance and outcome-based system to determine accurate county funding levels, reward increased county efficiency, and determine effectiveness of county efforts.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. DHCS has entered into a contract with an entity that will conduct this time study, create an ongoing monitoring plan and train A&I staff on monitoring and evaluation of time studies. DHCS explains that the time study and development of the new methodology have been delayed due to the volatility in enrollment resulting from the ACA as well as due to delays in the full operation of CalHEERs, the eligibility and enrollment system for Covered California.

Stakeholder Opposition

The County Welfare Directors Association (CWDA) opposes this proposed trailer bill language, stating that it is premature at best. CWDA points out that the need or justification to modify or eliminate the annual COLA can and should be considered within the context of developing the new budgeting methodology, per SB 28. Until that time, the Legislature and Governor have the ability to suspend the COLA on an annual basis, as has occurred in each of the past several years.

STAFF COMMENTS/QUESTIONS

The administration proposed this last year, and the trailer bill was denied by the Legislature. As raised by CWDA last year and this year, DHCS is on the cusp of launching a "comprehensive overhaul" (as DHCS describes it) of the budgeting methodology for counties. Given that the Legislature and Governor have the ability to continue suspending the COLA annually, as they deem necessary and appropriate, it still seems premature to eliminate it altogether at this time, rather than to consider its role within the context of developing the new methodology.

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this issue open to allow time for additional discussion and input.

ISSUE 4: HEALTH CARE REFORM IMPLEMENTATION ISSUES

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

ACA-Related Medi-Cal Estimate Adjustments
The following are the major adjustments to the Medi-Cal estimate based on ACA implementation:

Medi-Cal Expansion
Current year costs resulting from the "optional" and "mandatory" expansions are estimated to decrease by $14.5 million from the 2014 Budget Act and increase in 2015-16 by $199.2 million due to significant increases in caseload.

Mental Health Services Expansion
The 2014-15 estimate includes increased costs of $28.4 million for non-specialty mental health in managed care and the expansion of coverage to include group mental health counseling, primarily as a result of new caseload estimates. The estimate assumes increased costs of $109.2 million for 2015-16 as a result of increased utilization.

Increased County Eligibility Administration Funding
The 2013-14 and 2014-15 budgets included supplemental funding for the counties reflecting the substantial increase in workload expected as a result of implementation of the ACA of $240 million total funds for each of the two fiscal years. In recognition that the county workload was still growing and exceeding expectations, the proposed budget includes an additional $150 million total funds, one-time funding, for 2014-15, and $240 million for 2015-16. DHCS and the County Welfare Director's Association (CWDA) describe an on-going significant increase in workload for counties due to an increase in enrollment that vastly exceeds projections, ongoing technology system delays and manual workarounds to process this substantial increase in eligibility determinations and renewals. DHCS and CWDA are engaged in ongoing discussions about the projected needs for 2015-16, which CWDA believes will far exceed the proposed $240 million appropriation and hope to see a larger appropriation included in the May Revise.

County Medi-Cal Administration Funding (Dollars in Millions)			
	2014-15 Appropriation	**2014-15 Estimate**	**2015-16 Proposed**
General Fund	$727.9	$747.6	$715.6
Federal Funds	$2,967.1	$3,207.1	$2,869.7
Other Funds	$33.2	$26.8	$32.0
Total Funds	**$3,728.2**	**$3,981.5**	**$3,617.3**

ACA Enhanced Federal Funding for County Eligibility Administration
Under the ACA, DHCS had the opportunity to apply to the federal government to receive enhanced federal matching funds for certain county eligibility administration services, which DHCS successfully secured. Therefore, for certain services, for a limited period of time, California will receive 75 percent federal funding, rather than 50 percent. As a result of this enhanced federal funding, the estimate assumes General Fund savings of $122.6 million in 2014-15, and $23.3 million in 2015-16.

Health Insurer Fee
The ACA imposes an excise tax on certain health insurers, effective January 1, 2014. The 2015-16 costs are $20.3 million less than 204-15 because they are based on one year of payments rather than two.

Other ACA Costs
Other ACA costs, not reflected elsewhere, result in a combined increase of $127.5 million for 2014-15 and a decrease of $61.3 million in 2015-16. These costs include: Express Lane Enrollment, redeterminations delays, Newly Qualified Immigrants under the ACA, and the likely federal prohibition for shifting pregnant women receiving pregnancy-only Medi-Cal coverage to Covered California.

Transition from Covered California to Medi-Cal
The California Medical Association (CMA) has brought to the attention of the Subcommittee their concerns with the process for individuals transferring from Covered California coverage to Medi-Cal coverage, which occurs when their eligibility changes. Approximately 100,000 enrollees were transferred in January 2015, and CMA states that significant continuity of care deficiencies occurred within the process. Reportedly, Covered California sent notices to their affected enrollees too late for these individuals to actually be able to select their Medi-Cal managed care plans. CMA urges that the state develop standards and transition plans, perhaps using as an example the "Block Transfer Filings," a set of standards for redirecting enrollees when their health plan terminates the contract with their provider group or hospital. It requires health plans to file with the Department of Managed Health Care a detailed transition plan to ensure continuity of care for the enrollees.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of the major fiscal impacts on the budget of ACA implementation and respond to the following:

1. Please describe the continuity of care protections and the process generally, for the transition of 100,000 enrollees from Covered California to Medi-Cal earlier this year. What plans does the department have for improving such transitions?

Staff Recommendation: No action is recommended on these issues at this time.

ISSUE 5: HEALTH CARE REFORM BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS requests the extension of 6.0 limited-term positions and expenditure authority to support the continued implementation and ongoing work of the ACA. Specifically, DHCS requests $716,000 ($129,000 General Fund, 4587,000 federal funds) for 2015-16 and $547,000 ($78,000 General Fund, $469,000 federal funds) for 2016-17 to extend the positions through June of 2016 for 2.0 positions and June of 2017 for the other 4.0 positions.

BACKGROUND

The ACA was signed into law in March of 2010 and requires significant changes to be made to the Medi-Cal program, including changes to all of the following: eligibility, benefits, rates, program integrity and interactions with the ACA-mandated Health Insurance Exchange.

DHCS began implementing the law in 2011-12 by requesting additional resources that included 5.0 2-year limited-term positions for the Provider Enrollment Division (PED) that were to expire June 30, 2013. In May of 2013, DHCS requested to extend these positions for another two years, and requested an additional 3.0 2-year limited term positions for California Medicaid Management Information System (CA-MMIS) and 1.0 2-year limited term position for the Information Technology Services Division (ISTD). All of these positions are to expire on June 30, 2015 and are associated with mandatory provisions of the ACA, according to DHCS. The current request is to extend 3.0 CA-MMIS positions, 2.0 PED positions, and 1.0 ISTD position, as follows:

Division/Office	Classification	# of Positions	Term	Fund Split
CA-MMIS	Associate Information Systems Analyst (Spec)	2.0	7/1/15-6/30/17	10%GF/90%FF
CA-MMIS	Data Processing Manager I	1.0	7/1/15-6/30/17	10%GF/90%FF
PED	Staff Services Analyst	2.0	7/1/15-6/30/16	31%GF/69%FF
ITSD	Sr. Information Systems Analyst (Spec)	1.0	71/15-6/30/17	25%GF/75%FF

The positions for which an extension is being requested address the following:

1. Technical Medi-Cal eligibility, benefit, and payment modifications that are designed to improve coverage, quality and cost-effectiveness, such as implementing the use of Modified Adjusted Gross Income (MAGI), determining benchmark benefits, and increasing payments to primary care physicians.

2. Interaction of Medi-Cal eligibility systems with the Health Insurance Exchange.

3. Implementation of the ACA requirement to enroll fee-for-service physicians individually, rather than under the certification of their clinic or physician group.

DHCS states that if this request for resources to extend these positions is not approved, their ability to fully implement and comply with the ACA will be seriously compromised.

STAFF COMMENTS/QUESTIONS

DHCS states that they continuously evaluate workload, in this and all areas, and based on that evaluation, could request to extend these positions again, or could request to make some or all of these positions permanent at some point in the future, as needed and justified.

The Subcommittee requests DHCS to present this proposal and respond to the following:

1. Please provide some basic examples of the types of work these positions are engaged in and how this work was mandated by the ACA.

2. Does this request indicate that DHCS is behind schedule with regard to the implementation of the ACA, and if so, does DHCS have a plan to catch up?

Staff Recommendation: Staff recommends holding this item open to allow for more time for input from stakeholders.

ISSUE 6: HEALTH CARE REFORM FINANCIAL REPORTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS requests $1,959,000 ($980,000 General Fund, $979,000 federal funds) for 2015-16 and $1,797,000 ($899,000 General Fund, $898,000 federal funds) on-going to establish 18.0 new 3-year limited-term positions to address increased workload in the Administration Division/Accounting Section resulting from federally-mandated reporting requirements. These positions would be funded through a 50:50 state-federal match.

BACKGROUND

The federal Centers for Medicare and Medicaid Services (CMS) requires states to do quarterly cost reporting, which are complex and varied based on State Plan Amendments (SPAs) and Waivers, and include base provider payments. Expenditures are unique based on special terms and conditions agreed to by CMS and DHCS. DHCS states that each expenditure has specific reporting requirements that are complex, and therefore require a substantial workload. Moreover, the ACA has doubled the federally-mandated workload in this area, according to DHCS.

The ACA includes new federal reporting requirements, such that the number of forms DHCS must submit to CMS ultimately will double once the Medi-Cal expansion is complete. Furthermore, reconciliations for drug rebates, overpayment collections, and the False Claims Act for the new ACA population will substantially increase workload for the Accounting Section. According to DHCS, their current staff of 8.0 positions will not be able to handle twice the workload.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and respond to the following:

1. Please explain the justification for specifically 18 new positions. The BCP references the current staff of 8.0. If the workload is expected to double, would it not be sufficient to double the staff with a request for 8.0 new positions, as compared to this request for 18?

Staff Recommendation: Staff recommends holding this item open to allow for more time for input from stakeholders.

ISSUE 7: HEPATITIS C DRUGS PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

The Governor's proposed budget includes $100 million General Fund in 2014-15 and $200 million General Fund in 2015-16 to cover the costs of Hepatitis C drugs through several different programs and departments, including the Medi-Cal program.

BACKGROUND

Several new drugs that treat and cure Hepatitis C recently became available at an estimated cost of $85,000 per treatment. DHCS states that appropriate treatment protocols remain uncertain at this point in time, thereby making it impossible for DHCS to develop a precise cost estimate for the coverage of these drugs by the Medi-Cal program, though it is clear that the costs will be substantial. DHCS has been engaged in an effort to negotiate rebates with the pharmaceutical companies, as they do for other high-cost drugs, but to date their efforts have been met with virtually no interest by the pharmaceutical industry. The development of these new drugs represents an unprecedented cost risk for the state; although the Medi-Cal program, and other state programs, cover other high-cost drugs, the size of the population with Hepatitis C makes this a unique, and uniquely-costly, situation.

Stakeholder Workgroup

The administration has begun the process of convening a group of stakeholders to advise the state on appropriate treatment protocols, which will have a significant impact on actual state costs. DHCS explains that there are unique challenges with this condition and these drugs, such as: 1) Some, but not all, Hepatitis C patients can be treated effectively without these drugs; and 2) the Medi-Cal program has no way to ensure or enforce compliance with the full course of treatment, and therefore may cover the full cost for some individuals without actually curing the disease. Finally, DHCS points out that some individuals may be successfully treated with these high-cost drugs only to subsequently become re-infected; the workgroup will talk about how to manage the costs given this possibility. The administration hopes that the work of this group will lead to more precise cost estimate prior to the May Revision.

Proposed Budget Bill Language

The budget proposes the inclusion of "provisional" language to notify the Legislature of the expenditure of these funds as follows:

> "Notwithstanding any other provision of law, items of appropriation in this act may be adjusted as determined by the Director of Finance, to reflect changes to General Fund and Federal Trust Fund expenditures resulting from high cost medications. Adjustments authorized pursuant to this section shall be implemented upon notification to the chairpersons of the committees in each house of the Legislature that consider appropriations and the chairperson of the Joint Legislative Budget Committee."

Legislative Analyst

The LAO agrees with the administration's general approach to setting aside substantial resources for this purpose and notes that there is considerable uncertainty associated with the actual future costs for the state. The LAO also finds that the proposed provisional language does not provide for sufficient legislative oversight and recommends adding a required notification to the Legislature – 30 days prior to distribution of the funds – that includes: 1) the amount of funds being distributed; 2) a description of what the funds will be used for; and 3) the program(s) that will receive the funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and respond to the following:

1. Please describe the status, membership, and timing of the proposed workgroup.

2. Please explain, describe, and share any evidence related to the concern that individuals may become re-infected repeatedly, thereby costing the state significantly in the form of repeat treatments.

3. Please explain the purpose of the proposed provisional language and any reactions to the LAO suggestions.

Staff Recommendation: Staff recommends holding this item open to allow for more time for input from stakeholders.

ISSUE 8: PEDIATRIC PALLIATIVE CARE EXPANSION PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

The Governor's budget includes a proposal to expand an existing pediatric palliative care pilot program, expected to result in net savings of $1,356,000 ($857,500 General Fund, $498,500 federal funds) for 2015-16.

BACKGROUND

AB 1745 (Chan, Chapter 330, Statutes of 2006), also known as "The Nick Snow Children's Hospice & Palliative Care Act of 2006," requires DHCS to apply for a federal Waiver to operate the Pediatric Palliative Care Pilot Project. The Waiver was approved and the project makes palliative care services available to children concurrently with curative services. As described by CMS, palliative care is patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. California statute (Health & Safety Code Section 442 (e)) defines palliative care as medical treatment, interdisciplinary care, or consultation provided to a patient or family members or both that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

AB 1745 also required DHCS to evaluate the pilot through an independent evaluator, which was done by the University of California, Los Angeles (UCLA), Center for Health Policy Research, which found that the pilot resulted in state health care savings of $3,133 per member per month. This savings was driven primarily by a decrease in inpatient care costs.

The administration is proposing an expansion to the program in light of both the fiscal savings and positive satisfaction ratings found in the independent evaluation. Currently the pilot program operates in nine counties, serving approximately 150 children. This proposal is to expand the pilot to up to seven additional counties, potentially increasing caseload to approximately 270 participants.

STAFF COMMENTS/QUESTIONS

The administration proposed to expand the pilot to up to seven additional counties, however it remains unclear precisely how many and which ones. The administration explains that DHCS promotes the program through county California Children's Services (CCS) programs and states that in order to expand the program into a county; the county must be interested and willing, as it involves a partnership between the state, counties, and home health agencies, and involves local costs.

The Subcommittee requests DHCS to present this proposal and respond to the following:

1. Please explain what the challenges would be to expanding this pilot statewide?

2. In light of SB 1004 (described in the next issue in this agenda), does this mean that the concurrent provision of palliative and curative care services will be available to nearly all adults in Medi-Cal, yet not available to most children?

Staff Recommendation: Staff recommends holding this item open to allow for more time for input from stakeholders.

ISSUE 9: PALLIATIVE CARE MANAGED CARE BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS requests $125,000 ($63,000 General Fund, $62,000 federal funds) in 2015-16 and $116,000 ($58,000 General Fund, $58,000 federal funds) in 2016-17 and 1.0 2-year limited-term position to implement SB 1004 (Hernandez, Chapter 574, Statutes of 2014) requiring the establishment of minimum standards for eligibility for and delivery of palliative care services concurrent with curative services by Medi-Cal managed care plans.

BACKGROUND

As described in the prior issue in this agenda, a pilot program in California has provided evidence of the medical and fiscal value of making palliative care available to patients concurrent with curative care. SB 1004 requires that hospice services are provided at the same time that curative treatment is available, to the extent the services are not duplicative, and are provided regardless of the estimated length of time a beneficiary may be expected to live, for adults in managed care. SB 1004 also requires DHCS to establish standards for palliative care services delivered concurrent with curative services to Medi-Cal beneficiaries served by managed care plans. Specifically, SB 1004 requires DHCS to consult with stakeholders to:

1. Establish standards and provide technical assistance to health plans to ensure the delivery of palliative care services; and

2. Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for palliative care services.

The requested position will allow the Medi-Cal Managed Care Division to work with the Long-Term Care Division to establish this new statewide program, by focusing on the managed healthcare plans' implementation of a palliative care program, including: developing a project plan, writing policy letters, working with plans to develop a template for policies and procedures, developing a monitoring and evaluation system, analyzing results, and coordinating with stakeholders.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for more time for input from stakeholders.

ISSUE 10: DENTI-CAL PROGRAM

PANELISTS

- **Dale Carlson**, Senior Auditor Evaluator III, Bureau of State Audits
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jennifer Lopez**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

Overview and History

Federal regulations mandate that California's state plan meet the requirements for providing early and periodic screening, diagnostic, and treatment (EPSDT) services for beneficiaries under the age of 21 years. EPSDT services include dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age and dental care, at as early an age as necessary, to relieve pain and infections, restore teeth, and maintain dental health. The Denti-Cal program, a component of the Medi-Cal program, provides comprehensive dental care to pediatric and pregnant Medi-Cal beneficiaries and limited services to adult beneficiaries.

For children in Medi-Cal, dental care is provided on a fee-for-service basis in all counties, with Sacramento and Los Angeles Counties also offering services through managed care plans. Covered dental services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days).

The 2009 Budget Act eliminated dental benefits for adults in the Medi-Cal program. The 2011 Budget Act required DHCS to reduce by 10 percent its payments for many Medi-Cal fee-for-service benefits, including dental services. However, a partial restoration of benefits, primarily diagnostic and preventative services, was enacted in the 2013 Budget Act. Beginning May 1, 2014 adult Medi-Cal beneficiaries could begin receiving services.

Dental Program Administration

Under the fee-for-service model, providers are reimbursed according to a rate schedule set by DHCS. California's reimbursement rates for the 10 fee-for-service procedures most frequently authorized for payment averaged $21.60, or 35 percent of the national average of $61.96. California has not increased its reimbursement rates for Medi-Cal fee-for-service dental services since fiscal year 2000-2001.

Medi-Cal beneficiaries residing in Los Angeles County can access dental care either through the fee-for-service delivery system or through prepaid health plans, while Medi-Cal beneficiaries residing in Sacramento County are - with the exception of specific populations – mandatorily enrolled in prepaid health plans for dental care. If Sacramento County beneficiaries are unable to secure services through their prepaid health plan in accordance with the applicable contractual time frames and the Knox-Keen Act, they can qualify for the beneficiary dental exemption, which allows them to move into the fee-for-service delivery system. In 2012, about 143,000 child beneficiaries received services under the dental managed care plans operating in the counties of Los Angeles and Sacramento.

The Medi-Cal Dental Managed Care Program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with three Geographic Managed Care (GMC) Plans and five Prepaid Health Plans (PHP) that provide dental services to enrolled beneficiaries. Each dental plan receives a negotiated monthly per capita rate from the state for every recipient enrolled in their plan.

2012 Hearings

A series of legislative hearings in 2012 found a lack of oversight of the Dental Managed Care programs in Sacramento and Los Angeles counties by DHCS, resulting in significant underutilization by beneficiaries. On March 8, 2012, the Assembly Select Committee on Workforce and Access to Care convened a meeting to examine the state of the dental safety net, followed by a Senate Budget Hearing on March 22, 2012, that directly examined the Sacramento GMC Program.

As a result, 2012 budget trailer language provided for the beneficiary dental exemption process, which allows beneficiaries who are not receiving adequate or timely access to care to opt out of the managed care program, requires DHCS to establish performance measures and benchmarks for dental health plans, requires DHCS to utilize dental health plan performance data for contracting purposes, and requires the establishment of contract incentives and disincentives, along with enacting other oversight mechanisms.

2014 Denti-Cal Audit

In fiscal year 2013, nearly 56 percent of the 5.1 million children enrolled in Medi-Cal did not receive dental care through the program. On December 11, 2014, the California State Auditor issued a report titled *"California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care".* The report showed that insufficient dental providers willing to participate in Medi-Cal, low reimbursement rates, and a failure to adequately monitor the program, led to limited access to care and low utilization rates for Medi-Cal beneficiaries across the State.

While DHCS has not formally established criteria to measure the adequacy of the beneficiaries' access to dental services, a 1:2,000 provider-to-beneficiary ratio was used to meet the requests made by the State Auditor for the report. The Audit found that 16 counties either have no active providers or do not have providers willing to accept new

Medi-Cal patients, and 16 other counties have an insufficient number of providers to meet the 1:2,000 provider-to-beneficiary ratio.

Studies published by CMS, the National Academy for State Health Policy, and the National Bureau of Economic Research identify low reimbursement rates as a barrier to securing provider participation and thus children's access to dental care. California has not increased its reimbursement rates for Medi-Cal fee-for-service dental services since fiscal year 2000-01, and California's dental reimbursement rates are lower than national and regional averages. California's reimbursement rates for the 10 fee-for-service procedures most frequently authorized for payment under the program in 2012 averaged $21.60 or 35 percent of the national average of $61.96. The audit finds that DHCS has not complied with state law requiring it to annually review reimbursement rates to ensure reasonable access of Medi-Cal beneficiaries to dental services.

Additionally, DHCS has not enforced certain terms of its $7.8 billion contract with Delta Dental of California (Delta Dental) related to improving beneficiary utilization rates and provider participation. DHCS' contract with Delta Dental requires the development of a provider services manual, an action plan to increase provider participation in underserved counties, beneficiary outreach and education, in addition to other provisions.

Recent changes in federal and state laws could increase the number of children and adults who can receive additional covered dental services from 2.7 million to as many as 6.4 million, bringing into question the State's ability to provide timely and adequate care to beneficiaries.

2014 Budget Act

The 2014-15 budget approved of the administration's proposal for $17.5 million to increase dental care outreach activities for children ages zero to three years. DHCS proposed to fund this initiative with Proposition 10 funds from the California Commission on Children and Families; however, the Commission denied this funding request. Regardless, DHCS still intends to identify beneficiaries aged 0-3, during their birth months, who have not had a dental visit during the past 12 months, and mail parents/legal guardians a letter that: 1) encourages them to take their children to see a dental provider; and 2) provides educational information about the importance of early dental visits.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the following:

1. Please summarize the department's responses to the State Audit.

2. Please provide an update on improvements to pediatric dental care, both managed care and fee-for-services.

3. Please provide the most up-to-date pediatric utilization numbers, statewide, for both managed care and fee-for-service.

4. Please describe the access monitoring done by DHCS for pediatric and adult dental care. Please explain the difficulty with monitoring access in fee-for-service counties.

5. Please provide an update on the department's implementation plan for the outreach proposal included in last year's budget.

6. Please provide the level of increased utilization since the restoration of adult services; how closely aligned is utilization with what the administration anticipated for this point in time?

Staff Recommendation: Staff recommends no action on these issues at this time.

ISSUE 11: CHILD HEALTH & DISABILITY PROGRAM DENTAL REFERRAL TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS proposes trailer bill to amend statute (Health & Safety Code Section 124040) to require that local Child Health and Disability Prevention (CHDP) programs and providers refer all Medi-Cal eligible children participating in the CHDP program to a dentist, beginning at age one rather than at age three. DHCS estimates increased costs from increased utilization of dental services of $808,000 ($404,000 General Fund, $404,000 federal funds).

BACKGROUND

Implemented in, and operated by, all 58 counties, the CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth who are eligible for Medi-Cal. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth. State statute requires CHDP programs to provide a referral to a Medi-Cal dentist to any child who is at least three years old. The proposed trailer bill would require that such referrals be made for all children who are at least one year old.

The proposed requirement to provide dental referrals for children starting at age one is consistent with national consensus on best practice for pediatric oral health care and public health, and is supported by the following:

- Since 2003, the California Dental Association and the California Society of Pediatric Dentists have recommended to DHCS to provide dental referrals at age one.

- Also in 2003, the American Academy of Pediatrics issued a policy statement specifying that every child should have a dental home by one year of age.

- In addition to the organizations named above, dental referrals by age one is supported by all of the following: Medicaid EPSDT guidelines, American Public Health Association, American Association of Public Health Dentistry, Association of State and Territorial Dental Directors, and the California Society of Pediatric Dentists.

DHCS states that in response to these policies and recommendations, DHCS administratively modified CHDP policy in 2004 to recommend dental referrals be provided to children at age one. The proposed statutory change is in response to recent direction from the federal Centers for Medicare and Medicaid Services that California improves its performance ensuring children in Medi-Cal receive appropriate dental services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.

ISSUE 12: ANNUAL OPEN ENROLLMENT PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Yang Lee**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Felix Su**, Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS is proposing trailer bill language that would change the enrollment model for Medi-Cal managed care beneficiaries, in specified populations, who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; an enrollee could only change plans once a year as compared to monthly which is currently allowed. The January budget includes savings of $2,009,000 ($1,005,000 General Fund) as a result of this change.

BACKGROUND

Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month. Today, approximately 16,687 enrollees (in Two Plan Model and Geographic Managed Care) may switch plans each month, which totals 200,240 changes per year.

DHCS states that the absence of an annual open enrollment period is inconsistent with health care industry practice. All of the following utilize an annual open enrollment period: commercial health plans, Medicare Advantage and Part D Plans, CalPERS, and Health Insurance Exchange plans. DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;
- Greater opportunity for the continuity in maintenance drug therapies since enrollees would have to go through medication step therapies when they join a new Health Plan;
- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;
- Improvement in the monitoring of clinical measures used to assess quality of care, such as, HEDIS® (Healthcare Effectiveness Data and Information System);
- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using their Health Plan;

- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution); and,

- Reduces access to prescription drug abuse, which is the reason behind many plan changes, according to DHCS.

Per the proposal, the annual open enrollment period would coincide with the open enrollment period of Covered California, California's Health Insurance Exchange. DHCS would notify beneficiaries 90 days prior to the end of the enrollment calendar year of their option to change plans during the open enrollment period. This proposal would not limit initial enrollment, which can be done at any time during the year.

Only beneficiaries in the Family and Child aid codes (i.e., primarily children and parents) would be subject to the annual open enrollment period at implementation. The proposed trailer bill language requires DHCS to provide an assessment of the policy to the Legislature six months after the first calendar year of implementation. If the department finds that the process has increased the quality of care and that the process would be "appropriate" for these other populations, DHCS could seek additional legislation to extend the policy to other populations, such as seniors.

This proposal requires an amendment to California's 1115 Medicaid Waiver. Annual enrollment is expected to reduce the number of initial health assessments and mailings performed by plans, thereby resulting in modest savings. However, DHCS contends that savings are not the impetus for this proposal, as are the quality of care benefits described above.

Legislative Analyst

The LAO recommends the Legislature support this proposal, citing the following benefits: 1) the proposal likely will result in administrative efficiencies; 2) it would allow for more consistent outreach to families in which both Covered California and Medi-Cal cover different family members; and 3) it may result in more robust data that could be used to hold managed care plans accountable for the quality of care being provided.

STAFF COMMENTS/QUESTIONS

The Legislature has denied similar proposals in prior years.

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.

ISSUE 13: FAMILY HEALTH ESTIMATE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Shawn Martin**, Managing Principal Analyst, Legislative Analyst's Office
- **Public Comment**

The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Child Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts (EWC). The costs of these programs specific to Medi-Cal enrollees are captured in the Medi-Cal estimate. The administration is not proposing any substantial policy or fiscal changes to these four programs, however all of them have experienced decreasing enrollment in light of increasing coverage through Covered California and Medi-Cal as a result of the ACA. Therefore, the overall Family Health Estimate shows a projected 4.7 percent decrease in funding for 2015-16, as compared to the 2014-15 estimate, as shown in the table below.

Family Health Estimate
2014-15 and 2015-16

Program	Budget Act 2014-15	Projected 2014-15	Proposed 2015-16	CY to BY $ Change	CY to BY % Change
CCS	$95,781,000	$92,995,000	$91,291,000	$(4,490,000)	(4.8)%
CHDP	$1,713,000	$1,662,000	$1,677,000	$36,000	2.2%
GHPP	$128,739,000	$130,915,000	$136,337,000	$7,598,000	5.8%
EWC	$58,583,000	$54,311,000	$42,356,000	$(16,227,000)	(29.9)%
TOTAL	**$284,816,000**	**$279,883,000**	**$271,661,000**	**$(13,155,000)**	**(4.7)%**

BACKGROUND

California Children's Services (CCS)

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate.

The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

CCS Budget

Excluding Medi-Cal costs, the proposed 2015-16 CCS budget includes total funds of $91.3 million (including $86.7 million General Fund), as compared to the current year (2014-15) estimate of $92.9 million total funds ($27.3 million General Fund). The significant decrease in federal funds, coupled with a significant increase in General Fund reflects the department's understanding that the federal government will prohibit the inclusion of Safety Net Care Pool funding in the state's new 1115 Waiver, currently being developed by DHCS, although they are included in the state's current 115 Waiver.

CCS Budget (Non-Medi-Cal)

	2014-15	2015-16
TOTAL	**$92,994,800**	**$91,290,600**
Federal Funds	$65,635,300	$4,578,000
General Fund	$27,359,500	$86,712,600
*County Funds	$89,297,000	$91,076,600
Non Medi-Cal Caseload	16,062	16,303
Medi-Cal Caseload	161,788	164,268

*County Funds are shown here, however the Total is the total in the state budget and therefore does not include county funds.

CCS Redesign

For many years, the CCS program has operated as a managed care "carve out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve out was approved through AB 301 (Pan) Chapter 460, Statutes of 2011, which extended the sunset on the carve out until January 1, 2016. DHCS indicates that although the administration did not include a specific proposal in this year's budget, they believe that the program would greatly benefit from various reforms. DHCS states that these reforms would not necessarily transition the program to a managed care benefit; however, the program would be operated within the framework of an "organized delivery system." DHCS states that a great deal of confusion results from the current program organization,

given that children must leave their managed care networks in order to receive CCS services and it becomes somewhat unclear if the state or the managed care organization holds fiscal responsibility for these services.

DHCS has begun a stakeholder process to consider ways to redesign the program, with an initial meeting in December 2014, and a second meeting in January 2015. DHCS expects to hold three more meetings before July of this year. DHCS hopes to finish the stakeholder process in July with a clear path forward towards redesigning the program in a way that removes the inherent bifurcation, fragmentation, and alleged lack of coordination of care, without losing the program's highly valued network of specialists.

Child Health & Disability Program (CHDP)

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

CHDP Budget

The proposed CHDP 2015-16 budget includes $1,677,000 total funds ($1.6 million General Fund), as compared to the current year estimate of $1,662,000 million ($1.65 million General Fund). The program also receives $11,000 in Childhood Lead Poisoning Prevention Funds to cover the cost of blood tests for lead. There are no significant adjustments proposed for this program.

Genetically Handicapped Person's Program (GHPP)

The goal of the GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP, prevention and treatment services from highly-skilled Special Care Center teams, and ongoing care in the home community provided by qualified physicians and other health team members. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington’s disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease.

Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP however; GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP Average Monthly Caseload		
	2014-15	2015-16
GHPP State Only	946	967
GHPP Medi-Cal	866	905
TOTAL	**1,812**	**1,872**

GHPP Budget

The proposed 2015-16 GHPP budget includes total funds of $136,336,900 ($118.3 million General Fund), compared to the 2014-15 estimate of $130,915,000 ($67.2 million General Fund). There are no significant adjustments proposed to GHPP, with the exception of the increase in General Fund to account for the expected loss of federal Safety Net Care Pool funds in several state programs, as discussed elsewhere in this agenda.

Every Woman Counts (EWC)

EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services.

EWC also serves as one of the main gateways for enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment and services for eligible California residents diagnosed with breast and/or cervical cancer. BCCTP applicants are required to be screened and enrolled by CDC providers authorized to participate in EWC. HSC Section 104162.2 allows non-EWC providers, such as non-Medi-Cal providers, to diagnose cancer and make referral to an enrolled EWC provider for the purpose of enrollment into BCCTP. This process is known as a "courtesy enrollment." The individual seeking cancer treatment through BCCTP must

provide the pathology/biopsy report to an EWC provider to confirm diagnosis and request enrollment into BCCTP.

EWC provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC is expected to serve 213,000 women for fiscal year 2015-16.

EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage, and is funded through a combination of tobacco tax revenue, General Fund, and federal Centers for Disease Control (CDC) grant. The CDC grant requires the program to monitor the quality of screening procedures, and therefore the program collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal. This recipient data is then reported to CDC biannually and assessed for outcomes to determine if outcomes meet performance indicators, such as the number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment. EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC Budget

The proposed 2015-16 budget includes $42,356,000 total funds ($4.6 million General Fund) for EWC, a $11.9 million (22%) decrease from the 2014-15 estimate of $54,311,000 ($16.6 million General Fund). This significant decrease reflects a significant decrease in caseload as a result of ACA implementation; it is presumed that much of the EWC caseload has obtained comprehensive coverage through either Covered California or Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee would like DHCS to respond to the following:

1. Please provide a brief overview of the Family Health Estimate and each of its programs.

2. Please describe the department's plans for reforming the CCS program. Specifically, please explain the need to reform or reorganize the program.

Staff Recommendation: This item should be held open pending updates and changes at May Revise.

ISSUE 14: LIMITED SCOPE PROGRAMS PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Shawn Martin**, Managing Principal Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS proposes trailer bill that:

1. Requires individuals applying for the Genetically Handicapped Persons Program (GHPP), to apply for insurance affordability programs through Covered California (Covered CA), in addition to the existing requirement that they apply for Medi-Cal, or in lieu of these requirements, provide evidence of other health care coverage. To the extent they are found eligible for an insurance affordability program and GHPP, they will be required to enroll in the insurance affordability program and receive only those specialized services in GHPP that would not otherwise be provided through Medi-Cal or Covered California through their qualified health plan. This proposal does not prohibit eligible individuals from receiving GHPP services during the time they are awaiting an eligibility determination.

2. Requires enrolling providers who participate in Every Woman Counts (EWC), Family Planning Access Care and Treatment (FPACT), and IMProving Access, Counseling, and Treatment for Californians with Prostate Cancer (IMPACT), to provide to the enrolling individuals, information on how to apply for insurance affordability programs, in a manner determined by DHCS. This proposal does not prohibit eligible individuals from receiving medically necessary services from these programs.

There is no fiscal impact associated with this proposal.

BACKGROUND

Genetically Handicapped Persons Program (GHPP)
The GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP; prevention and treatment services from highly-skilled Special Care Center teams; and, ongoing care in the home community provided by qualified physicians and other health team members. Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP however; GHPP clients may

be required to pay an annual enrollment fee based on the client's adjusted gross income. As of January 8, 2015, there were 1,753 individuals in the active statewide GHPP caseload with 869 of these enrolled in Medi-Cal.

Every Woman Counts (EWC)
EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services.

EWC also serves as one of the main gateways for enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment and services for eligible California residents diagnosed with breast and/or cervical cancer. BCCTP applicants are required to be screened and enrolled by CDC providers authorized to participate in EWC. HSC Section 104162.2 allows non-EWC providers, such as non-Medi-Cal providers, to diagnose cancer and make referral to an enrolled EWC provider for the purpose of enrollment into BCCTP. This process is known as a "courtesy enrollment." The individual seeking cancer treatment through BCCTP must provide the pathology/biopsy report to an EWC provider to confirm diagnosis and request enrollment into BCCTP.

EWC provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC is expected to serve 213,000 women for fiscal year 2015-16.

Family Planning, Access, Care and Treatment (FPACT)
FPACT has been operating since 1997 to provide comprehensive family planning and reproductive health services at no cost to California residents at or below 200 percent of the Federal Poverty Level (FPL). From December 1999 through June 2010, FPACT operated under the authority of a Section 1115 Demonstration Waiver. In March 2011, the Section 1115 FPACT Demonstration Waiver transitioned to the Medicaid State Plan retroactive to July 1, 2010. FPACT currently has 2.8 million individuals enrolled in the program and serves 1.8 million income-eligible men, women, and adolescents annually through a network of 2,300 public and private providers. FPACT providers also assist individuals who are diagnosed with breast and/or cervical cancer and need treatment and services to enroll directly into BCCTP using an online application.

IMProving Access, Counseling, and Treatment for Californians with Prostate Cancer (IMPACT)
While known throughout the state as IMPACT, the Prostate Cancer Treatment Program (PCTP) was established in 2000, under HSC Section 104322, to develop, expand, and ensure high quality prostate cancer treatment for, uninsured and underinsured California men who are age 18 and older and whose income is at or below 200 percent FPL. Eligible men are enrolled for twelve months of prostate cancer treatment service. The PCTP collaborates statewide with local hospitals, clinics, and private practitioners to provide treatment services (in the nearest participating facility) including but not limited to surgery, radiation, hormone therapy, chemotherapy, and watchful waiting.

Coverage also includes medical tests and services, hospital, outpatient, and pharmaceutical charges. IMPACT currently serves 413 men.

Justification
DHCS provided the following justification for this proposal:

- The ACA requires consumers to obtain comprehensive coverage or pay a penalty. Certain populations, based on their income, will also be afforded financial subsidies which will result in no or low cost coverage.

- Prior to the advent of ACA, limited benefits programs were primarily established to provide limited coverage options to individuals unable to obtain coverage in publicly financed programs such as Medi-Cal or the commercial market.

- Compliance with the ACA requires health plans to cover a list of ten essential health benefits, including, but not limited to: maternity and newborn care, chronic disease management, rehabilitative services and devices, and laboratory services. Some of these essential benefits are duplicative of services provided by the limited benefits programs.

- Under ACA, insurers are no longer able to deny health care coverage due to pre-existing conditions and the expanded coverage options have resulted in declining caseloads for the limited benefit programs. Furthermore, limited benefits programs provide health services that do not qualify as comprehensive coverage which is inconsistent with state policy goals and may result in enrollees being assessed the financial penalty.

- Many of the individuals enrolled in these limited benefit and special population programs are now eligible for coverage in Medi-Cal, Covered CA, or in the commercial market, and generally with more comprehensive benefits and lower or no cost to the individual.

This proposal requires all persons applying for GHPP to seek comprehensive coverage but still allows enrollment into the program. For applicants seeking services under EWC, FPACT and IMPACT, the proposal requires providers, or the enrolling entity, to make available to applicants prior to or concurrent with enrollment, information on how to apply for comprehensive coverage, in a manner determined by DHCS, but does not prevent eligible individuals from receiving services through these programs.

Individuals impacted by this proposal would be eligible for continuity of care which ensures continued access to all services provided to an individual prior to his or her transition to managed care until a new care plan can be established by the managed care plan. Continuity of care also allows individuals to continue to see their same providers with a few exceptions until such time that their provider becomes a part of the MCP's network or the individual is transitioned through a warm hand off to an MCP in-network provider.

DHCS states that the aim of this proposal is to ensure that individuals who are currently in limited benefit and special population programs that do not qualify as comprehensive coverage are being provided information about and, when appropriate, enrolling into comprehensive coverage, if eligible, in order to maintain eligibility for these specialized services.

Stakeholder Concerns

The Hemophilia Council of California has concerns with this proposal, primarily relating to the high cost of care through Covered California. The Council states that most ACA plans do not allow access to Hemophilia Treatment Centers, which lead to reduced morbidity and mortality (according to research they cite). The Council believes that the increased financial burden of ACA plans (premiums and copayments) may cause hemophilia patients to drop out of GHPP and not receive the high quality care that they need.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and to respond to the following:

1. The proposed trailer bill provides that GHPP (and other programs') services would continue to be available for any care or services not covered by an individual's health plan; what happens if the care or service is "covered" by the health plan but at a significantly higher, and possibly unaffordable, cost?

2. Has the department done a patient-based cost comparison between coverage in GHPP and coverage through Covered California?

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.

ISSUE 15: MAJOR RISK MEDICAL INSURANCE PROGRAM PROPOSAL & TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Shawn Martin**, Managing Principal Analyst, Legislative Analyst's Office
- **Public Comment**

DHCS proposes trailer bill language to limit enrollment in the Major Risk Medical Insurance Program (MRMIP) to: 1) the population with End State Renal Disease; and 2) anyone who cannot secure comprehensive coverage elsewhere. The proposed language also extends the deadline for DHCS to reconcile final claims for the former Guarantee Issue Program until June 30, 2016.

BACKGROUND

Since 1991, MRMIP has provided health insurance to Californians who are unable to obtain coverage, or charged unaffordable premiums, in the individual health insurance market due to a pre-existing condition. Californians who qualify for MRMIP contribute to the cost of their health care coverage by paying monthly premiums equal to 100 percent of the average market cost of premiums (based on the Silver level coverage through the Exchange), an annual deductible and copayments. These monthly premiums are subsidized through the Cigarette and Tobacco Products Surtax Fund (Proposition 99). MRMIP has an annual benefit cap of $75,000, and a lifetime benefit cap of $750,000. MRMIP is not an income-based eligibility program.

MRMIP services are delivered through contracts with health insurance plans and the program provides comprehensive health benefits to both subscribers and their dependents. Health plan participation in the program is voluntary. Currently, one preferred provider organization and three health maintenance organizations participate in the program. MRMIP provides statewide coverage and subscribers have a choice of two or more health plans in most urban areas of the state. DHCS assumed responsibility for MRMIP on July 1, 2014.

MRMIP was originally established as a state high-risk pool; however, the need for high-risk pools such as MRMIP has been greatly reduced as a result of the passage of the ACA. The ACA prohibits the denial of coverage to individuals due to a pre-existing condition and also prohibits charging individuals with a pre-existing condition a higher premium due to their condition. As a result, MRMIP has seen a dramatic decline in caseload since ACA open enrollment in the Exchange began in October 2013. The current caseload is approximately 2,600 individuals.

Individuals with End Stage Renal Disease and Undocumented Individuals

When the federal government established the framework for Medicare supplemental coverage, control over the regulation of health insurance and health plans remained with the states. Medicare most commonly provides coverage for persons age 65 and older, and it is also available to persons under age 65 who are disabled or diagnosed with ESRD.

The federal framework for Medicare supplemental coverage gives states flexibility as to whether to include persons under age 65 who are disabled or diagnosed with ESRD in the Medicare supplemental coverage market. Health and Safety Code Section 1358.11 and Insurance Code Section 10192.11 authorize the Medicare supplemental coverage market to include persons with disabilities but exclude persons under age 65 with ESRD, by specifically allowing insurers and plans to exclude them from coverage. As a result, MRMIP subscribers with ESRD use MRMIP as their Medicare supplemental coverage. About 50,000 Californians are believed to be diagnosed with ESRD and approximately 60 ESRD individuals are enrolled in MRMIP.

Individuals under the age of 65 with ESRD who have Medicare coverage do not qualify for coverage in the Exchange or in the individual market because of federal "anti-duplication" laws. Some of these individuals do not qualify for Medi-Cal because they do not meet eligibility requirements. DHCS estimates that there are approximately 60 individuals enrolled in MRMIP with ESRD.

In addition, since MRMIP is a state-only funded program, proof of citizenship is not required for enrollment; therefore, undocumented individuals are eligible for the program. Undocumented individuals are not eligible for full scope no SOC Medi-Cal and are prohibited from purchasing coverage through the Exchange; however, they do qualify for health coverage in the individual market.

Major Risk Medical Insurance Fund

Welfare and Institutions Code Sections 15893 et seq. allocate funds derived from Proposition 99 funds to the Major Risk Medical Insurance Fund (MRMIF), which supports MRMIP. Historically, no General Fund monies have been used to support MRMIP.

Because MRMIP has seen a dramatic decline in caseload since ACA open enrollment in the Exchange began in October 2013, the Legislature passed Senate Bill 857 (Committee on Budget, Chapter 31, Statutes of 2014, Section 93), that requires DHCS to convene a stakeholder workgroup (Section 93 Workgroup) to develop a plan to utilize any MRMIF funds that are currently not being used by MRMIP. The Section 93 Workgroup has provided suggestions regarding the future of MRMIP, and DHCS has considered stakeholder comments in the development of this proposal. These Section 93 Workgroup discussions are ongoing and details on the specifics of the modified program are still being determined and may alter the construct of this trailer bill language.

Justification for the Proposal

DHCS provides the following justification for this proposal: The ACA has largely eliminated the need for high-risk pools such as MRMIP; however, there are still some populations who are ineligible for other health coverage. Therefore, DHCS proposes to provide health coverage through a modified program, as of January 1, 2016, for individuals who are unable to secure other health coverage. All other subscribers, applicants and their dependents would be encouraged to enroll in other health coverage for which they are eligible. DHCS points out that for citizens, coverage through MRMIP does not meet federal ACA requirements as MRMIP does not cover Minimum Essential Coverage.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

1. If a majority of the current MRMIP caseload were to qualify for other coverage, would it be possible to operate the program with only a very small caseload remaining?

2. Has the department done a cost comparison for an individual enrolled in MRMIP as compared to being covered through the individual market?

Staff Recommendation: Staff recommends holding this item open to allow for additional time for review and public input.