ITUP
Insure the Uninsured Project

MAPPING THE FUTURE MEDI-CAL

What's next?

MARCH 2019

The federal Affordable Care Act (ACA) changed the health care landscape in California and significantly reduced the number of uninsured Californians under age 65 to nearly three million in 2017.[1]

Medi-Cal (California's Medicaid program) grew dramatically under ACA implementation from 9.7 million in 2013 to more than 13 million in 2019 (all ages).

Medi-Cal is center stage as state policymakers consider further expansion of the program and focus on the significant challenges facing a program that now serves nearly 1 in 3 Californians.

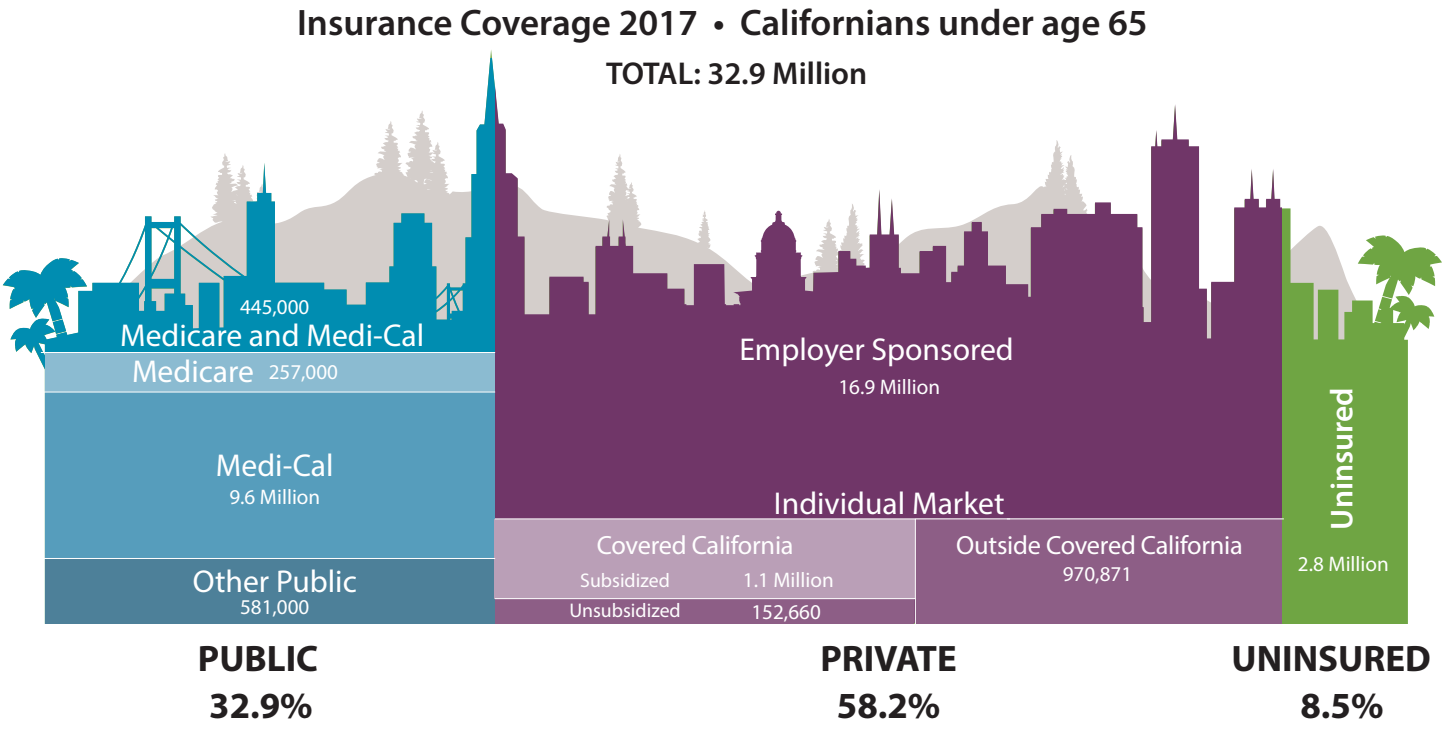
The Medi-Cal program is at a crossroads. Multiple deadlines, changes in federal law and system challenges will be converging over the next few years, requiring thoughtful and comprehensive review of the current program.

IN THIS ISSUE

Purpose of this Report

This publication and the companion publication, *Mapping the Future of Individual Coverage*, examine pressing issues related to these coverage options for Californians without employer-sponsored coverage or Medicare.

The discussion of each topic includes the relevant federal and state context with a brief analysis.



Sources: Estimates from California Health Interview Survey 2017 data, Covered California, Active Member Profiles, December 2017 and Katherine Wilson, "State Release Data on California 2017 Health Insurance Enrollment," California Health Care Foundation, August 2018, companion Excel file.

DEFINITIONS

Essential Health Benefits. Ten core benefits defined in the ACA and covered by Medi-Cal: outpatient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder (SUD) services, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services, including oral and vision care.

Full-Scope Medi-Cal. Comprehensive benefits and services covered for Medi-Cal beneficiaries who meet income and other eligibility requirements, including federally mandated Medicaid benefits, ACA essential health benefits, and optional Medi-Cal benefits, as determined by the state. These currently include adult dental, optometry, physical therapy, acupuncture and chiropractic services, among others.

Restricted-Scope Medi-Cal. A limited benefit program covering emergency services, pregnancy-related services and, when needed, state-funded long-term care for individuals not eligible for full-scope Medi-Cal (primarily undocumented adults).

Medi-Cal Fee-For-Service (FFS). A Medi-Cal delivery system where providers submit claims directly to the Medi-Cal program's fiscal intermediary and receive payment for each medical service provided to an eligible beneficiary.

Medi-Cal Managed Care (MCMC). DHCS contracts with public and private health plans to deliver Medi-Cal covered benefits to beneficiaries through health plan contracted provider networks.

MCMC "Carve-Outs." Certain benefits and populations excluded from MCMC contracts, including dental, mental health and SUD services, and beneficiaries on restricted scope Medi-Cal. Medi-Cal beneficiaries access carve-out services through other specialized managed care entities, such as county mental health plans, or through Medi-Cal FFS.

I. The Basics

Medi-Cal is jointly financed by the state and federal governments, and administered by the California Department of Health Care Services (DHCS). The basic program features are:

- ***Eligibility.*** Medi-Cal eligibility extends to income-eligible, federally mandated population groups, populations that are optional under federal rules and populations that the state chooses to cover primarily with state funds.
- ***Benefits***. Medi-Cal currently provides a core set of comprehensive benefits, such as doctor visits, hospital care, immunizations, pregnancy-related services and nursing home care. Included are all ten ACA essential health benefits, as well as optional benefits, such as adult dental.
- ***Delivery System***. Medi-Cal provides services on a fee-for-service (FFS) basis (18 percent of beneficiaries) and through Medi-Cal managed care (MCMC) plans (82 percent)[2] but excludes from managed care certain "carved out" services and populations. For example, mental health and substance use disorder treatment services are carved out of MCMC plans. Most individuals eligible for both Medi-Cal and Medicare have the option to enroll in MCMC but are not required to enroll like most children and other adults.
- ***Provider payments.*** In general, the state sets payment rates for FFS providers and health plans, while health plans determine payment rates for most participating MCMC plan providers.

Key Characteristics of the Medi-Cal Program

- Medi-Cal covers more than 13 million low-income Californians and provides comprehensive benefits comparable to private coverage at no or low-cost to beneficiaries.
- Medi-Cal provides coverage through a complex, fragmented delivery system. Although managed care dominates, many services are carved-out of MCMC contracts, requiring managed care beneficiaries to access these services outside of their MCMC plan. Some populations, such as those on restricted scope Medi-Cal, are also carved out and remain in fee-for-service programs.
- In recent years, California expanded Medi-Cal eligibility to advance coverage for the remaining uninsured, including adopting the ACA optional federal expansion for low-income adults, and uses state funds to cover children ineligible for full-scope Medi-Cal because of immigration status.
- Over time, and especially with the eligibility expansions under the ACA, Medi-Cal shifted from a program serving primarily low-income families with children, pregnant women, seniors and persons with disabilities, to becoming the primary source of coverage for most low-income Californians (excluding undocumented adults).
- Even though Medi-Cal is a state-administered program, Medi-Cal beneficiaries can have very different experiences depending on their county of residence. There is wide variation in the number and types of providers in the program, from multi-site, county owned and operated health systems in large metropolitan areas, to small community clinics and hospitals as the primary providers in remote and rural areas.

The Federal Medicaid Program

State Medicaid programs receive federal funds and are subject to federal rules and requirements (Title XIX of the Social Security Act) affecting eligibility, benefits and federal financial participation levels.

Federal funds are available to match state contributions for Medicaid required services and populations, as well as optional benefits and beneficiary groups. States that go beyond authorized federal services or beneficiary groups must use state-only funding. The level of federal matching funds (known as the Federal Medical Assistance Percentage (FMAP)) varies by state (50-77 percent) and by program element. California's basic FMAP is 50 percent, with higher matching rates for some services and populations.

States have flexibility to expand full-scope eligibility to certain optional populations, such as low-income adults without dependent children, and to offer certain optional benefits, including prescription drugs, case management, dental and optometry services.[6]

State Children's Health Insurance Program (CHIP). CHIP provides federal matching funds for states to provide health coverage to low- and moderate-income children. States have flexibility in deciding income eligibility levels.[7] They receive a higher matching rate for CHIP than Medicaid (76.5-95.4 percent) for children up to 300 percent of the Federal Poverty Level (FPL), while those that cover children above 300 percent FPL receive matching funds at the state's regular Medicaid FMAP.[8] States have the option to administer a separate CHIP or expand Medicaid programs to include CHIP-eligible beneficiaries.

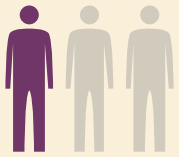
ACA Coverage Expansions. Pre-ACA, most low-income childless adults, parents over 100 percent FPL and caretaker relatives over 100 percent FPL were generally not eligible for full-scope Medicaid. The ACA expanded full-scope Medicaid coverage to young adults aging out of foster care up to age 26 and authorized states to cover other low-income adults up to 138 percent FPL (household income of $16,754 per year for an individual in 2019), with states receiving a higher FMAP for the expansion population (91.5 percent in state fiscal year (SFY) 2019-20 and 90 percent in SFY 2020-21 and thereafter).

The State Medi-Cal Program

Medi-Cal generally provides full-scope coverage for low-income adults, families with children, seniors, persons with disabilities, pregnant women, children in foster care and former foster youth up to age 26. In addition, California uses primarily state-only funding to provide full-scope coverage for legal permanent residents who are subject to a five-year waiting period for federal Medicaid eligibility, as well as low-income undocumented children up to age 19. Most undocumented adults are only eligible for emergency and pregnancy-related services (restricted scope Medi-Cal).

California initially operated a separate CHIP, known as the Healthy Families Program, and integrated CHIP into Medi-Cal in 2013. In 2017, CHIP covered 25 percent of all children in Medi-Cal and 13 percent of all children in California.[9] Most of these children participate in the MCMC delivery system (94 percent) and a majority are Latino/Hispanic (61 percent).[10]

MEDI-CAL FAST FACTS



1 in 3

Californians are enrolled in Medi-Cal.[3]

84%

nondisabled, nonelderly adult Medi-Cal beneficiaries are in working families.[4]

Medi-Cal covers almost half the births in California.[5]

4 out of 5

Medi-Cal beneficiaries are enrolled in a MCMC plan.

Medi-Cal Delivery System

Medi-Cal provides coverage through a complex and often fragmented delivery system, with 18 percent of beneficiaries in FFS and 82 percent enrolled in MCMC plans. In the 1970s, California was the first state in the nation to implement managed care in Medi-Cal.[11] Most new Medi-Cal expansion groups are designated mandatory managed care beneficiaries, meaning that they must enroll in a MCMC plan, such as newly-eligible childless adults and low-income undocumented children.

There are multiple MCMC plan models which vary by county and developed over time as outlined in Figure 1 below.

Local Public Health Plans. As the state increased MCMC enrollment, California authorized locally-developed public MCMC plans to organize Medi-Cal services and work closely with local stakeholders and safety net providers,[12] including public hospitals and community clinics.[13] County Organized Health System (COHS) plans and local initiatives, together known as Local Public Health Plans (LPHPs), are available in 36 of California's 58 counties and now serve the majority of MCMC enrollees. In 2018, of the 10.6 million beneficiaries in managed care, LPHPs served 7.2 million, or 68.3 percent.[14]

Figure 1. MCMC Models

CHARACTERISTICS OF MEDI-CAL MANAGED CARE MODELS		COUNTIES SERVED
Two-Plan Model	▪ One county-organized local initiative public health plan and a commercial health plan ▪ Statewide December 2018 enrollment: 6.8 million	▪ Operates in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare
COHS	▪ One county-wide, public health plan originally organized by the county serves all Medi-Cal beneficiaries in the county ▪ Three of the six COHS plans currently serve multiple counties ▪ Statewide December 2018 enrollment: 2.1 million	▪ Operates in 22 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo
GMC	▪ Multiple commercial health plans are chosen by the state ▪ Statewide December 2018 enrollment: 1.1 million	▪ Operates in San Diego and Sacramento
Regional Model and County-specific Models	▪ At least two commercial plans in 20 primarily rural counties ▪ Statewide December 2018 enrollment: 378,000	▪ Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba ▪ In Imperial County, beneficiaries choose from among two commercial plans, DHCS separately refers to this as the "Imperial Model" ▪ In San Benito County, beneficiaries choose between one commercial plan and FFS, DHCS refers to this as the "San Benito" model

MCMC Carve-Outs. While 82 percent of beneficiaries are enrolled in MCMC, certain services and populations are excluded from MCMC. For example, most beneficiaries enrolled in MCMC must access major organ transplants, most psychotherapeutic drugs, and most HIV/AIDS drugs through the FFS program. Most individuals "dually-eligible" for Medicare and Medi-Cal are not required to enroll in MCMC but may do so voluntarily. In Sacramento and Los Angeles counties, dental health plans separately provide covered dental services, while in the remaining counties beneficiaries access dental care through the FFS program.

In most counties, children who have specific medical conditions are enrolled in both MCMC and FFS, and receive services for the specific condition through the California Children's Services program, outside of the MCMC plan.[15] Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The state has also consolidated most covered services into managed care. Covered services recently moved or added to MCMC plans include medically necessary services to treat autism, outpatient mental health services for mild to moderate conditions, palliative care, adult immunizations, End of Life Option Act services, and Community-Based Adult Services (CBAS). Some Medi-Cal covered services, such as CBAS, are primarily limited to Medi-Cal managed care beneficiaries.

Mental Health and SUD Services. Specialty mental health services and substance use disorder (SUD) services are also carved-out of MCMC contracts. Counties administer specialty mental health services for severe mental illness through a county mental health plan and MCMC plans cover services for mild-to-moderate mental illness. Counties and MCMC plans are required to coordinate services subject to a local memorandum of understanding.

The Drug Medi-Cal (DMC) program covers a limited set of SUD benefits administered by counties. Starting in 2017, counties began voluntarily implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot through the state's Medi-Cal 2020 Waiver. DMC-ODS is a managed care model for delivering and organizing more comprehensive SUD benefits. As of this writing, 40 counties have submitted implementation plans to DHCS and 24 have final approval to offer the program.

Proposed Pharmacy Benefit Carve-Out. On January 7, 2019, Governor Gavin Newsom signed an executive order directing DHCS to standardize and transfer all pharmacy services provided by existing MCMC plans to a fee-for-service system.[16] The Governor's plan requires DHCS to negotiate prescription drug prices on behalf of all 13 million Medi-Cal beneficiaries. Currently, the state negotiates for FFS prices and MCMC plans negotiate for their respective managed care members. The Administration estimates the proposal will result in hundreds of millions of dollars in annual Medi-Cal savings starting in FY 2021-22.

Medi-Cal Covered Services*

Covered by MCMC Plans and Carved-Out

Covered by MCMC Plans	Services Carved-Out of MCMC Plans
▪ Physician Services	▪ Specialty Mental Health
▪ Outpatient (Ambulatory) Services	▪ Alcohol/SUD Treatment
▪ Emergency Services	▪ Institutional Long-term Care (Except for County Organized Health Systems or COHS)
▪ Hospice and Palliative Care	▪ Home and Community Based Waiver Services
▪ Hospitalization	▪ In-Home Supportive Services
▪ Outpatient Surgery	▪ Non-Medical Dental
▪ Maternity and Newborn Care	▪ Major Organ Transplants
▪ Pediatric Services	▪ Most Psychotherapeutic and SUD Drugs, Blood Factor, Antiviral
▪ Prescription Drugs	▪ Most HIV/AIDS Drugs
▪ Rehabilitative and Habilitative Services and Devices	▪ CCS Services (Except for the plans administering the Whole Child pilot)
▪ Laboratory Services	▪ Certain Lab Tests and Certain Management and Tuberculosis Services
▪ Preventive and Wellness Services and Chronic Disease Management	▪ Special Care Services for Adults with Genetic Diseases
▪ Chiropractic	
▪ Podiatry	
▪ Vision	
▪ Acupuncture	
▪ Outpatient Mental Health Services for Mild to Moderate Conditions	

*Note: This list, prepared by ITUP using multiple sources, is not an exhaustive list of Medi-Cal covered services. Some services covered by MCMC plans are only available through a Federally Qualified Health Center. Medi-Cal services must be medically necessary and may be subject to limitations, including prior authorization or other service limits as allowed by law.

Financing Medi-Cal

The Medi-Cal program is funded through a combination of federal Medicaid funds (FMAP) and "nonfederal" funds. California will spend an estimated $100 billion combined federal and nonfederal funding for SFY 2018-19 on the Medi-Cal program.[17] In SFY 2018-19, the Medi-Cal program overall will receive an estimated 64 percent in federal funds and 36 percent from nonfederal sources.[18]

For most Medi-Cal populations, the state must provide 50 percent in nonfederal share to receive 50 percent FMAP, but for some populations California receives a higher FMAP. For example, California receives a higher federal match for CHIP (typically 76.5 percent) and low-income adults covered under the ACA Medicaid expansion (91.5 percent in SFY 2019-20 and 90 percent in SFY 2020-21 and ongoing). In 2019, California's FMAP for CHIP-eligible beneficiaries is 88 percent, dropping to 76.5 percent in 2020, because temporary increases of the CHIP FMAP included in the ACA are set to expire.[19]

Federal Financial Participation
ACA Optional Medicaid Expansion Population
Low-Income Adults

SFY	FMAP
2018-19	93.5%
2019-20	91.5%
2020-21	90.0%
2021-ongoing	90.0%

Chart prepared by ITUP.

In addition to state general fund, California relies on various sources to provide the nonfederal share, primarily funding from local governments and fees charged to providers and MCMC plans. California will contribute $35.8 billion in nonfederal matching funds, including $21.6 billion from the state general fund, or 60 percent of the total nonfederal share.[20] The remaining approximately 40 percent of nonfederal share is derived from other nonfederal sources.

Medi-Cal Payment Rates. In general, DHCS sets payment rates for FFS providers and health plan payment rates, while health plans determine rates and payment methods for participating plan providers. DHCS pays MCMC plans a fixed monthly payment (known as a capitation payment) for each Medi-Cal beneficiary enrolled in the health plan. MCMC capitation rates take into consideration beneficiary age, eligibility category, average county costs, medical cost trends, enrollee demographics, state and federal program changes and indicators of enrollee health status.[21]

Historically, Medi-Cal FFS provider rates have been among the lowest in the nation,[22] discouraging providers from seeing Medi-Cal patients and resulting in access challenges for Medi-Cal beneficiaries. Although many MCMC plans pay providers more than FFS rates, the legacy of persistently low provider rates continues to adversely impact provider participation in MCMC plans.[23]

Growth in the Medi-Cal Program

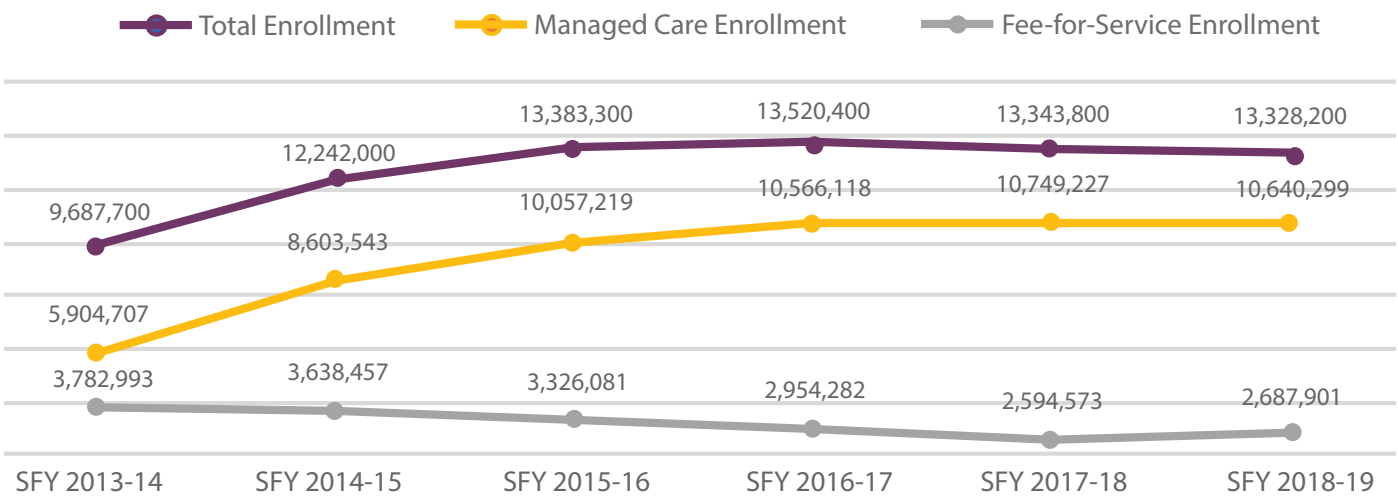
In the last few years, Medi-Cal added over four million new beneficiaries. (See Figure 2.) With 13 million beneficiaries, Medi-Cal is the largest Medicaid program in the nation. Prior to the ACA Medicaid expansion, Medi-Cal covered one in four Californians.[24] In 2018, Medi-Cal provided health coverage to nearly one in three Californians, including five million children.[25]

The rapid growth in the Medi-Cal program also poses challenges for the state, including ensuring an adequate Medi-Cal provider network to serve new and existing beneficiaries, coordination between different systems (and silos) of care and meeting the diverse needs of a heterogeneous population, among others.

Medi-Cal has different managed care plans providing physical health benefits, separate plans and programs providing behavioral health benefits and still other plans providing dental benefits in some counties. A beneficiary may be served by multiple systems, health plans and programs, with the resulting challenges for them to obtain coordinated, quality care.

The dramatic growth in Medi-Cal enrollment highlights the importance of adequate and stable financing and solid infrastructure for the program. It also highlights the challenges the Medi-Cal program faces in ensuring timely and adequate access to needed providers and services. Medi-Cal is and will continue to be center stage in the ongoing state discussions on how to cover the remaining uninsured and ways to reshape coverage options, such as proposals for a "public option" or a single payer approach to universal coverage.

Figure 2. Medi-Cal Enrollment Estimates by State Fiscal Year



Source: Department of Health Care Services (DHCS). May Medi-Cal Estimates - Estimated Average Monthly Certified Eligibies, May 2015, 2016, 2017 and 2018. DHCS, MCMC Enrollment Reports, October 2014, 2015, 2016 and 2017 and September 2018. Chart prepared by Insure the Uninsured Project.

HOW THE STATE CHANGES MEDI-CAL POLICY

Various state and federal mechanisms are available to change Medi-Cal program and policy as below.

State Legislation and Budget Policy. California maintains a robust statutory and regulatory framework for all aspects of the Medi-Cal program. State law sets the benefits, eligibility and eligibility process, delivery system, program requirements and rate setting structure for Medi-Cal, as well as the broad parameters of federal waiver requests and provider fees. State law outlines the authority of the DHCS to implement and refine Medi-Cal program and policy changes. California lawmakers respond to federal Medi-Cal policy changes by incorporating the changes in state law, or developing state-specific modifications or alternatives, consistent with the federal authority provided to states.

State Plan Amendments (SPAs). A Medicaid State Plan is the agreement between a state and the federal government describing how the state administers its Medicaid program under existing federal laws, including details about state program administration, who the program serves, the benefits provided and the payment / delivery system. When a state wishes to significantly change program policies or operational approaches, the state submits a SPA to the Centers for Medicare and Medicaid Services (CMS) for review and approval, which amends the State Plan. States also submit SPAs to CMS as notification when the state makes permissible program changes.

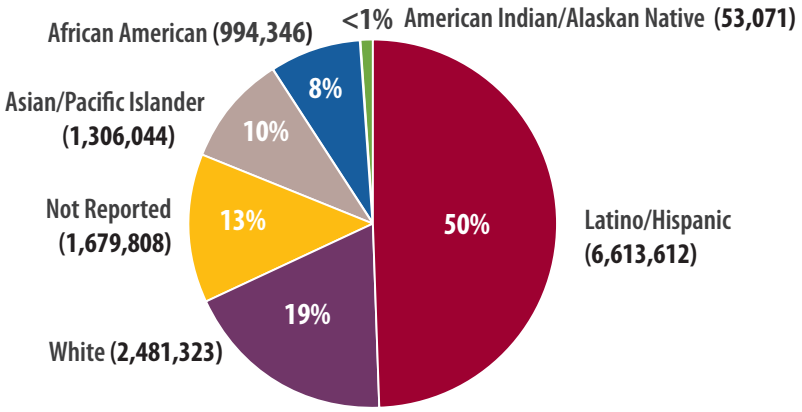
Federal Medicaid Waivers. Federal law authorizes CMS to waive certain Medicaid rules for individual states. Generally, California's existing federal waivers allow the state to provide additional services to specific beneficiaries, limit services to specific geographic areas, and provide coverage to individuals that may not otherwise be eligible under traditional Medicaid rules.

All Plan Letters (APLs). DHCS periodically issues APLs to MCMC plans to convey information or the DHCS interpretation of changes in Medi-Cal policies or procedures. APLs instruct MCMC plans on how policy changes affect operations or delivery of services.

Other Policy Communications. DHCS issues bulletins, manuals, information notices and letters to counties or Medi-Cal contractors to inform these entities of Medi-Cal changes in policies or procedures. Policy communications include:

- All County Welfare Directors Letters
- Medi-Cal Eligibility Division Information Letters
- Mental Health and Substance Use Disorder Services Information Notices
- Medi-Cal Provider Bulletins
- Medi-Cal Provider Manuals

Figure 3. Medi-Cal Enrollment by Race/Ethnicity, 2018



Source: Rearch and Analytic Studies Division, "Medi-Cal at a Glance," California Department of Health Care Services, June 2018. Chart prepared by Insure the Uninsured Project.

Future Issues in Medi-Cal

Overview of Included Issues

TOPIC		ISSUE SUMMARY	Page
Medi-Cal Program Design Issues			9
Issue 1	*Eligibility Expansion to Cover the Remaining Uninsured*	Multiple proposals would reduce the number of California's remaining uninsured by expanding Medi-Cal eligibility	9
Issue 2	*Expiration of the Medi-Cal 1915(b) Specialty Mental Health Waiver*	The federal Medicaid waiver that allows for the organization and delivery of specialty mental health services at the county level expires June 30, 2020.	10
Issue 3	*Revisions to Federal Medicaid Managed Care Rules (MMCR)*	In 2016, federal CMS issued the MMCR with new standards and consumer protections for Medi-Cal managed care	11
Issue 4	*Efforts to Better Coordinate Care Through System Improvement Initiatives*	California currently manages multiple programs aimed at improving care coordination for individuals with chronic and complex conditions	12
Issue 5	*Medi-Cal Managed Care Plan Re-Procurement Process*	The state DHCS has stated its intent to initiate a competitive re-procurement of commercial MCMC plans	14
Medi-Cal Financing Issues			16
Issue 1	*Medi-Cal 2020: Federal Waiver; New Federal Barriers to Waiver Renewal*	California's Section 1115 federal Medicaid waiver expires December 31, 2020; New Federal Waiver Guidance could challenge the state to meet requirements that would apply in a new waiver	17
Issue 2	*Developing Effective Payment Reform Models*	California is currently developing and considering alternative payment models including proposals to incorporate value and pay-for-performance approaches	19
Issue 3	*Expiration of the Medi-Cal Managed Care Organization Tax*	The MCO tax which California relies on to secure additional federal Medicaid funding expires June 31, 2019	20
Issue 4	*Use of Proposition 56 Funding to Cover Existing Medi-Cal Expenditures*	A 2017 agreement regarding the allocation of Proposition 56 revenues expires this year and California policymakers will consider how to allocate the funds going forward	20
Issue 5	*Medicaid Managed Care Rule: Rate Setting and Provider Payments*	The 2016 MMCR revises federal standards for how states develop managed care plan rates and structure provider fees and taxes that are passed through managed care plans.	22

II. Program Design Issues

This section highlights emerging issues and specific policies related to the design of the Medi-Cal program likely to engage policymakers and stakeholders in the near future.

***MEDI-CAL PROGRAM DESIGN ISSUE 1**: Eligibility Expansion to Cover the Remaining Uninsured*

Overview

In the last few legislative cycles, lawmakers advanced legislation and budget proposals to cover subgroups of the remaining uninsured. The two populations that legislators considered for expansion of Medi-Cal eligibility are:

Low-income undocumented adults. The majority of the remaining approximately three million uninsured Californians under 65 are undocumented adults.[26] Currently, most undocumented adults are limited to Medi-Cal coverage for emergency and pregnancy-related services and, if necessary, state-funded long-term care services.

Certain low-income seniors. Most uninsured, lawfully residing and U.S. citizen adults under age 65 are eligible for no cost Medi-Cal so long as their incomes are at or below 138 percent FPL. However, approximately 27,000 seniors and persons with disabilities with incomes between 124 and 138 percent FPL are only eligible for full Medi-Cal benefits after they first pay a monthly out-of-pocket amount (share of cost) for medical care, similar to a health insurance deductible.[27]

Federal Context

Under federal law, states choosing to provide comprehensive (full-scope) Medicaid coverage for undocumented adults must generally do so with state or local funds. There is no FMAP for covering undocumented adults for services beyond emergency and pregnancy-related care.

For lawfully residing and U.S. citizen seniors and persons with disabilities, federal law establishes the Aged and Disabled (A&D) FPL program, a Medicaid option for states to cover seniors and persons with disabilities with incomes of 75 percent FPL up to a maximum of 100 percent FPL.[28]

State Context

Even before the ACA, Medi-Cal coverage went beyond federal mandatory and optional programs, covering additional population groups, including some groups of legal and undocumented immigrants and certain seniors and persons with disabilities.

Undocumented adults. Most undocumented adults are currently only eligible for restricted scope Medi-Cal.

California currently includes the following low-income immigrants in comprehensive (full-scope) Medi-Cal:

- Children under age 19 who meet specified income standards, regardless of immigration status.
- Lawfully present immigrants during the five-year waiting period for federal Medicaid.[29]
- Certain immigrant groups that are known to federal immigration authorities, including young adults with Deferred Action for Childhood Arrivals status.[30]

Of the remaining 3.5 million uninsured Californians, approximately 1.8 million are undocumented adults, or 58 percent of the remaining uninsured. According to a recent report by the Legislative Analyst's Office (LAO), a Medi-Cal expansion for this population could cover up to 1.2 million low-income undocumented adults.[31]

LAO estimates the total state cost of covering low-income, undocumented adults in full-scope Medi-Cal would be $3 billion ($4.7 billion total funds, including federal FMAP and existing general fund spending for restricted-scope Medi-Cal services).[32]

The Governor's 2019-20 budget proposes $260 million ($194 million state general fund (GF)) to cover an estimated 138,000 undocumented young adults up to age 26, otherwise eligible for Medi-Cal except for their immigration status.

Low-income seniors. In 2000, California adopted the federal option and created the Medi-Cal A&D FPL program which covers seniors and persons with disabilities up to 100 percent FPL, plus a standard income disregard of $230 for an individual and $310 for a couple. The resulting formula for countable income deducts $230 from monthly income, along with any other applicable deductions or exclusions, and individuals are eligible if the remaining monthly income is at or below 100 percent FPL.

If California chooses to cover all seniors up to 138 percent FPL, the state would receive 50 percent FMAP. The Assembly version of the 2018-19 Budget added $30 million state GF to expand eligibility up to 138 percent FPL in the A&D FPL program.[33] The proposal was not included in the final budget.

For a more detailed analysis of these two issues, see the ITUP publication, "California Strategies: Covering California's Remaining Uninsured and Improving Affordability."[34]

Analysis

Covering additional subgroups of the remaining uninsured would make a significant down payment in moving the state to universal coverage. Covering undocumented adults would make the greatest impact on reducing the number of uninsured.

There are concerns that proposed federal rule changes could increase confusion and fear among all immigrant families about using public programs for themselves and their children, regardless of whether they are directly affected by the policy changes. (See ITUP public comments on the proposed rule on "public charge" for more information.)[35]

The current limits on eligibility in the Medi-Cal A&D FPL program resulted from a failure to update the eligibility standard in the program over time. The limits also mean that this small group of seniors has not benefited from the ACA coverage expansion in the same way as other low-income adults. Expanding access to this subgroup of seniors would extend to these low-income seniors the same coverage protections afforded to other low-income adults.

MEDI-CAL PROGRAM DESIGN ISSUE 2: Expiration of the Medi-Cal 1915(b) Specialty Mental Health Waiver

Overview

In the early 1990s, California significantly expanded MCMC and pursued a similar path for the provision of Medi-Cal specialty mental health services (specific services for individuals with severe mental illness.)

Under the terms of a federal Medicaid 1915 (b) "Freedom of Choice" Waiver, California consolidated inpatient and outpatient mental health services into one program through county-administered mental health plans (MHPs). California is currently on its ninth waiver for specialty mental health, which expires on June 30, 2020.

Federal Context

States can implement a managed care delivery system using waiver authority under 1915(b). There are four 1915(b) waivers:

- (b)(1) Freedom of Choice Waiver – restricts Medicaid enrollees to receiving services within the managed care network
- (b)(2) Enrollment Broker Waiver – utilizes a "central broker"
- (b)(3) Non-Medicaid Services Waiver – uses cost savings to provide additional services to beneficiaries
- (b)(4) Selective Contracting Waiver – restricts the provider from whom Medicaid beneficiaries may obtain services.

State Context

California's 1915(b) Freedom of Choice Waiver allows the state to require that Medi-Cal beneficiaries enroll in county MHPs to receive specialty mental health services. Under the terms of the waiver, and state realignment,[36] counties provide the nonfederal share for mental health and SUD services using realignment and other county revenues.

The ACA expanded access to behavioral health care services by including treatment for mental health and SUD conditions as essential health benefits for individual and small group coverage. California opted to cover all ten essential health benefits in the Medi-Cal program.

With coverage for behavioral health services greatly expanded, MCMC plans assumed greater responsibility for mental health services for adults with mild-to-moderate conditions (primarily short-term outpatient services), while counties remain responsible for providing specialty mental health services (inpatient, residential and intensive outpatient services). Prior to the ACA expansion, Medi-Cal beneficiaries had very limited access to mental health services other than those provided by counties.[37]

Oversight of County MHPs

As managed care plans, county MHPs are subject to most federal and state rules for MCMC plans, including new comprehensive federal rules for MCMC adopted in 2016 (described below). County MHPs have struggled to meet some of these requirements.

In approving California's last few 1915(b) waivers, CMS raised overarching concerns with "program integrity" and under the last waiver imposed Special Terms and Conditions (STCs) aimed at improving monitoring and performance of MHPs, including:

- DHCS must have a publicly available mental health plan dashboard reporting performance data for each MHP, including performance for each subcontracted provider.

- Each MHP must have a system for tracking and measuring timeliness of care, including wait times to access providers, and DHCS must establish a baseline for access to services based on this information.
- DHCS must publish corrective action plans imposed on MHPs, based on state compliance assessments.
- DHCS must ensure compliance with any changes in federal law affecting Medi-Cal during the waiver approval period.

If a DHCS audit finds areas of noncompliance, DHCS requires plans to develop corrective action plans and evidence progress on making the necessary corrections. Currently, the majority of county MHPs have active corrective action plans.

Areas of MHP noncompliance include:

- Network adequacy standards;
- Operation of a toll-free telephone number 24 hours a day, 7 days per week;
- Cultural competency requirements;
- Timely completion of beneficiary assessments;
- Beneficiary protections related to documentation of consent and sharing of care information; and
- Documentation in medical records and for billing purposes.

Analysis

DHCS and MHPs have worked to comply with the STCs outlined in the current 1915(b) waiver. If California chooses to renew the current 1915(b) waiver, CMS will likely evaluate whether California has made enough progress on the STCs and what additional standards might be required if a new waiver is granted.

In addition, DHCS and stakeholders are currently evaluating different models for delivery of specialty mental health services, including regional models, exploring the carve-in of specialty mental health services into MCMC plans, or carving-in the mild to moderate benefit into MHPs. These discussions will inform the discussion about renewal of the 1915(b) waiver.

MEDI-CAL PROGRAM DESIGN ISSUE 3: *Revisions to Federal Medicaid Managed Care Rules*

Overview

In 2016, CMS issued a comprehensive and sweeping Medicaid managed care rule (MMCR), the first comprehensive MMCR in over a decade. Because California has been a trailblazer in its adoption of managed care in Medi-Cal, California was already compliant with many of the new requirements but has been working to come into compliance on others, including new consumer protection requirements.

In 2018, CMS issued proposed revisions to the MMCR including changes to consumer protection provisions. If finalized, the 2018 proposed revisions could rollback many of the consumer protections in the original 2016 rule. The 2018 revisions are pending following a public comment period that ended on January 9, 2019.

DHCS, MCMC plans and other stakeholders have been working to revise and comply with additional network adequacy standards consistent with the 2016 MMCR rule since it became final.

Federal Context

The 2016 MMCR added various consumer protection provisions to improve quality of care and beneficiary experience including:

- Requirement that states implement beneficiary support systems with enrollment information and up-to-date provider directories;
- Requirement that all services covered in the state Medicaid program are available and accessible to enrollees in managed care;
- Network adequacy requirements for 11 specified types of providers, an annual state certification of compliance, and allowable exceptions to the standards in recognition of special situations;
- Requirement to offer at least one federally qualified health center (FQHC), one rural health clinic (RHC) and one freestanding birth center (FBC), where available in the contracted service area; and
- Requirement to develop quality of care standards, including performance measures, a state plan to reduce health disparities, and a quality rating system.

The 2018 proposed revisions to the 2016 MMCR diminish some of these protections. For example, the 2018 proposed rule allows states to establish state-specific network adequacy standards, instead of complying with the standards outlined in the 2016 rule. Requirements to ensure limited English proficient beneficiaries can access plan information are proposed to be relaxed, as are some of the requirements intended to ensure up-to-date provider directories.

State Context

Existing state law already meets and, in some cases exceeds, requirements in the 2016 MMCR. Other 2016 MMCR requirements have been challenging to implement as described below. This section highlights the state's response to the network adequacy standards in the MMCR.

To comply with the 2016 rules, California added new requirements in state law. Assembly Bill (AB) 205 (Wood, Chapter 738, Statutes of 2017) added network adequacy requirements in the MMCR to state law. The provisions of AB 205 sunset on January 1, 2022.

Compliance with MMCR Network Adequacy Requirements

Prior to the MMCR, California had time and distance network adequacy requirements that applied to plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) and to other MCMC plans contracting with DHCS.

However, the previous network adequacy standards did not apply to county MHPs or DMC-ODS county programs. The 2016 MMCR expanded federal network adequacy requirements and extended the federal requirements to all health plans, including those previously excluded.

In March 2018, DHCS issued final network adequacy standards in compliance with the MMCR and AB 205. (See Appendix A.)

In the first Compliance Assurance Report sent to CMS in 2018, DHCS reported that while 17 of the 26 MCMC plans met the standards; nine plans only passed conditionally and required corrective action plans to come into full compliance.[38]

In 2018, county MHPs also struggled with compliance, with half the MHPs (28) passing all five review components and the other 28 MHPs failing to meet one or more of the requirements.[39] The six DMC-ODS county plans also did not fully meet the new standards.[40] Medi-Cal's three dental plans met network adequacy standards related to provider-to-member ratios, but did not meet time and distance standards.

Both federal and state law allow MCMC plans to propose an "alternative access standard" if the plan can certify it has exhausted all reasonable options to secure the providers necessary to meet the network adequacy standard.[41] As of mid-December 2018, DHCS had made decisions on over 18,000 alternative access standard requests from MCMC plans, including approving more than 2,000 alternative access standard requests, and was still reviewing more than 1,000 requests.[42]

Analysis

Offering an adequate provider network to ensure that MCMC plan enrollees can access necessary care and services in a timely, accessible manner is fundamental to ensuring that MCMC plans are effectively meeting the needs of Medi-Cal beneficiaries.

The state-level discussion and activity prompted by the 2016 MMCR necessitated a laser focus on this issue by policymakers, DHCS, MCMC plans and efforts to address many shortcomings in meeting the standards. More work is required to continue improving and to address provider shortages and other factors that contribute to the high number of alternative access standards.

Proposed revisions to the MMCR may be finalized in 2019 and it appears likely that the final rule will allow states to revisit consumer protection provisions, including network adequacy standards. California lawmakers and health care stakeholders will have the chance to evaluate the current state standards and consider whether any changes are warranted.

Given the work and effort to date, California should continue working to ensure MCMC plans have adequate networks, regardless of any federal rollback of the 2016 MMCR.

MEDI-CAL PROGRAM DESIGN ISSUE 4: *Efforts to Better Coordinate Care Through System Improvement Initiatives*

Overview

California organized the Medi-Cal delivery system with a heavy emphasis on managed care to reduce costs but also because of longstanding concerns about poor access to care for Medi-Cal beneficiaries and related coordination of care problems. However, MCMC remains a fragmented system with numerous carve-outs and multiple plans and programs providing services to beneficiaries.

This section reviews some of the federal and state initiatives focused on improving care coordination for specific services and beneficiary groups in Medi-Cal.

Federal Context

Federal Medicaid law and policy offer states financial incentives, program flexibility and demonstration project opportunities to organize care and better integrate services for specific Medicaid beneficiaries. California participates in two federal programs as well as several other state initiatives described below.

Health Homes. The Medicaid Health Home State Plan Option, authorized under the ACA (Section 2703/1945 of the Social Security Act), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. As part of this benefit, Health Home providers coordinate primary, acute, behavioral health and long-term services and supports to treat the beneficiary as a whole person.

States receive enhanced federal funding during the first eight quarters of implementation to support the roll out of this new integrated model of care.

Financial Alignment Demonstration. In 2011, the CMS Innovations Center announced the Financial Alignment Demonstration (FAD) as an optional state program. The FAD seeks to better align financial incentives between Medicaid and Medicare, as well as to improve coordination of services for beneficiaries eligible for both Medicare and Medicaid (dual-eligible enrollees).

Through this initiative, CMS works with states to test models that integrate and coordinate primary, acute, behavioral health and specified long-term services and supports (LTSS) for dual-eligible enrollees. California's FAD is known as the Coordinated Care Initiative.

State Context

California is currently implementing multiple programs aimed at improving care coordination for Medi-Cal individuals with challenging chronic and complex conditions.

Health Homes Program. California's Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination.

The HHP coordinates the full range of physical health, behavioral health and community-based services needed by eligible beneficiaries. The HHP provides six core services:

- Comprehensive care management;
- Care coordination (physical health, behavioral health and community-based LTSS);
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and
- Referral to community and social support services, including housing.

The state does not provide the state match (nonfederal share) to implement the HHP. The California Endowment, a private nonprofit foundation, provides the nonfederal share.

DHCS recently announced the HHP implementation schedule for 14 counties beginning with implementation in San Francisco starting July 1, 2018 and phasing in implementation with other counties through January 2020.[43]

The Coordinated Care Initiative. Enacted as part of the SFY 2012-13 budget, the Coordinated Care Initiative (CCI) seeks to better coordinate and integrate services for older adults and people with disabilities who are dual-eligible beneficiaries.

California's CCI includes three program components operated in the seven participating counties: 1) Cal MediConnect; 2) Managed Long-Term Services and Supports (MLTSS), through which specified LTSS are provided through MCMC plans, including Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP), as well as nursing facility care; and 3) mandatory MCMC enrollment for dual eligibles.

Cal MediConnect is the state's implementation of the federal FAD and focuses on improving care for dual-eligible enrollees. The state, CMS and MCMC plans enter into a three-way contract, with the MCMC plans receiving a prospective (preset) blended payment to provide comprehensive, coordinated care. Seven California counties are participating in Cal MediConnect with over 110,000 beneficiaries enrolled.

In the SFY 2017-18 budget, the California Department of Finance determined the CCI program was not cost-effective and DHCS restructured the program, carving out In-Home Support Services (IHSS) from the range of LTSS offered.[44]

In the seven CCI counties, all Medi-Cal beneficiaries (not just dual-eligibles) must enroll in a MCMC plan to receive MLTSS benefits (MSSP and CBAS) or live in a nursing facility paid by Medi-Cal. For MSSP, the transition to a full managed care plan benefit has been delayed to no sooner than January 1, 2020 (except for San Mateo County, which already made the transition).[45]

The CCI was originally scheduled to expire in 2019. DHCS requested a one-year extension of Cal MediConnect through 2020 to better sync up with the expiring Medi-Cal 2020 Waiver (described below). Synchronizing the expiration dates allows California to consider its options for Cal MediConnect and MLTSS at the same time as the other waiver programs. CMS has offered California a three-year extension of Cal MediConnect through 2022.

Medi-Cal Long-Term Services and Supports

Community-Based Adult Services. Offers services to seniors and adults with disabilities to restore or maintain their optimal capacity for self-care. Services include professional nursing services, therapeutic activities, social services, personal care, a meal and transportation to and from CBAS centers.

In-Home Support Services. Provides personal care services such as bathing, housecleaning, meal preparation, and laundry, to help beneficiaries at risk of nursing home placement remain safely in the community.

Institutional Long-Term Care. Residential facilities that assume total care of the beneficiaries who are admitted, including nursing facility care.

Multi-Purpose Senior Services Program. A 1915(c) Home and Community-Based Services waiver program, providing care management and supplemental services to assist Medi-Cal beneficiaries aged 65 and older at risk of nursing facility placement.

Whole Child Model. The Whole Child Model (WCM) is a pilot project to integrate CCS services into MCMC, specifically in the 21 counties served by the five COHS plans. As described previously, the CCS program serves children with certain serious chronic medical conditions including cystic fibrosis, hemophilia and cerebral palsy. Although most CCS children are enrolled in MCMC, services related to their CCS qualifying conditions are carved-out and administered by county health departments. This fragmentation of service delivery has caused problems with care coordination.[46]

Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorizes the phase-in and an evaluation to assess COHS plan performance and outcomes from integrating CCS. SB 586 maintains the carve-out of CCS services for all other counties until January 1, 2022. Participating counties are gradually phasing in implementation of the WCM. As of this writing, four COHS counties have implemented the pilot.

Whole Person Care Pilot. The Whole Person Care (WPC) pilots are part of the Medi-Cal 2020 federal waiver. WPC is aimed at coordinating health, behavioral health, and social services for Medi-Cal beneficiaries who are high users of multiple systems and continue to have poor health outcomes. The pilots implement collaborative leadership, data sharing between systems, coordination of care in real time, and evaluate individual and population progress.

There are 25 WPC pilots in California. Participating pilot agencies include counties, cities and health facilities that provide match funding to meet the state's nonfederal share. Governor Newsom's proposed SFY 2019-20 budget includes $100 million in one-time only state general fund for WPC, specifically focused on supportive housing and other supports for homeless and at-risk individuals, particularly those with mental illness.

Analysis

Most of the current "system improvement" initiatives are county-based, none are statewide, and many rely on non-state general fund to provide the state's nonfederal share. Today, Medi-Cal continues to be a fragmented program with beneficiaries potentially served by multiple managed care delivery systems and a relatively small FFS program.

Current system improvement initiatives may provide direction and pathways to integrate or better coordinate care across all counties and delivery systems. The pilots have evaluation components built-in that can inform decisions to sustain, broaden or end initiatives, as well as opportunities to incorporate the lessons learned more broadly into MCMC and the Medi-Cal program overall.

The multiple initiatives underway offer an opportunity for the state to gradually develop a more comprehensive integration plan for Medi-Cal.

MEDI-CAL PROGRAM DESIGN ISSUE 5: *Medi-Cal Managed Care Plan Re-Procurement Process*

Overview

As described above, MCMC in California operates using different models, involving both public and commercial health plans. In 2016, DHCS noticed its intent to initiate a re-procurement of contracted commercial managed care plans.

At the time, DHCS and the Office of Medi-Cal Procurement released a tentative procurement schedule for commercial plans with rolling Requests for Proposals (RFPs) by county and model type beginning in late 2019 through 2024. DHCS recently removed the schedule from its website stating that they are reviewing the schedule which will be released in the future.

Federal Context

Federal Medicaid rules (highlighted below) allow states to provide for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations. Federal policy contemplates states paying health plans a set per member per month (capitation) payment for these services.

Nationally, approximately 68 percent of Medicaid beneficiaries are enrolled in some form of managed care.

States must comply with the federal regulations that govern managed care delivery systems. These regulations include requirements for a managed care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed care plans, among others.

Under federal law, states may implement a managed care delivery system using the following federal authorities:

1) Under Social Security Act (SSA) §1915(a) states can implement voluntary managed care programs by executing a contract(s) with health plans selected through a competitive procurement process;
2) For mandatory managed care enrollment programs, states must obtain approval from CMS under two primary authorities:
   a) SPA under Section 1932(a), except for individuals dually eligible for Medicare and Medicaid, Alaska/Indian natives (except under specific terms in §1932(a)(2)(C)) and children with special needs;
   b) Medicaid waiver under SSA §1915(b) allowing a state to require all Medicaid recipients to enroll in a managed care delivery system (as is the case for California's county mental health managed care system);
3) Alternatively, as part of SSA §1115(a) states can secure approval for managed care demonstration programs that require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible recipients (as is the case for MCMC in California).

The federal waiver authorities allow states to implement managed care without having to meet certain federal requirements. For example, states may not have to meet the requirement of "statewideness," allowing for different programs in different geographic regions, or "comparability" allowing states to offer different benefits to managed care enrollees.

State Context

California currently operates the MCMC program as part of the state's Section 1115(a) waiver, Medi-Cal 2020, which expires December 31, 2020 and is described in more detail under Financing Section, Issue 1.

California law provides significant authority to DHCS to implement managed care in the Medi-Cal program. Specifically, the DHCS "director may contract, on a bid or non-bid basis, with any qualified individual, organization, or entity to provide services to, arrange for or case manage the care of Medicaid beneficiaries. At the director's discretion, the contract may be exclusive or nonexclusive, statewide or on a more limited geographic basis."[47]

MCMC plans are subject to state statutory and contractual requirements that ensure California complies with federal Medicaid rules and that the Medi-Cal program meets state goals and standards. For each managed care model type and individual health plan, the state negotiates from a publicly available model contract.

All MCMC plans, except for COHS plans, must also be licensed under Knox-Keene, the state regulatory framework for public and commercial managed care plans.[48]

Passed in 1975, Knox-Keene imposes requirements on managed care plans including consumer protections and disclosure requirements, financial solvency requirements, access to care, mandated benefit requirements, consumer grievance and appeals processes, and other plan requirements.

Analysis

The decision to rebid MCMC plan contracts presents an opportunity for the state to modernize, update and improve the process and requirements by which health plans provide services to Medi-Cal beneficiaries.

As just one example, the state has implemented quality measurement and quality improvement standards for MCMC plans that could be incorporated as selection criteria in the procurement process.

However, the potential for a lack of transparency, and no formal stakeholder process, could limit the ability of policymakers and stakeholders to provide meaningful input that would improve the program and the process.

Stakeholder Engagement

When DHCS proposed the re-procurement schedule, it did not incorporate or publicly suggest that there would be a formal stakeholder process to allow for input on the RFP process or MCMC plan contract provisions.

Notably, similar procurements in other states have included a formal stakeholder process. In a review of the Medicaid managed care procurement landscape, Health Management Associates (HMA) identified five states that conducted procurement processes in 2018.[49]

Based on review of publicly available information from the five states, the procurement processes in all of the states included formal stakeholder engagement to support the development of a RFP, potential contract requirements and public input on draft solicitation documents.

Based on this review of 2018 Medicaid managed care procurement processes in other states, the absence of a formal process for stakeholder engagement would be unique to California.

III. Medi-Cal Financing Issues

The Medi-Cal program is funded through a combination of federal Medicaid funds, known as FMAP, and nonfederal funds. California will spend an estimated $100 billion combined federal and nonfederal funding for SFY 2018-19 on the Medi-Cal program.[50] In SFY 2018-19, the Medi-Cal program overall will receive an estimated 64 percent in federal funds and 36 percent from nonfederal sources.[51]

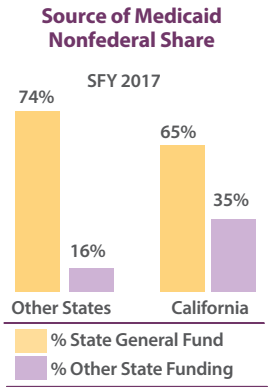
California relies on various sources to provide the nonfederal share, primarily funding from local governments and fees charged to providers and MCMC plans. California will contribute $35.8 billion in nonfederal matching funds, including $21.6 billion from the state general fund, or 60 percent of the total nonfederal share.[52] The remaining approximately 40 percent of nonfederal share is derived from other nonfederal sources.

Medicaid Share of State Budgets. According to 2017 data from the National Association of State Budget Officers:

- For the state-funded portions of state budgets Medicaid accounted for 19.8 percent of total state general fund spending.[53] This calculation excludes California.
- 74 percent of the nonfederal share for state Medicaid programs came from state general fund revenues; the remaining 16 percent came from other state sources.[54] This calculation excludes California.

Medi-Cal and California's Budget. For SFY 2017-18, Medi-Cal accounted for 18.3 percent of state general fund spending.[55] Sixty-five percent of the nonfederal share for Medi-Cal came from state general fund revenues. The remaining 35 percent came from other state sources. (See text box for sources of the nonfederal share.)

Nationally, states allocated 19.8 percent of state general fund to Medicaid compared to California's 18.3 percent in Medi-Cal.



The current and previous federal administrations have scrutinized many of the funding mechanisms used to secure federal Medicaid matching funds.

For example, in 2004 the U.S. General Accounting Office testified before the U.S. House Subcommittee on Energy and Commerce documenting instances where states, using intergovernmental transfers, received large federal matching funds as payments to providers and required those providers to return all or most of the federal money back to the states.[56]

These practices and others questioned by the CMS lead recent federal administrations to periodically limit, phase-out or revise how states can use and generate funding for the nonfederal share.

The federal posture on how states use non-state general fund match to draw down federal Medicaid funding has the potential to create challenges and sustainability concerns for states like California that rely heavily on these non-state general fund sources for state matching funds, and for the providers who rely on these resources to ensure adequate Medicaid reimbursement, especially safety-net providers.

How California Raises the Nonfederal Share For Medi-Cal

Certified Public Expenditure (CPE). State and local government entities certify that they have spent CPE funds on items or services eligible for federal matching Medicaid funds. For example, California counties providing Medicaid reimbursable, school-based targeted case management services incur the total cost of the services and certify the total amount of expenditures are Medicaid reimbursable to secure a federal match.

Intergovernmental Transfer (IGT). Transfers of public funds between or within levels of government (e.g., county to state). For example, under California's current §1115 waiver, public health care systems and district hospitals receive payment for meeting quality outcomes under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, financed by their own IGTs. For additional information on the PRIME program, see discussion under Issue 1 and 2.

Provider Taxes/Fees. State-imposed taxes or fees on health care providers. To use provider taxes/fees as the nonfederal share, federal rules require the fee or tax to be broad-based and uniformly imposed. Federal rules also prohibit the state from holding any similar providers harmless from the tax/fee burden. For example, the Hospital Quality Assurance Fee (HQAF) Program collects fees from private hospitals in California and uses these funds, matched with federal funds, to enhance Medi-Cal reimbursement for hospital services.

Special Funds. Funds created by statute, including through ballot initiatives, restricted by law for specific government activities. For example, by taxing cigarettes and tobacco products, Proposition 56, passed in 2016, created a special fund to help finance health care expenditures, including Medi-Cal expenditures.

MEDI-CAL FINANCING ISSUE 1: Medi-Cal 2020: Federal Waiver; New Federal Barriers to Waiver Renewal

Overview

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (Secretary) authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program.

Under §1115, the Secretary may waive certain provisions of Medicaid law providing states additional flexibility and in many cases additional funding.

California's §1115 waivers have funded broad Medi-Cal initiatives. Historically, California has leveraged state and local funds to draw down federal matching funds normally not permitted under traditional Medicaid rules.

Federal law requires that §1115 waivers not cost the federal government more money than otherwise would have been spent on the Medicaid program – a concept referred to as "budget neutrality." Recent changes to federal guidance on the §1115 waiver budget neutrality requirement mean less federal funding will be available if California seeks to renew its waiver. The loss of federal waiver funds leaves funding gaps in programs initiated under previous California §1115 waivers and raises questions about how or whether the gaps can be filled.

California §1115 Federal Waivers Prior to Medi-Cal 2020 Waiver

Medi-Cal Hospital Care Waiver. California secured its first statewide, five-year §1115 waiver, starting in 2005 through 2010, the "Medi-Cal Hospital Care Waiver." California proposed the waiver in response to CMS concerns about California's reliance on IGTs as the mechanism for financing the nonfederal share of Medi-Cal payments to hospitals. The Hospital Care Waiver moved instead to use CPEs for hospital financing. The 2005 waiver also created a Safety Net Care Pool, a fixed amount of federal matching funds to support public hospitals in caring for the uninsured.

Bridge to Reform Waiver. California sought a five-year renewal and expanded scope in the Bridge to Reform Waiver 2010-2015. The Bridge to Reform Waiver helped California prepare for the implementation of the ACA Medicaid expansion for low-income adults before the 2014 federal timeline.

The 2010 waiver phased-in coverage for low-income adults aged 19 to 64 with incomes up to 200 percent FPL and maintained the Safety Net Care Pool and other waiver initiatives. In addition, the renewal expanded MCMC to most beneficiaries including seniors, persons with disabilities, and children with special health care needs, and implemented the Delivery System Reform Incentive Pool (DSRIP) program. DSRIP provided payment incentives to help enhance the quality of care of California's public hospitals and health systems. Public health care systems continued to self-finance their waiver payments through a mix of CPE and IGT mechanisms.

Federal Context

CMS typically approves §1115 waivers for an initial five-year period and will renew or extend waivers in additional five-year increments. As mentioned, §1115 waivers must be budget neutral to the federal government.

Section 1115 Waivers and Budget Neutrality. In calculating budget neutrality, CMS and the applicant state agree on projected federal expenditures that could have occurred absent the waiver, known as "Without Waiver" or baseline expenditures. CMS and the applicant state also calculate federal expenditures with the proposed state §1115 waiver or "With Waiver" expenditures.

If the projected expenditures are higher than expenditures under the waiver, the applicant state can capture some or all of the projected federal savings.

Many states, including California, Minnesota, New Mexico, Florida, Iowa, Texas, Wisconsin, Hawaii, Kansas, Arizona, Delaware, Maryland, New Jersey, New York and Tennessee, applied for §1115 waivers to implement or expand Medicaid managed care and identified savings from managed care (compared to FFS costs) to fund waiver programs.

Previously, when a waiver is renewed, the baseline calculations from the original waiver are used allowing for a rollover of projected federal savings from the previous waiver.

New Budget Neutrality Guidance. In early 2016, CMS revised its budget neutrality policy to limit the amount of savings a state could capture in a §1115 waiver. While the waiver calculations are complex, the new guidance essentially limits and ultimately phases out savings states rolled over from waiver to waiver. Starting with waivers on or after January 2020, the guidance also allows CMS to rebase or update projected expenditures without a waiver using more recent cost trends. Specifically, CMS will base costs and savings on recent managed care costs rather than as a comparison to past or estimated FFS expenditures.

In 2018, CMS issued guidance to state Medicaid directors affirming the basic policy announced in 2016.[57]

State Context

In 2015, California secured a waiver renewal to the 2015 Bridge to Reform Waiver, known as "Medi-Cal 2020," which expires December 31, 2020. Key provisions of Medi-Cal 2020 include, among other elements:

- ***Safety Net Funding.*** Revises California's Safety Net Care Pool and combines it with a portion of Medicaid Disproportionate Share Hospital (DSH) funding to create the Global Payment Program (GPP). GPP supports care for the uninsured provided by public health care systems. The Medicaid DSH program requires state Medicaid programs to make supplemental payments to qualifying hospitals that serve large numbers of Medicaid and uninsured individuals.
- ***Payment Reform.*** Transitions the Delivery System Reform Incentive Pool (established under Bridge to Reform) to the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. PRIME provides the opportunity for public and district/municipal hospitals to earn performance-based incentives, up to $3.7 billion in federal funds over five years, and supports public hospital efforts to develop risk-based alternative payment arrangements.
- ***Care Coordination.*** Adds the Whole Person Care (WPC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. The WPC pilot coordinates health, behavioral health, and social services for individuals who access multiple systems of care. DMC-ODS expands substance use disorder treatment services and provides these services under a managed care delivery system.
- ***Dental Transformation Initiative (DTI).*** The DTI improves dental health for Medi-Cal children by focusing on high-value care, improved access, and use of performance measures to drive delivery system reform.

The waiver terms for the Medi-Cal 2020 Waiver began to phase-out budget neutrality savings derived from managed care in California. By 2020, annual budget neutrality savings will be reduced by 20 percent to 77 percent, with the largest reductions from savings for populations that were among the first to be served in MCMC plans.

Other Federal options. Other federal policy changes may serve as viable alternatives to secure federal funding for certain elements of the Medi-Cal 2020 Waiver. The 2016 MMCR authorizes states to cover nonmedical interventions (referred to as "in lieu of services") that address social and structural factors influencing health, including poverty, access to stable housing, and exposure to violence. In addition, the MMCR encourages states to improve care coordination, adopt alternative payment models, and provide long-term services and supports in the home and community for beneficiaries.

Analysis

If California seeks an extension when Medi-Cal 2020 expires, new federal rules, including those related to budget neutrality, will apply as described above.

Some of the programs in the Medi-Cal 2020 Waiver may meet the revised budget neutrality standard but others may need to be substantially revised or restructured to obtain federal matching funds.

As California considers whether to develop a new §1115 waiver, and what alternatives might be possible outside of a waiver renewal, policymakers will need to evaluate the financial and program consequences, including the potential for a loss of federal funds, and the impact on support of the health care safety net, delivery system improvement efforts, and other initiatives funded under California's current §1115 waiver.

Addressing these issues will be a complex undertaking, requiring active stakeholder engagement and creative policy planning. Despite the complexities and the challenges, the waiver deadline also provides an opportunity for policymakers to consider and reshape the Medi-Cal program in ways that can improve the program for Medi-Cal beneficiaries.

MEDI-CAL FINANCING ISSUE 2: *Developing Effective Payment Reform Models*

Overview

The Medi-Cal program has several payment reform efforts underway or in the planning stages. Medi-Cal initiatives include value-based payment programs, pay-for-performance and changes to the rate setting process for MCMC plans that incentivize and hold plans accountable for reducing long-term costs through better health outcomes and improving quality.

Federal Context

Alternative Payment Models (APMs) are payment approaches that offer incentive payments for providing high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Federal law allows states to adopt APMs in Medicaid managed care in the categories described below.

Payment Reform Models

Pay-for-Performance. Rewards providers or managed care organizations for achieving specific quality benchmarks or other goals.

Shared Savings Arrangements. Participating plans or providers share net savings with payers for a defined population over a specific period.

Risk Sharing Arrangements. Participating plans or providers agree to share both net savings and any losses with payers for a defined population over a specific period.

Value-Based Payments. Rewards providers with incentive payments for providing quality care, based on performance against identified quality measures.

State Context

Medi-Cal payment reform strategies underway or in process include:

Auto Assignment Incentive Program (AAIP). In place since 2005, the AAIP rewards MCMC plans based on plan performance on specified performance measures. In general, beneficiaries required to enroll in MCMC must select a participating health plan. If an enrollee does not select a plan, they are "auto-assigned" or "defaulted" to a plan based on the relative performance of available plans on the AAIP. The AAIP includes eight measures, six Healthcare Effectiveness Data and Information Set (HEDIS) measures and two safety net measures.[58]

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). Part of the Medi-Cal 2020 Waiver, PRIME helps public hospitals and health systems maximize health care value and implement APMs. PRIME funding is tied to performance in 18 clinical project areas and to a set of reporting and performance metrics.

Participating health care systems must contract with a MCMC plan in their service area using an APM such as capitation, risk-pool payments, and other risk-sharing arrangements. In addition, public health care systems must gradually increase the percentage of assigned MCMC beneficiaries who receive all or a portion of their care under a contracted APM.

Value-Based Payment Program (VBP). The Governor's 2019-20 Budget proposes to establish a VBP program in MCMC focused on management of chronic diseases, prenatal/post-partum care, and behavioral health integration. The proposed budget allocates $360 million including $180 million in Proposition 56 funds for this program.

Analysis

The growth in the size and scope of the Medi-Cal program, along with the costs for covering nearly one in three Californians, provide strong incentives for consideration of payment reforms that focus on promoting cost effectiveness while creating incentives to maintain or improve quality.

In the next few years, as part of the Medi-Cal 2020 discussion (e.g., PRIME) and through other budget and program deliberations, policymakers will face decisions on whether to expand, maintain, eliminate or revise current payment reform efforts.

Issues surrounding payment reform should continue to be part of the broader conversation on improving the quality and the effectiveness of Medi-Cal, especially for high-cost, vulnerable beneficiaries with complex needs.

MEDI-CAL FINANCING ISSUE 3: *Expiration of the Medi-Cal Managed Care Organization Tax*

Overview

One of the strategies California has used to generate a portion of the nonfederal share for Medi-Cal is through a tax on state managed care organizations (MCOs) along with other changes to taxes that health plans pay.

In 2016, to become compliant with federal law, the state adjusted the MCO tax so that it applies not only to MCMC plans but to all full-service MCOs (e.g., excluding dental and vision plans) in the state. California's restructured MCO tax is scheduled to expire at the end of the SFY 2018-19.

According to the Legislative Analyst's Office (LAO) Medi-Cal Fiscal Outlook for the 2019-20 state budget, California would lose $1.5-1.9 billion if the MCO tax package is not renewed.[59]

Federal Context

Federal law authorizes states to use provider taxes to generate revenues for the nonfederal share of Medicaid costs. Federal rules require the tax to be broad-based and uniformly imposed. States are also prohibited from holding like providers harmless from the tax burden.

State Context

Before 2016, MCMC plans were the only entities subject to California's MCO tax. DHCS determined the tax amount based on Medi-Cal enrollment in each plan. In 2014, CMS informed DHCS that this structure violated federal guidance on provider taxes, requiring California to restructure its MCO tax by 2016 or forgo federal funding.

New MCO Tax. SB X2-2 (Hernandez, Chapter 2, Statutes 2016) enacted a new MCO tax for the period of July 1, 2016 through June 30, 2019. Unlike prior versions of California's MCO tax, the restructured MCO tax applies broadly to full service MCOs and their various lines of business, not just MCMC business. MCOs are taxed according to enrollee "member months," the number of members who are enrolled for one month.

The tax is a tiered rate structure with MCOs generally taxed at a higher rate for Medi-Cal enrollees than for non-Medi-Cal enrollees and at lower rates for MCOs with higher enrollment. As part of the restructured MCO tax, non-Medi-Cal MCOs receive corporate tax and gross premiums tax relief and other adjustments.

Proposed SFY 2019-20 Budget. The Governor did not propose continuation of the MCO tax in the proposed SFY 2019-20 Budget. The LAO noted that federal approval of California's MCO tax package is likely and recommended that the Legislature seriously consider renewal of the MCO tax.

Analysis

As part of budget deliberations this year, presumably California policymakers will consider whether to renew, and possibly revise, the state's MCO tax.

MEDI-CAL FINANCING ISSUE 4: *Use of Proposition 56 Funding to Cover Existing Medi-Cal Expenditures*

In 2016, voters passed Proposition 56 creating a rare and sizable infusion of new funds to increase Medi-Cal provider rates through supplemental payments to certain providers. Medi-Cal first received Proposition 56 funds in 2017-18.

Proposition 56 funding is intended to ensure timely access to quality care for Medi-Cal beneficiaries. Since its passage, policymakers have considered the best uses of the new funding consistent with the specific requirements of Proposition 56 and the broader context of funding for the Medi-Cal program.

Federal Context

CMS has expressed concerns regarding whether California's low Medi-Cal provider payments hamper provider participation. These concerns were translated into a required assessment of network adequacy in the Medi-Cal 2020 Waiver Special Terms and Conditions.

CMS required DHCS to perform an access assessment to evaluate primary, core specialty and facility access. The Special Terms and Conditions require DHCS to compare health plan network adequacy compliance across different lines of business and to make recommendations if the assessment reveals systemic network adequacy issues. In September 2018, CMS approved the draft design for the assessment and a subcontractor for DHCS began to work on it. DHCS plans to submit the report to CMS by July 2019.

State Context

In 2016, a coalition of health providers, hospitals and other health-related groups placed a tax on tobacco products on the ballot establishing a special fund to support supplemental rates for Medi-Cal providers.

The text of Proposition 56 specifies that revenues first replace lost revenues in existing state tobacco tax programs. According to the Proposition, the largest share of revenues (82 percent of the remaining Proposition 56 funds) are directed to increase funding for Medi-Cal programs and services to ensure timely access, limit specific geographic shortages of services and ensure quality care.[60]

In 2017-18, the Legislature and Governor Brown reached a two-year agreement on how to use Proposition 56 funding in Medi-Cal. This agreement allocates Proposition 56 for three distinct purposes: (1) increasing Medi-Cal provider payments, (2) offsetting general fund spending for Medi-Cal cost growth and (3) creating a physician and dentist student loan repayment program in SFY 2018-19.[61]

According to the LAO, in the first two years of implementation about half of the funding allocated to Medi-Cal has been used to increase Medi-Cal provider payment rates.[62]

Proposition 56 Funding in Medi-Cal SFY 2018-19 Budget	
Supplemental Medi-Cal/Denti-Cal Provider Payments	$786.7 Million
Managed Care Rate Increases	$34.6 Million
Loan Assistance for new Medi-Cal Physicians and Dentist	$220 Million
Medi-Cal Expenditures for Existing Service Levels	$217.7 Million
Total Special Fund Amount	$1.3 Billion

Source: California Department of Finance, 2018-19 State Budget: Enacted Budget Summary Health and Human Services, June 27, 2018.

Proposed SFY 2019-20 Budget. Governor Newsom's proposed budget continues to dedicate Proposition 56 funds to supplemental payments and rate increases for certain Medi-Cal providers. The budget also proposes to make most of the provider payment increases permanent and ongoing.

The Administration proposes three new programs using Proposition 56 funds:

- A Value-Based Payment Program with incentives for MCMC plans to meet specific metrics in management of chronic diseases, prenatal/post-partum care and behavioral health integration, with the stated goal of improving care for certain high-need high-cost populations ($360 million including $180 million in Proposition 56 funds.)
- Increase early developmental screening, and trauma screening for all children ages 0-21 and for adults enrolled in the full-scope Medi-Cal program ($105 million including $52.5 million in Proposition 56 funds).
- Additional $50 million in Proposition 56 funding for Medi-Cal family planning services. The budget estimates that the new state funding could yield as much as $500 million in total funds as a result of enhanced federal Medicaid match for family planning services.

Analysis

Early in the state's implementation of Proposition 56 there were questions and some controversy as to how the revenues would be allocated, particularly for general support of existing Medi-Cal program costs.

However, the SFY 2019-20 budget assumes $2.3 billion in decreased expenditures in Medi-Cal compared to the 2018 Budget Act.[63] With decreased expenditures projected, the state had no reason to allocate Proposition 56 funds to support Medi-Cal program "cost growth."

The Governor's Budget would eliminate the general fund offset of Medi-Cal costs with Proposition 56 and proposes to expand and make permanent provider-focused payments and programs. During state budget deliberations, the Legislature will be scrutinizing the proposed new programs and considering whether the increased funding for provider payments is sustainable over the long run. This is important because tobacco tax revenues decline over time.

MEDI-CAL FINANCING ISSUE 5: *Medicaid Managed Care Rule: Rate Setting and Provider Payments*

Overview

The MMCR revised federal standards relating to the development of capitation rates for managed care plans and clarified state authority to implement performance-based payment methods in managed care contracts. The MMCR also included specific provisions requiring states to change the structure of payments passed through managed care plans to specific providers.

The MMCR maintains the requirement that states pay actuarially sound rates to health plans. The MMCR defines actuarially sound rates as rates projected to provide for all reasonable, appropriate and attainable costs required under the terms of the contract. Rates must be developed using specific standards in the MMCR and be approved by CMS.

Federal Context

The 2016 MMCR invalidates certain state directed provider payment structures made through managed care plans and allows states to phase-out noncompliant structures over a specified timeframe.

The MMCR allows states to make "directed payments" to specific providers but phases out the more general approach of "pass-throughs" to managed care plans not tied to the provision of services in the contract.

States that transition noncompliant payment structures to allowable directed payments must still ensure that rates paid to plans, including allowable directed payments, are actuarially sound. States must seek approval from CMS for the supplemental payment structure as well as specific managed care plan and provider rates once developed by the state.

The MMCR outlines four allowable directed payment provisions:

1. Value-based purchasing models, such as pay-for-performance arrangements;
2. Delivery system reform and/or performance improvement initiatives;
3. Minimum or maximum fee schedules for network providers that provide specific services under the contract; or
4. Uniform dollar or percentage increases for network providers that provide specific services under the contract.

Proposed Revisions to the MMCR. Recently, CMS issued proposed revisions to the MMCR, including some changes to state directed provider payment provisions. Among other changes, the proposed revision adds another allowable directed payment method for states:

5. Adopt a cost-based rate, Medicare equivalent rate, commercial rate or other market-based rate for network providers that provide a service under the contract.

State Context

Some states, including California, use various payment structures, including provider fees, to finance supplemental provider payments that are passed through managed care plans to providers.

Prior to the MMCR, California's supplemental payment and pass-through programs generally distributed funds to providers based on the total revenues available (e.g. revenues from a provider fee) with a fixed formula in statute typically based on historical utilization for a base year.

The changes in the MMCR necessitated that DHCS gradually revise existing pass-through payments to comply with the new standards for directed provider payments. The MMCR requires, among other things, that directed supplemental payments be based on actual utilization of services through contracted network providers rather than a historical point-in-time baseline.

Since the passage of the MMCR, DHCS worked with MCMC plans and affected stakeholders to revise state-directed provider payments to comply with the new standards. As of this writing, DHCS has restructured or implemented directed payments for public hospitals, private hospitals, physicians and dental services.

The Hospital Quality Assurance Fee (HQAF), a fee on certain general acute care hospitals, is used, for the most part, as the nonfederal share of supplemental Medi-Cal payments to eligible hospitals for inpatient and outpatient services. The HQAF expires in state law on June 30, 2019 and the state will need to make changes to the program to gradually phase in the MMCR requirements.

Analysis

The implications of the MMCR affecting supplemental provider payments are still unfolding.

California received CMS approval for the restructured supplemental payment programs described above. However, the state is still in the process of securing CMS approval for the resulting contract and MCMC plan rate changes, with approvals still pending as far back as the 2016-17 fiscal year for some of the programs.

The revised payment structures present some risks since MCMC plan rates must be set based on projected utilization but the MCMC plans will have to make the payments to network providers based on actual utilization. MCMC plans could experience shortfalls or surpluses depending on how actual utilization compares to the projections.

In addition, the state, MCMC plans and providers are still working through the challenges of developing the data systems necessary to administer the supplemental payments. The state draws down the federal matching funds based on the revenues raised but the distribution of the payments must be based on encounter data provided by contracted providers to MCMC plans.

For each provider category, the restructured payment programs also incorporate separate guidelines or performance metrics linked to whether the providers receive the supplemental payments.

Going forward, the new federal rules will control the types of payments the state can negotiate with MCMC plans and providers, as well as potentially limit the total amount of federal funds the state can receive using the directed payment approach.

IV. The Future of Medi-Cal

The Medi-Cal program has grown substantially in recent years, so that nearly one in three Californians rely on the program for some or all of their health care. As such, Medi-Cal will continue to be at the center of California's efforts to advance universal coverage and explore broader health system improvement.

California policymakers are considering state-level proposals to improve health care and coverage, from incremental coverage expansions for the remaining uninsured to large-scale system change, such as enactment of a state single payer program. In addition, as outlined in this report, in the next several years, the Medi-Cal program is facing multiple deadlines affecting program financing as well as program design challenges.

California is in the process of administering and refining multiple special programs and strategies to improve care and service coordination for Medi-Cal beneficiaries. The state is also developing and refining new payment methods for MCMC plans and providers, in response to new federal restrictions and to accomplish specific program and fiscal goals.

Federal officials have signaled for some time their intention to limit the strategies states use to secure the nonfederal share of Medicaid costs. California continues to rely heavily on non-state general fund revenues, such as provider fees, but is having to reconsider how those programs are structured and whether they are sustainable over the long-run.

The challenges and opportunities facing the Medi-Cal program reflect the broader issues affecting health care and coverage in the state. More than ever before, how the state organizes, manages, funds and improves the Medi-Cal program will have lasting impacts on health care for all state residents, especially for those with complex physical health, mental health and addiction treatment needs.

Appendix A. California's Final Network Adequacy Standards for Medi-Cal

California's Final Network Adequacy Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent Appointments**
Primary Care (Adult and Pediatric)	10 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request
Specialty Care (Adult and Pediatric)	Based on county population density as follows: *Rural Counties:* 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties:* 15 miles or 30 minutes from the beneficiary's residence	Within 15 business days to appointment from request
Obstetrics/ Gynecology (OB/GYN)	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care or specialist services *Primary Care:* 10 miles or 30 minutes from the beneficiary's residence Specialty Care is based on county population density as follows: *Rural Counties:* 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence	Primary Care or Specialty Care standards as determined by beneficiary access to OB/GYN provider as primary care or specialist services *Primary Care:* Within 10 business days to appointment from request *Specialty Care:* Within 15 business days to appointment from request
Hospitals	15 miles or 30 minutes from beneficiary's residence	
Mental health (non-psychiatry) *Outpatient Services*	Based on county population density as follows: *Rural Counties:* 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties:* 15 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request

California's Final Network Adequacy Standards		
Provider Type	**Time and Distance**	**Timely Access for Non-Urgent Appointments**
Substance Use Disorder *Outpatient Services*	Based on county population density as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 60 miles or 90 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties:* 15 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request
Substance Use Disorder *Opioid Treatment Programs*	Based on county population density as follows: *Rural Counties:* 60 miles or 90 minutes from the beneficiary's residence *Small Counties:* 45 miles or 75 minutes from the beneficiary's residence *Medium Counties:* 30 miles or 60 minutes from the beneficiary's residence *Large Counties:* 15 miles or 30 minutes from the beneficiary's residence	Within 3 business days to appointment from request
Pharmacy	10 miles or 30 minutes from beneficiary's residence	Request for prior authorization made via telecommunication: 24 hours Dispensing of at least a 72- hour supply of a covered outpatient drug in an emergency situation
Pediatric Dental	10 miles or 30 minutes from beneficiary's residence	*Routine appointment:* Within 4 weeks to appointment from the request *Specialist appointment:* Within 30 calendar days to appointment from the request
Long-term Services and Supports (LTSS) *Skilled Nursing Facility (SNF)*	None	Based on county population density as follows: *Rural Counties:* Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties*: Within 7 business days of request
Long-term Services and Supports (LTSS): *Intermediate Care Facility (ICF)*	None	Based on county population density as follows: *Rural Counties:* Within 14 calendar days of request *Small Counties:* Within 14 calendar days of request *Medium Counties:* Within 7 business days of request *Large Counties:* Within 5 business days of request
Long-term Services and Supports (LTSS): *Community-Based Adult Services (CBAS)*	None	Capacity cannot decrease inaggregate statewide below April 2012 level

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About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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