LAO

The 2021-22 Budget:
LAO Preliminary Comments on the May Revision Medi-Cal Budget

MAY 2021

Below, we provide our preliminary comments on the Governor's 2021-22 May Revision proposal for Medi-Cal. We first provide an overview of the proposal, noting the major changes made relative to the Governor's January budget, as well as changes made to estimated 2020-21 spending relative to the January estimates. We then describe, and provide our comments on, the Governor's proposal to augment the January proposal for the California Advancing and Innovating Medi-Cal (CalAIM) package. We follow with descriptions of, and comments on, the Governor's modified telehealth policy proposal, the proposal to extend full-scope Medi-Cal coverage to older undocumented immigrants, and the proposal to use American Rescue Plan Act funding to provide financial relief for designated public hospitals.

OVERVIEW

Revises Medi-Cal Budget Downward by $1.8 Billion General Fund Across 2020-21 and 2021-22. As shown in Figure 1, the May Revision revises the General Fund budget for Medi-Cal downward by $1 billion in 2020-21 and $800 million in 2021-22. These downward revisions are largely the result of technical budget adjustments. While a large number of positive and negative adjustments contribute to these net negative adjustments in 2020-21 and 2021-22, the following bullets describe three of the major drivers of these changes in estimated and proposed spending.

- ***Caseload Revised Significantly Downward.*** The *2020-21 Budget Act* and the Governor's 2021-22 budget both projected extraordinary Medi-Cal caseload growth as a result of coronavirus disease 2019 (COVID-19). While significant caseload growth has occurred to date, this growth has been substantially less than anticipated. With the May Revision, the administration recognizes that caseload growth has been slower than previously anticipated and revises its expectations of current and future caseload growth down significantly. This downward revision results in General Fund savings of around $2.5 billion across 2020-21 and 2021-22 relative to the January budget assumptions. We provide further analysis of the Governor's updated caseload projections below.
- ***Lower Federal Repayments and Deferrals.*** The Governor's January budget assumed $1.3 billion in General Fund would be needed across 2020-21 and 2021-22 to repay the federal government or backfill deferred federal funding for federal funds that were claimed in error. A significant portion of this

Figure 1

Proposed Medi-Cal Budget: May Revision Versus Governor's Budget

(In Billions)

	2020-21		2021-22		Difference	
	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Governor's January budget	$117.9	$22.5	$122.2	$28.4	$4.3	$5.9
May Revision	115.6	21.5	123.8	27.6	8.2	6.1
Difference	**-$2.3**	**-$1.0**	**$1.6**	**-$0.8**	**$3.9**	**$0.2**

funding related to erroneous federal claiming for Medi-Cal services delivered to immigrant populations that are not eligible for federal funding and therefore have to be fully funded by the state. The May Revision revises the amount of General Fund needed to cover federal repayments and deferrals downward by $900 million General Fund across 2020-21 and 2021-22. This downward revision largely is due to (1) higher federal claiming levels for certain federally eligible immigrant populations following the discovery of situations where the state was under-claiming federal funding and (2) the release of federal funding following resolution of several large deferrals.

- ***Delay in Medi-Cal Rx Implementation.*** The Governor's January budget had assumed implementation of Medi-Cal Rx would begin in April 2021. Following ownership changes at the state's contracted Medi-Cal Rx administrative services vendor, implementation of Medi-Cal Rx was delayed. The May Revision now assumes the transition will occur on January 1, 2022. This delay is assumed by the administration to increase General Fund costs by around $400 million relative to what they would otherwise be across 2020-21 and 2021-22.

Higher Proposed General Fund Spending of $6.1 Billion Between 2020-21 and 2021-22. As shown in Figure 1, the May Revision proposes increased General Fund spending in Medi-Cal of $6.1 billion over 2020-21 levels. While this growth in year-over-year General Fund spending is the result of many factors, the largest drivers are (1) nearly $1.7 billion in discretionary spending proposals, (2) around $1.4 billion in higher projected caseload costs, (3) roughly $1.2 billion in underlying per-enrollee cost growth (largely due to medical inflation), and (4) new costs to reimburse COVID-19 testing in schools and the projected phase out of savings from reduced service utilization during COVID-19.

Discretionary Spending Proposals in the May Revision. The Governor's January budget proposed around $1.5 billion in discretionary General Fund spending in Medi-Cal in 2021-22—with the bulk of this spending proposed to implement the CalAIM package and to develop behavioral health continuum infrastructure. The May Revision adds (on net) $408 million in discretionary General Fund spending proposals. $222 million of this discretionary spending reflects a deposit into the Medi-Cal Drug Rebate Fund, which would be available in future years to smooth volatility in the Medi-Cal budget. The remaining $186 million in proposed discretionary General Fund spending reflects various Medi-Cal augmentations. Figure 2 lists the major May Revision discretionary General Fund spending proposals.

Figure 2

Major May Revision Discretionary Spending Proposals in Medi-Cal

2021-22 General Fund (In Millions)

CalAIM	
Providing Access and Transforming Health (PATH)	$100
Population health management service	30
Medically tailored meals pilot program	9
Other	
One-time deposit into drug rebate fund	$222[a]
Coverage expansion for older undocumented immigrants	50
Postpartum coverage extension	45
Eliminate rate freeze for ICF-DDs and pediatric subacute facilities	11
Accelerated enrollment for adults	7
Community health worker and doula benefit expansion	6
Medication therapy management program	4
Funds dental integration pilot program	0.3
Enhancement to January telehealth proposal	—[b]
Transition to dental fee for service in Los Angeles and Sacramento counties	-8
Behavioral health continuum infrastructure	-69[c]
Total	**$408**

[a] Deposit would be made in 2020-21.
[b] No fiscal estimate of the expanded telehealth proposal is available at this time.
[c] Funding reduction generally reflects a proposed shift in funding from the General Fund to American Rescue Plan Act funds.
ICF-DD = Intermediate care facility for the developmentally disabled.

Administration's Caseload Projections Align With LAO Expectations

Administration Previously Projected Excess Caseload Growth, Leading to Overstated Caseload-Related Costs. The *2020-21 Budget Act* and the Governor's 2021-22 January budget projected enormous Medi-Cal caseload growth as a result of COVID-19. In the Governor's January budget, the administration projected that caseload would grow by 3 million enrollees (24 percent) by 2021-22, increasing General Fund costs by over $6 billion compared to what they would have been absent the pandemic. In our February 2021 analysis of the Governor's January Medi-Cal budget, we found that the administration's caseload growth projections exceeded the actual caseload trends observed during the pandemic. Moreover, we had concerns that the administration had projected higher growth among certain high-cost Medi-Cal enrollee populations than was consistent with the caseload data. These two factors led us to conclude that the Governor's January budget overstated costs related to Medi-Cal caseload growth.

Administration Has Lowered Its Caseload Growth Projections Significantly in the May Revision. Following our preliminary review, we find that the May Revision's updated caseload projections appear much more reasonable. Rather than reaching a caseload of 15.6 million enrollees in 2021-22, as projected in the Governor's January budget, the May Revision projects more modest caseload growth of somewhat more than 2 million enrollees, leading to a total caseload of 14.5 million enrollees. Moreover, the May Revision significantly changes its caseload growth assumptions among the high- and low-cost Medi-Cal enrollee populations. For example, the May Revision assumes a much larger portion of the higher caseload due to COVID-19 will fall within the childless adult population (which is low cost from a state perspective) and a much smaller portion of higher caseload will fall within the senior and persons with disabilities population (which is high cost from a state perspective). With these updated assumptions, the May Revision lowers projected General Fund costs due to COVID-19-related caseload increases to around $3.6 billion across 2020-21 and 2021-22, a roughly $2.5 billion reduction compared to the Governor's budget.

Revised Caseload and Related Cost Projections Generally Align With LAO Expectations. The administration's updated Medi-Cal caseload and related cost projections are much more in line with LAO expectations for caseload. While there is risk that 2021-22 caseload actually could be somewhat higher than projected by the administration, we generally find the updated estimates reasonable and do not recommend any associated adjustments to the May Revision.

CALAIM AUGMENTATIONS

Proposal

The May Revision proposes three new, largely one-time augmentations related to CalAIM. Otherwise, the CalAIM proposal remains largely unchanged from January (though certain details absent in January have been provided). The May Revision package of new CalAIM proposals collectively would cost $139 million General Fund, bringing total proposed CalAIM spending to $649 million General Fund in 2021-22. Below, we describe and provide our initial comments on the May Revision's new CalAIM proposals. For an overview of CalAIM, see our February post.

Medi-Cal Population Health Management Service. The Governor's January CalAIM proposal included new requirements on Medi-Cal managed care plans to operate population health management programs, which represent a bundle of administrative activities aimed at (1) identifying beneficiaries' medical and nonmedical risks and needs and (2) facilitating care coordination and referrals. The May Revision proposes to spend $30 million General Fund ($300 million total funds) on a Medi-Cal population health management service that is intended to help improve care coordination, delivery, and monitoring for the Medi-Cal program as a whole. The service, which would be provided by a contracted vendor, would serve as a centralized data repository and portal whereby users could obtain administrative and clinical services data on Medi-Cal recipients

(de-identified, as necessary). The administration's goal is to collect beneficiary data from multiple Medi-Cal delivery systems—such as managed care, fee-for-service, and behavioral health—and other social services programs—such as In-Home Supportive Services (IHSS) and CalFresh. Potential users and uses of the service include Medi-Cal beneficiaries, who could access the portal to view their own clinical service records; Medi-Cal providers, who could view patients' prior responses to standard medical assessments; and state policymakers, who could use the data and associated analytics to identify and serve members with elevated risk and generally inform care quality and needs.

Providing Access and Transforming Health (PATH) Infrastructure Funding. CalAIM, as proposed in January, would place new requirements on counties to initiate Medi-Cal enrollment, care coordination, and services for county inmates prior to their release from jail. These new requirements would take effect in January 2023. To help counties build the capacity necessary to meet the new requirements under CalAIM, the May Revision proposes $100 million General Fund ($200 million total funds). In budget documents, the administration notes that this proposal remains under development and could change following consultation with implementation partners such as stakeholders and the federal government (the latter of which would provide the non-General Fund share of cost).

One-Time Medically Tailored Meals Augmentation. The medically tailored meals pilot program is a three-year pilot, which began in 2018, to provide Medi-Cal participants with congestive heart failure medically tailored meals. The *2020-21 Budget Act* extended the pilot through calendar year 2021. Under CalAIM, as part of the suite of 14 in-lieu-of-services (ILOS) benefits, Medi-Cal managed care plans could, for the first time, receive Medi-Cal reimbursement for the medically tailored meals delivered to their enrollees beginning in January 2022. The May Revision proposes a one-time augmentation of $9 million General Fund to expand the availability of medically tailored meals to additional populations and counties. This funding would go directly from the state to service providers, rather than flowing through Medi-Cal managed care plans.

LAO Comments

Medi-Cal Population Health Management Service Could Improve Medi-Cal Performance Monitoring and Care Delivery… In our *March 2021 analysis of CalAIM equity considerations*, we raised the question of how enhancements to Medi-Cal managed care plans' population health management infrastructure would translate into improved statewide performance monitoring of health equity and quality outcomes in Medi-Cal, including through public reports and dashboards. In concept, the proposed Medi-Cal population health management service could facilitate this improved statewide performance monitoring by serving as a central repository for administrative and clinical data across Medi-Cal delivery systems and other programs. For example, the service potentially could collect and report information on Medi-Cal beneficiaries' self-reported health status and housing stability, which would be collected via assessments that managed care plans would be required give their members. In addition, better data sharing across health care providers and delivery systems on Medi-Cal beneficiaries' services and needs could improve care coordination and delivery.

…However, Proposal Lack Detail. We have a number of outstanding questions about the Medi-Cal population health management services proposal. These include (1) whether the proposal reflects an information technology (IT) project subject to the state's IT project oversight rules, (2) what the full intended scope of functionality for the project would be (for example, how the service might interface with related state efforts to expand the use of health information exchanges), (3) what the anticipated time line for when the service would be operational would be, and (4) what the ongoing cost of maintaining the service would be. We recommend that the Legislature consider deferring action on this proposal until some of these important details are provided by the administration.

While Building Capacity Among Criminal Justice Agencies Likely Is Warranted, Fundamental Details on the PATH Proposal Are Missing. CalAIM's new requirements for local criminal justice agencies to enroll inmates in Medi-Cal and coordinate and initiate health care services prior to their release represent significant new responsibilities for criminal justice agencies. Accordingly, while the full extent of existing agency capacity is not clear at this time, assisting these agencies in building their capacity to meet their new responsibilities likely is warranted. However, fundamental details related to the Medi-Cal PATH proposal are missing. Available budget documents do not indicate (1) what kinds of agencies would be eligible to receive this funding, (2) how the funding would be distributed, (3) what capacity-building activities would be funded, and (4) what the rationale for the proposed funding amount of $200 million total funds is. Moreover, receiving federal Medicaid funding to support this effort appears uncertain, which could result in additional General Fund being needed if the full $200 million reflects the true funding needs of this effort. As with the Medi-Cal population health management services proposal, we recommend the Legislature consider deferring action on this proposal until more detail is made available.

Rationale for Temporarily Augmenting Medically Tailored Meals Programs Is Not Clear. Under existing law and the Governor's CalAIM proposal, funding for the medically tailored meals program would expire at the same time as medically tailored meals paid for by Medi-Cal managed care plans would begin to be reimbursable. Consequently, in concept, there should not be a gap in the ability of managed care plans to offer these services. The May Revision Medi-Cal proposal does not augment other programs or services that correspond to the other 13 ILOS that could begin to be offered in January 2022. Accordingly, why the May Revision proposes to fund an expansion of one program that corresponds to the ILOS benefits but not any other programs or services that do so is unclear. We recommend the Legislature ask the administration for more detail on the rationale for this augmentation before deciding whether to approve the proposal.

Modified Telehealth Proposal

Proposal

In the January budget, the Governor proposed to establish—through statutory language—a permanent Medi-Cal telehealth policy to take effect after the declared national public health emergency related to COVID-19 ends. (The state has temporarily expanded Medi-Cal telehealth flexibilities during the pandemic.) In response to the Governor's January proposal, our office published an analysis in which we raised a number of issues. The Governor's May Revision includes some updates to the proposed permanent Medi-Cal telehealth policy. We offer our comments on these updates in the next section.

May Revision Expands Upon January Telehealth Proposal. The Governor's May Revision includes some further detail and changes related to the administration's proposal to establish a permanent Medi-Cal telehealth policy (originally proposed in the January budget). First, the May Revision clarifies through updated budget-related legislation that the Department of Health Care Services (DHCS) would set Medi-Cal reimbursement rates for telephonic care at 65 percent of rates for services provided in person. Second, the updated proposal limits coverage of telehealth services to health care providers located in California or in border areas adjacent to California, where it is typical for California residents to seek health care services. Third, the updated proposal would allow for telephonic services to be covered at health centers and paid at a lower reimbursement rate than what would be required under the prospective payment system (PPS), provided that an alternative payment methodology for health centers is approved.

LAO Comments

Modified Proposal Reflects an Improvement on the January Proposal. We find that these May Revision updates generally reflect an improvement over the Governor's January proposal. The May Revision provides detailed reimbursement rates for services provided through telephone that were missing from the January proposal. In addition, we find extending coverage of telephonic services to health centers and providing reimbursement for these services on a separate fee schedule from PPS to be a reasonable approach. (In our earlier analysis, we noted concerns about disparities in access to telehealth care among Medi-Cal beneficiaries if coverage of telephonic care was not extended to health centers, and also raised questions about the appropriateness of providing reimbursement for telehealth services at an equivalent rate to services provided in person through PPS.) However, we would note that gaining federal approval for the alternative payment methodology that would allow for the May Revision's policy at health centers to be implemented remains uncertain.

Outstanding Questions Around the Quality and Fiscal Impact of Telehealth Expansions Remain, Making It Premature to Set Permanent Medi-Cal Telehealth Policy. In our earlier analysis, we noted that much about the clinical effectiveness and fiscal impact of expansions of telehealth services is not well understood. Accordingly, we found that it was premature to establish a permanent Medi-Cal telehealth policy. Although we find that the Governor's May Revision update reflects an improvement over the January proposal (for the reasons stated above), we find that these outstanding uncertainties persist and that establishing permanent policy remains premature.

Moreover, Proposal Still Raises Equity and Fiscal Concerns. In our earlier analysis we raised concerns with the equity implications of the Governor's January proposal (particularly in terms of access to care at health centers). While the Governor's May Revision addresses some of these concerns, others remain. For example, the administration still does not propose to extend the new remote patient monitoring benefit to health centers, a common source of preventive care for Medi-Cal beneficiaries. Furthermore, the administration still has not released a fiscal estimate of its Medi-Cal telehealth proposal (other than for the cost of the new remote patient monitoring benefit). We find (as noted in our earlier analysis) that there is significant potential that the proposed policy will result in new ongoing costs given potential increases in utilization of health care. Accordingly, release of a fiscal estimate of the proposal would be important for the Legislature to make an informed decision on the Governor's proposal.

Consider Extending Remote Patient Management Benefit to Health Centers. As noted above, the concerns we have about not extending the new remote patient monitoring benefit to health centers remain. Accordingly, we would suggest that the Legislature consider extending this benefit to health centers (we note that this extension would result in additional costs).

Consider Setting a Sunset Date to Allow for Evaluation and Reconsideration of Permanent Medi-Cal Telehealth Policy. Given our outstanding questions about the clinical effectiveness and fiscal impact of telehealth expansions, we find that it is premature to establish a permanent Medi-Cal telehealth policy. Accordingly, the Legislature could consider adding a sunset date (several years into the future) to the proposed statutory change to allow for evaluation of the proposed policy and provide the opportunity to reconsider the state's ongoing Medi-Cal telehealth policy as more information becomes available.

FULL-SCOPE EXPANSION FOR OLDER UNDOCUMENTED IMMIGRANTS

Proposal

Proposed Expansion of Comprehensive Medi-Cal Coverage for Otherwise Eligible Undocumented Immigrants Ages 60 and Older. The May Revision proposes to spend $50 million in 2021-22 to expand comprehensive Medi-Cal coverage to undocumented immigrants ages 60 and older no sooner than May 1, 2022. As

shown in Figure 3, the administration projects that ongoing costs for the expansion gradually will rise over the next several years, reaching $856 million General Fund in 2024-25. These funding amounts reflect the incremental cost of expanding coverage beyond what the state would otherwise pay for emergency- and pregnancy-related services used by undocumented immigrants ages 60 and older currently enrolled in restricted-scope coverage. Additionally, the funding amounts include those projected in DHCS' and the Department of Social Services' budgets, the latter of which administers IHSS. For additional background, please see our post on expanding comprehensive Medi-Cal coverage for undocumented immigrants.

LAO Comments

Currently Evaluating the Reasonableness of the Administration's Cost Estimate as Administration's Underlying Assumptions Are Unknown. The administration's cost estimate for the 60 and older population appears higher than we would anticipate based on our recent assessment of the cost of such expansions. However, the administration has yet to provide detail on the assumptions behind its cost estimate, making it challenging to evaluate the reasonableness of the cost estimate. We have requested this detail and will share any concerns we have about the reasonableness of the estimate once this detail becomes available.

PROVIDER FINANCIAL RELIEF FOR DESIGNATED PUBLIC HOSPITALS

The COVID-19 pandemic has significantly affected health care delivery in the state, generally resulting in declines in routine service utilization; surges in COVID-19-related hospitalizations; and likely higher care-delivery costs due, for example, to the additional safety precautions that have to be made to combat the pandemic. To mitigate financial losses on the part of health care providers and sustain health care access during and after the pandemic, the federal government has provided billions of dollars in relief funding to California health care providers.

Proposal

Proposes $300 Million in Provider Financial Relief for Designated Public Hospitals. California has 21 designated public hospitals, which are safety-net hospitals operated by counties or the University of California. The May Revision proposes to spend $300 million in American Rescue Plan fiscal relief funds in 2021-22 on grants to designated public hospitals to cover the costs of care provided during and after the COVID-19 pandemic.

LAO Comments

Proposal to Exclusively Provide Financial Relief to One Group of Health Care Providers Warrants Scrutiny. To date, individual health care providers' and facilities' net fiscal position as a result of (1) changes in health care utilization and associated reimbursement and (2) federal health care provider financial relief is not clear. Accordingly, we do not know which health care providers and facilities—or which provider and facility types—are under the greatest financial stress as a result of the pandemic. Why the administration has proposed financial relief for one class of providers is unclear. Prior to deciding on whether to approve this proposal, we recommend the Legislature ask the administration why designated public hospitals alone are being targeted with health care provider financial relief and what information on designated public hospitals' net financial position during the pandemic informed its proposal.

Figure 3

Cost of Expanding Comprehensive Coverage to Undocumented Immigrants Age 60 and Older

Administration's May Revision Estimate, General Fund (In Millions)

	2021-22	2022-23	2023-24	2024-25
DHCS (Medi-Cal)	$50	$296	$337	$362
DSS (IHSS)	—	15	353	494
Totals	**$50**	**$310**	**$690**	**$856**

DHCS = Department of Health Care Services; DSS = Department of Social Services; and IHSS = In-Home Supportive Services.

LAO Publications

This report was prepared by Ben Johnson and Corey Hashida, and reviewed by Mark C. Newton and Carolyn Chu. The Legislative Analyst's Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.