The 2019-20 Budget:

Analysis of the Medi-Cal Budget

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Executive Summary

Overall Medi-Cal Budget Picture. The Governor's January budget estimates that $20.7 billion General Fund ($98.5 billion total funds) will be required to fund Medi-Cal in 2018-19, reflecting a significant $2.3 billion General Fund downward adjustment relative to the *2018-19 Budget Act.* The Governor's budget proposes $22.9 billion for Medi-Cal from the General Fund ($100.7 billion total funds) in 2019-20, an increase of $2.2 billion (10.6 percent) over the revised 2018-19 General Fund estimate. At these funding levels, the Medi-Cal program represents a significant share of the state's overall General Fund budget. In light of Medi-Cal's size and the potential for future cost growth (particularly during a recession), legislative oversight of the Medi-Cal program is critical.

Legislature Should Seriously Consider Renewal of the Managed Care Organization (MCO) Tax Package. For several years, the state has imposed a tax on MCOs that leverages significant federal funding. In combination with a package of associated tax changes, the existing MCO tax generates a net General Fund benefit of around $1.5 billion. Under state law, the MCO tax package expires at the end of 2018-19. Extending the MCO tax package past 2018-19 would require statutory reauthorization from the Legislature and approval from the federal government. Based on the recent federal approval of a similar tax in Michigan, federal approval of a reauthorized California MCO tax package appears likely. Despite this development, the administration did not propose an extension of the MCO tax package in 2019-20. Allowing the MCO tax package to expire would forego a significant General Fund benefit. Accordingly, we recommend the Legislature seriously consider renewal of the MCO tax package and explore the trade-offs of renewing the MCO tax package in its current or a modified form.

Governor Proposes to Expand Medi-Cal Coverage for Income-Eligible Young Adults, Regardless of Immigration Status. In 2019-20, the Governor's budget proposes to extend comprehensive Medi-Cal coverage to income-eligible undocumented immigrants ages 19 through 25. Under the Governor's proposal, the administration projects that 138,000 undocumented young adults will gain comprehensive Medi-Cal coverage in 2019-20, at a net General Fund cost of $134 million. This proposal presents the Legislature with decisions to make on whether it wishes to use its discretionary ongoing resources to fund an expansion of health care coverage and on which of the state's demographic groups it wishes to prioritize for expanded coverage at this time.

Proposed Use of Proposition 56 Revenues in Medi-Cal Raises Several Issues for Legislative Consideration. Proposition 56 (2016) raised state taxes on tobacco products and dedicates most revenues to Medi-Cal on an ongoing basis. To date, Proposition 56 funding in Medi-Cal has been used for two main purposes: (1) augmenting the program, such as by increasing Medi-Cal provider payments, and (2) offsetting General Fund spending on underlying cost growth in Medi-Cal. Proposition 56 currently provides about $1 billion annually to Medi-Cal. In the 2019-20 budget, the Governor proposes to make a number of changes to Proposition 56 funding in Medi-Cal. First, the Governor proposes to use *all* Proposition 56 funding on provider payment increases, thus eliminating the General Fund offset. Second, the Governor states an intent to make most of the Proposition 56-funded provider payment increases permanent. Third,

the Governor proposes new provider payment increases aimed at improving care in such areas as the identification of children with developmental disabilities and chronic disease management.

In our assessment, we advise the Legislature to consider the long-term sustainability of using a declining revenue source to fund ongoing Medi-Cal provider payment increases. We also find that making the Proposition 56 provider payment increases permanent is premature at this time, and advise the Legislature to consider making the provider payment increases limited-term until their impact on access and quality can be evaluated. Finally, we advise the Legislature to use the upcoming budget process to gather more information on the new provider payments proposed by the Governor, as only limited information was available at the time of this publication on the structure justification of the new proposed payments.

Recommend Taking Short- and Long-Term Steps to Improve Medi-Cal Fiscal Estimates and Transparency. For a variety of reasons, the Medi-Cal budget has become increasingly difficult to predict. Significant, unanticipated changes to the program's budget, including the significant $2.3 billion downward adjustment reflected in the Governor's revised estimates for General Fund Medi-Cal spending in 2018-19, have become routine. These unanticipated changes complicate legislative oversight and decision making. As part of his budget proposal, the Governor makes two proposals intended to help address these issues: (1) increased staffing at the Department of Health Care Services (DHCS) to improve fiscal estimates and cash monitoring and (2) the creation of a new special fund to smooth the impact of drug rebates on the Medi-Cal budget. We recommend that the Legislature approve these proposals. We further recommend that the Legislature require DHCS to share key information gained from improved monitoring with the Legislature. Finally, we recommend that the Legislature require DHCS to submit a report to the Legislature with a plan for longer-term structural and systems changes to promote sound estimates and transparency in the Medi-Cal budget.

Additional Analysis on the Governor's Medi-Cal Budget Forthcoming. In the coming weeks, we intend to release additional analysis on the Governor's proposed use of Proposition 56 funding in Medi-Cal, the Governor's initiatives to reduce prescription drug costs, proposals related to improving early intervention for children with developmental delays, and proposed changes to 1991 realignment.

BACKGROUND

Medi-Cal, the state's Medicaid program, is administered by the Department of Health Care Services (DHCS) and provides health care coverage to over 13 million of the state's low-income residents. Coverage is cost-free for most Medi-Cal enrollees. Instead, Medi-Cal costs are generally shared between the federal and state governments.

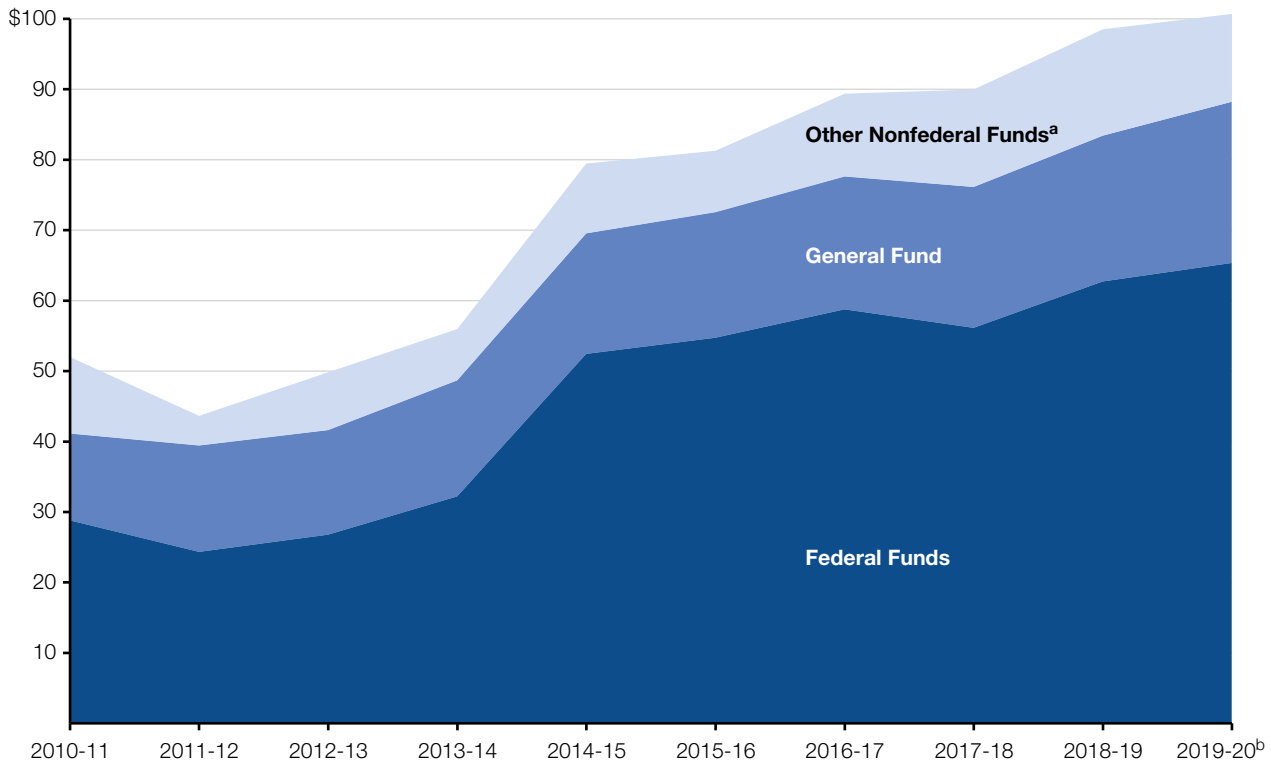
Medi-Cal Has Grown Significantly Under the Patient Protection and Affordable Care Act (ACA). Before 2014, Medi-Cal eligibility was mainly restricted to low-income families with children, seniors, persons with disabilities, and pregnant women. As allowed under the ACA, in 2014, the state expanded Medi-Cal eligibility to include additional low-income populations—primarily childless adults who did not previously qualify for the program. This eligibility expansion is sometimes referred to as the "ACA optional expansion." Medi-Cal has grown significantly both in terms of caseload and spending as a result of the ACA optional expansion and the other changes under the ACA to encourage health care coverage. Figure 1 shows the growth in Medi-Cal spending over the last decade.

Federal Share of Cost Varies, Primarily by Eligibility Group. The costs of state Medicaid programs are generally shared between the federal government and states based on a set formula.

Figure 1

A Decade of Medi-Cal Spending: 2010-11 Through 2019-20

(In Billions)



[a] Include funding from state special funds as well as some local funds.

[b] Proposed funding.

The percentage of Medicaid costs paid by the federal government is known as the federal medical assistance percentage (FMAP).

For most families and children, seniors, persons with disabilities, and pregnant women, California generally receives a 50 percent FMAP—meaning the federal government pays half of Medi-Cal costs for these populations. However, a subset of children in families with higher incomes qualifies for Medi-Cal as part of the Children's Health Insurance Program (CHIP). Currently, the federal government pays 88 percent of the costs for children enrolled in CHIP and the state pays 12 percent. (The state share is scheduled to ramp up to the historical cost share of 35 percent over the coming years.) Finally, under the ACA, the federal government paid 100 percent of the costs of providing health care services to the ACA optional expansion population from 2014 through 2016. Beginning in 2017, the federal cost share decreased to 95 percent and phases down further to 90 percent in 2020 and thereafter.

Delivery Systems. There are two main Medi-Cal systems for the delivery of medical services: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment from DHCS for each medical service delivered to a beneficiary. Beneficiaries in Medi-Cal FFS may generally obtain services from any provider who has agreed to accept Medi-Cal FFS payments. In managed care, DHCS contracts with managed care plans to provide health care coverage for Medi-Cal beneficiaries. Managed care enrollees may obtain services from providers who accept payments from the managed care plan, also known as a plan's "provider network." The plans are reimbursed on a "capitated" basis with a predetermined amount per person per month, regardless of the number of services an individual receives. Medi-Cal managed care plans provide enrollees with most Medi-Cal covered health care services—including hospital, physician, and pharmacy services—and are responsible for ensuring enrollees are able to access covered health care services in a timely manner. Managed care enrollment is mandatory for most Medi-Cal beneficiaries, meaning these beneficiaries must access most of their Medi-Cal benefits through the managed care delivery system. FFS enrollment largely consist of newly enrolled beneficiaries that will soon enroll in a managed care plan and certain seniors and persons with disabilities. In 2018-19, more than 80 percent of Medi-Cal beneficiaries are estimated to be enrolled in managed care.

OVERVIEW OF THE GOVERNOR'S BUDGET

The Governor's January budget estimates that $20.7 billion General Fund ($98.5 billion total funds) will be needed to fund Medi-Cal in 2018-19. In 2019-20, the Governor's budget proposes $22.9 billion for Medi-Cal from the General Fund ($100.7 billion total funds), an increase of $2.2 billion (10.6 percent) over the revised 2018-19 General Fund estimate. Below, we describe major changes in the current and upcoming fiscal years in the Medi-Cal budget.

Current-Year Adjustments

Estimated General Fund Spending Down $2.3 Billion in 2018-19. The Governor's budget reflects a very significant reduction in estimated General Fund spending in Medi-Cal in 2018-19—nearly $2.3 billion or 10 percent—relative to what was assumed in the *2018-19 Budget Act.* There are several factors that contribute to this reduction in estimated spending, as displayed in **Figure 2** and described below. The magnitude of this downward revision is the most recent example of the large unanticipated changes in estimated Medi-Cal spending—both cost increases and cost decreases—that have been observed in recent years. As we describe later in this report, the Medi-Cal budget has become increasingly difficult to predict, complicating legislative oversight and decision making. Later in this report, we describe some of the underlying factors that have led to increased difficulty in estimating Medi-Cal spending and provide an assessment of the Governor's proposals to try to address some of these factors.

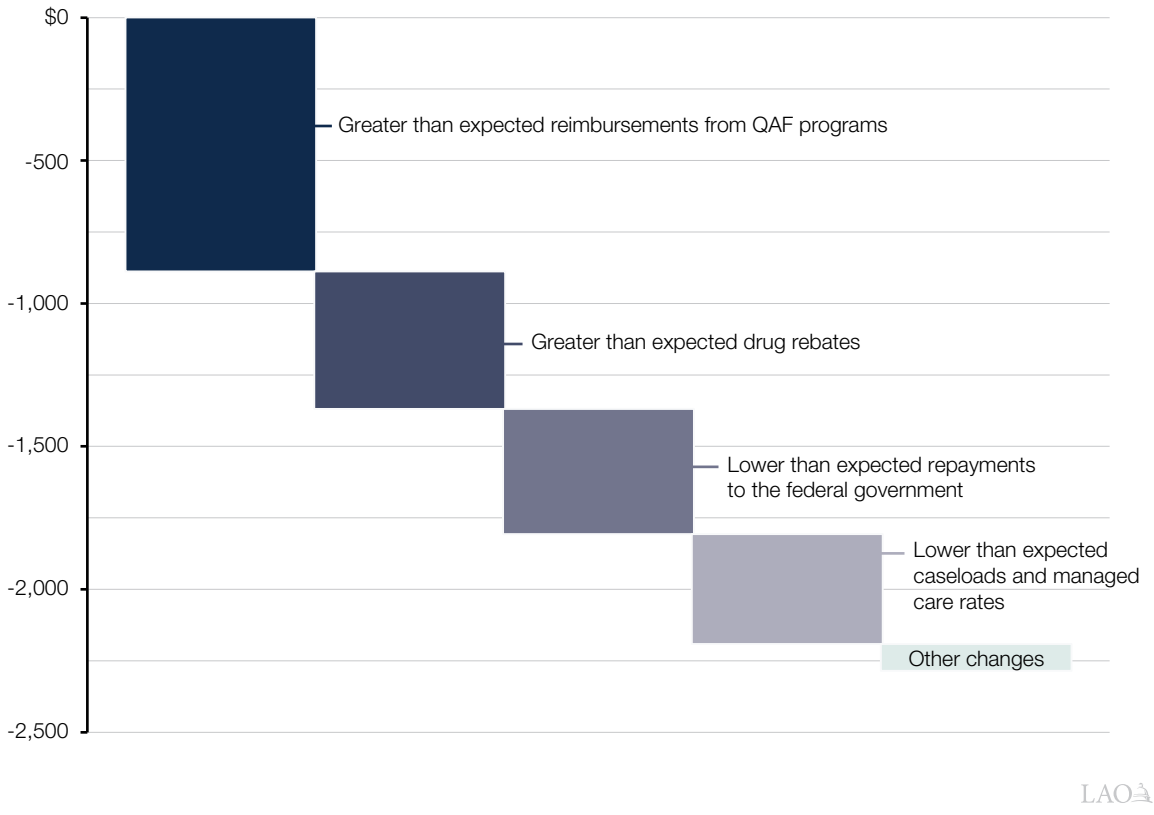
Higher Than Expected Reimbursements Related to Quality Assurance Fee (QAF) Programs. As part of Medi-Cal, the state operates QAF programs wherein certain providers pay fees that are used to draw down federal funding and increase the rates paid to those providers. These programs also result in transfers to the General Fund to offset state costs in Medi-Cal. The *2018-19 Budget Act* assumed that the state's QAF programs for hospitals and certain long-term care providers (such as skilled nursing facilities) would reimburse the General Fund $1.4 billion in 2018-19. The administration's revised estimates assume that these reimbursements will now total almost $2.3 billion in 2018-19, reducing General Fund spending by $870 million for the year. The revised estimates largely reflect updates to account for actual cost data as well as an adjustment to reflect certain reimbursements from prior years that were delayed until 2018-19. General Fund savings from these updated estimates are largely onetime in nature.

Higher Than Expected Drug Rebate Revenues. The state receives rebates from drug manufacturers for prescription drugs paid for by Medi-Cal. The Governor's budget revises upward the estimated amount of drug rebates to be received in 2018-19 by about $480 million. The upward revision reflects changes in the timing of the rebates as well as increased estimated amounts of rebates to account for more recent data. The amount of rebates fluctuates from year to year, but a portion of these increased rebates (and related General Fund savings) is likely ongoing.

Figure 2

Major Factors Contributing to $2.3 Billion Reduction in Estimated Medi-Cal Spending in 2018-19

(General Fund, In Millions)



QAF = Quality Assurance Fee.

Lower Than Expected Repayments to Federal Government for Potentially Disallowed Claims. The state claims significant federal funding for the support of the Medi-Cal program. When the federal government disputes the state's claims for which the state has already received federal funding, the federal government requires the state to repay previously claimed funds until the state can provide additional funding to justify the claim. The *2018-19 Budget Act* included $675 million in General Fund costs to repay disputed claims. The Governor's budget revises downward the estimated amount of repayments to be made in 2018-19 by nearly $440 million because the state has had fewer disputed claims than expected and the state has also been able to justify some previously disputed claims and recover the funds that had already been repaid.

Lower Than Expected Caseload and Managed Care Rates. The Governor's budget reflects a lower caseload in Medi-Cal in 2018-19 than was assumed in the *2018-19 Budget Act.* This is associated with lower projected utilization of services in the FFS system and payments to managed care plans on behalf of fewer enrollees. Additionally, the rates paid to managed care plans, estimated at the time of the *2018-19 Budget Act*, were finalized at a lower level than previously estimated. Taken together, these adjustments account for roughly $400 million of the reduced General Fund spending in 2018-19, relative to previous estimates.

Budget-Year Adjustments and Policy Proposals

Under the Governor's proposed budget, General Fund spending in Medi-Cal would grow from $20.7 billion in 2018-19 to $22.9 billion in 2019-20—a $2.2 billion, or 10.6 percent, increase in year-over-year spending. Most of this change in spending is due to anticipated changes in the funding requirements of the program, notably the statutorily scheduled expiration of the MCO tax (thereby ending a source of revenue to offset General Fund costs) and scheduled reductions in the federal share of cost for certain populations. Around $400 million, however, is attributable to new discretionary policy proposals that are included in the Governor's budget. These discretionary changes are (1) the proposed extension and expansion of provider payment increases using Proposition 56 (2016) funding (which raises General Fund costs by an equivalent amount) and (2) the proposed expansion of comprehensive Medi-Cal coverage to income-eligible young adults regardless of immigration status. **Figure 3** summarizes the major factors responsible for the proposed growth in General Fund spending in Medi-Cal from 2018-19 to 2019-20.

Expiration of the MCO Tax Raises General Fund Costs by $1.1 Billion. The most significant change in year-over-year Medi-Cal spending relates to the assumed expiration of the MCO tax. In 2018-19, the MCO tax is expected to generate almost $1.9 billion in additional funding for Medi-Cal, funding which offsets General Fund costs in the program. Under state law, the MCO tax is set to expire at the end of 2018-19. As a result, the General Fund offset from the MCO tax is projected to go down by $1.1 billion. Due to a lag in the availability of MCO tax funding, around $750 million from the MCO tax is projected to remain available to offset General Fund costs in Medi-Cal in 2019-20.

Increased State Share of Cost for Certain Medi-Cal Populations Associated With as Much as $600 Million in Higher State Spending. As previously noted, the federal government provides an enhanced share of cost for the ACA optional expansion and CHIP populations. Under federal law, the federal share of cost for these populations is scheduled to decline over the next several years. This results in a higher state share of cost for these populations, and higher state costs in Medi-Cal overall. For the ACA optional expansion, the state share of cost increased from 6 percent to 7 percent on January 1, 2019. The state's share will further increase to 10 percent on January 1, 2020, where it is scheduled to remain going forward. For CHIP, the state's share of cost will increase from 12 percent to 23.5 percent on October 1, 2019, and further increase to 35 percent on October 1, 2020, where it will remain going forward. **Figure 4** (see page 8) shows the state's "effective" share of cost in Medi-Cal for relevant enrollee populations over the next several fiscal years. California's effective

share of cost is the state's average share of cost within a state fiscal year.

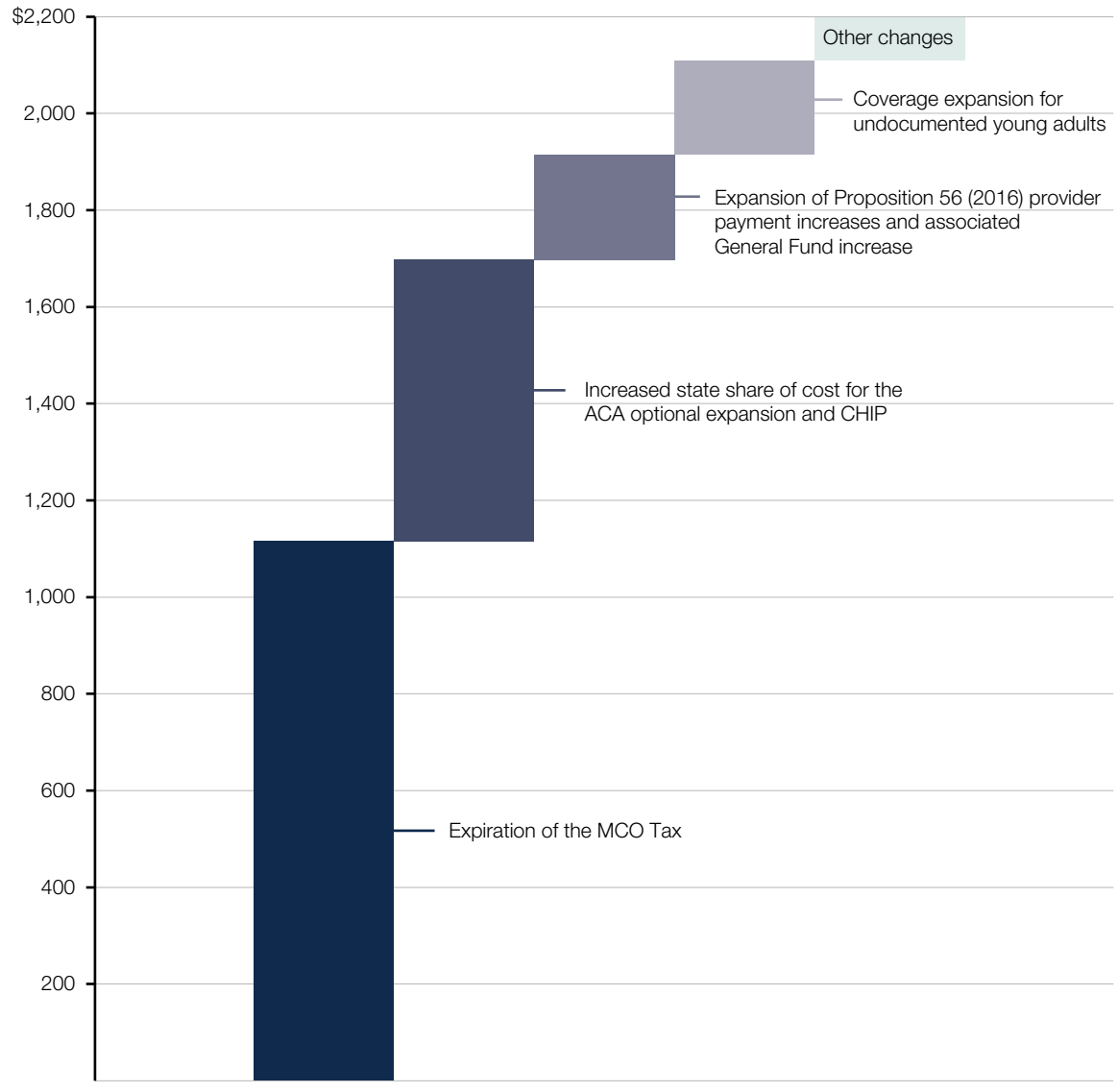
Coverage Expansion to Income-Eligible Adults, Regardless of Immigration Status. The Governor's budget provides $194 million General Fund ($257 million total funds) in Medi-Cal to expand comprehensive, or "full-scope," coverage to undocumented immigrants ages 19 through 25. Currently, undocumented adults are only eligible for restricted-scope Medi-Cal, which covers emergency and pregnancy-related services.

Proposed Expansion of Provider Payment Increases and Associated Increase in General Fund Spending in Medi-Cal. Proposition 56 raised

Figure 3

Major Factors Contributing to $2.2 Billion Growth in Year-Over-Year Medi-Cal Spending in 2019-20

(General Fund, In Millions)



ACA = Patient Protection and Affordable Care Act; CHIP = Children's Health Insurance Program; and MCO = managed care organization.

Figure 4

Effective State Share of Cost for ACA Optional Expansion and CHIP Populations Scheduled to Increase[a]

	2018-19	2019-20	2020-21	2021-22 and Ongoing
ACA optional expansion	6.5%	8.5%	10%	10%
CHIP	12	21	32	35
Remaining enrollee populations	50	50	50	50

[a] Federal law establishes the federal share of cost for state Medicaid and CHIP programs. Under federal law, the federal share of cost is scheduled to decrease over the next couple years, resulting in a higher state share of cost. California's "effective" share of cost reflects its average share of cost over a state fiscal year.

ACA = Patient Protection and Affordable Care Act and CHIP = Children's Health Insurance Program.

state taxes on tobacco products and dedicates the majority of its revenues to Medi-Cal. In 2018-19, most Proposition 56 funding for Medi-Cal ($717 million) supported provider payment increases, with $218 million used to offset General Fund spending on cost growth in the program. The Governor's budget proposes to eliminate the General Fund offset and instead dedicate all Proposition 56 funding for Medi-Cal to provider payment increases. This proposal has the effect of increasing General Fund spending in Medi-Cal by $218 million in 2019-20 relative to 2018-19, generally on an ongoing basis.

Other Budget-Year Adjustments. The above four changes account for the vast majority of the overall change in General Fund Medi-Cal spending from 2018-19 to 2019-20. However, a large number of other adjustments—some projecting higher costs, others projecting lower costs—significantly affect the change in General Fund costs in Medi-Cal going into 2019-20. For example, medical inflation is projected to increase General Fund costs in Medi-Cal by hundreds of millions of dollars in 2019-20. Such projected cost increases—excluding the four adjustments and proposals described in the preceding paragraphs—are very roughly offset by a variety of projected cost decreases, such as reductions in the projected amount of Medi-Cal funding the state will have to repay the federal government for disputed claims in 2019-20.

Proposition 55

Proposition 55 Formula Provides Funding for Medi-Cal Under Certain Conditions. In 2016, voters passed Proposition 55, which extended tax rate increases on high-income Californians. Proposition 55 includes a budget formula that went into effect in 2018-19. This formula requires the Director of Finance to annually calculate the amount by which General Fund revenues exceed constitutionally required spending on schools and the "workload budget" costs of other government programs that were in place as of January 2016. Half of General Fund revenues that exceed constitutionally required spending on schools and workload budget costs, up to $2 billion, are directed to increase funding for existing health care services and programs in Medi-Cal. The Director of Finance is given significant discretion in making calculations under this formula.

2018-19 Budget Package Included No Additional Funding for Medi-Cal Pursuant to Proposition 55 Formula. For 2018-19, the Director of Finance calculated that no additional funding would be available for Medi-Cal under the Proposition 55 formula. This result follows from decisions made by the Director of Finance in interpreting the requirements of Proposition 55. As we noted in our report *The 2018-19 Budget: The Administration's Proposition 55 Estimates*, the administration's approach to the Proposition 55 calculation had the effect of (1) reducing the amount of revenues considered by the formula and (2) increasing the size of the workload budget. Taken together, these factors reduce funding available for Medi-Cal under the formula. At the time, we noted that alternative interpretations of Proposition 55 requirements could have increased available funds for Medi-Cal in 2018-19 and potentially in future years. Ultimately, the 2018-19 budget reflected the Department of Finance approach to the Proposition 55 formula and accordingly allocated no additional funding to Medi-Cal.

2019-20 Governor's Budget Similarly Allocates No Additional Funding to Medi-Cal Pursuant to Proposition 55 Formula. Using the interpretation of Proposition 55 developed as part

of the 2018-19 budget, in 2019-20 the Director of Finance defines the vast majority of proposed spending augmentations in the budget as costs related to the workload budget. As a result, the Director of Finance again estimates that the costs of constitutionally required spending on schools and the administration's estimate of the workload budget exceed available revenues in 2019-20, such that no additional funding would be provided to Medi-Cal pursuant to the Proposition 55 formula.

Caseload Projections

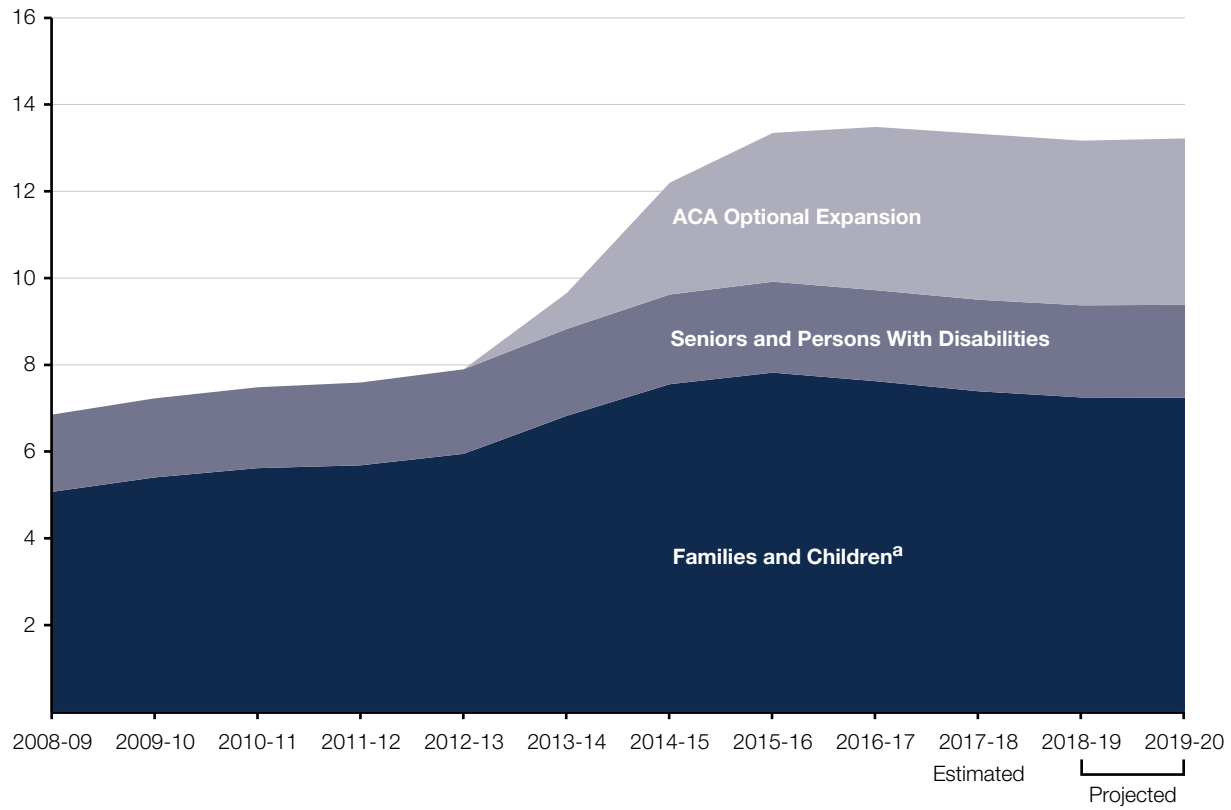
Governor's Budget Projects Essentially Flat Caseload Growth. Figure 5 shows how Medi-Cal caseload grew significantly over the last decade, while being projected to remain essentially flat through 2019-20. The Governor's budget projects an average monthly caseload of 13.2 million in 2018-19, a 1.2 percent decrease relative to estimated total caseload in 2017-18. The budget further projects the Medi-Cal caseload will grow slightly but remain essentially flat at 13.2 million in 2019-20. Within the total caseload projection for 2019-20, the Governor's budget assumes that (1) the families and children population will decline by 0.1 percent, much more slowly than in the prior year; (2) the seniors and persons with disabilities population will increase by 0.6 percent, consistent with prior years and our expectations; and (3) the optional expansion population will increase slightly by 0.1 percent.

Caseload Projections Are Cautious. Overall, the administration's Medi-Cal caseload projections appear to be generally reasonable, but cautious. In

Figure 5

Budget Assumes Essentially Flat Medi-Cal Caseload

Average Monthly Enrollees (In Millions)



[a] Includes certain refugees, undocumented immigrants, and hospital presumptive eligibility enrollees.

ACA = Patient Protection and Affordable Care Act.

recent years, the families and children population has gradually declined, reflecting a strong labor market in which fewer families are eligible for coverage. The optional expansion caseload appears to have leveled off and shows some indications of beginning to decline. In projecting essentially no change in caseload from 2018-19 to 2019-20, the Governor's budget departs from these recent trends. There are new policies in the Governor's proposed Medi-Cal budget that will increase the caseload, notably the expansion of coverage to all income-eligible young adults regardless of immigration status. However, the effect of this expansion on the caseload is relatively minor and does not fully explain the difference between projections in the Governor's budget and recently observed trends. We are unsure what other factors would cause recently observed declines in caseload to slow. Accordingly, and dependent upon continuing strong economic conditions, we believe there is some possibility that caseload levels could turn out to be lower than currently projected in 2019-20. More information will be available to assess this possibility in May.

Legislative Oversight of Medi-Cal Budget Is Critical

Medi-Cal Program Makes Up Significant Share of State Budget. At $20.7 billion in 2018-19, the Medi-Cal program makes up 14 percent of the state's total General Fund spending and a little less than one-third of General Fund spending not dedicated to funding education under Proposition 98 (1988). Because Medi-Cal makes up such a large share of the state's General Fund budget, changes in Medi-Cal spending have a significant influence on the state's overall General Fund budget condition. In the past, caseloads and spending in the Medi-Cal program have been countercyclical—that is, they have grown in times of recession when the state's General Fund revenues typically shrink. In past recessions, the state has received some federal funding assistance to offset state costs in Medi-Cal. However, the availability and/or extent of such assistance in the future is highly uncertain. Due to the program's size and the potential for countercyclical cost growth, legislative oversight of the Medi-Cal budget is critical. Accordingly, proposed ongoing augmentations to Medi-Cal should be evaluated in light of the potential risk posed by the program in times of fiscal stress.

Significant Changes Possible in Coming Months. Several factors, such as changes in the timing of provider payments and drug rebates or new data on caseload trends, could significantly affect estimated spending in Medi-Cal, in either direction, in both 2018-19 and 2019-20. These changes could have significant impacts on policy decisions the Legislature may wish to make relative to the Medi-Cal program and, because of the large amount of General Fund support dedicated to Medi-Cal, other state programs funded from the General Fund. We recommend that the Legislature keep the potential for such changes in mind as budget deliberations proceed in the coming months.

Layout of the Remainder of the Report

In the sections that follow, we (1) provide issues for consideration related to the assumed expiration of the MCO tax, (2) assess the proposed eligibility expansion, (3) provide a preliminary analysis of the Governor's proposed use of Proposition 56 funding to extend and expand provider payment increases, and (4) make recommendations related to the Governor's proposal to improve fiscal oversight of the Medi-Cal program. We would note that we will provide additional analyses of the Governor's Medi-Cal-related proposals in a series of separate, forthcoming reports, briefs, and policy posts.

GOVERNOR DOES NOT PROPOSE TO EXTEND THE MCO TAX PACKAGE

Executive Summary. For several years, the state has imposed a tax on MCOs that leverages significant federal funding. In combination with a package of associated tax changes, the existing MCO tax package generates a net General Fund benefit of around $1.5 billion. Under state law, the MCO tax package expires at the end of 2018-19. Extending the MCO tax past 2018-19 would require statutory reauthorization from the Legislature and approval from the federal government. Based on the recent federal approval of a similar tax in Michigan, federal approval of a reauthorized California MCO tax package appears likely. Despite this development, the administration did not propose an extension of the MCO tax package in 2019-20. Allowing the MCO tax to expire would forego a significant General Fund benefit. Accordingly, we recommend the Legislature seriously consider renewal of the MCO tax package and explore the trade-offs of renewing the MCO tax package in its current or a modified form.

BACKGROUND

Federal Government Regulates Health Care-Related Taxes. Many states levy licensing fees, assessments, or other mandatory payments on the provision of health care services or items. These are referred to as "health care-related taxes." The federal government has rules that regulate states' health care-related taxes to the extent that they are used to draw down federal Medicaid funds. The rules apply, for example, to taxes on direct health care services (such as hospital inpatient stays) as well as to taxes on health insurer revenue or enrollment. The rules are in place to prevent states from imposing taxes that place too great a burden on federal Medicaid funds. Therefore, to receive federal approval, a state must prove to the federal government that the burden of paying a health care-related tax does not fall too disproportionately on Medicaid as opposed to non-Medicaid services. In addition, a state may not hold payers of the health care-related tax harmless by providing its payers direct or indirect payments that do so.

Structure of California's MCO Tax Package. MCOs are health insurance plans that arrange and pay for the health care of their members and are overseen either by the Department of Managed Health Care or DHCS. They do not include health insurance products regulated by the California Department of Insurance. Since 2016-17, the state has imposed a per-member tax on the Medi-Cal and non-Medi-Cal enrollment of MCOs. The structure of the existing MCO tax—in effect from 2016-17 through 2018-19—is as follows:

- ***Imposed on Most MCOs, Including Their Non-Medi-Cal Lines of Business.*** The MCO tax is imposed on most of the state's MCOs, and applies to their Medi-Cal and non-Medi-Cal lines of business. Certain health plans are exempt from the tax—for example, those that offer only limited services such as vision or dental coverage.
- ***Enrollment-Based Tax.*** The existing MCO tax is an enrollment-based tax where MCOs are taxed according to their total number of enrollee member months, counted over the fixed time period of October 2014 through September 2015. A member month is defined as one member being enrolled for one month in an MCO. For example, if an individual is enrolled in the Kaiser Foundation Health Plan for the 12-month period specified above, Kaiser would be taxed for 12 member months for each of the fiscal years 2016-17, 2017-18, and 2018-19.
- ***Tiered Rate Structure.*** The existing MCO tax features a tiered rate structure whereby MCOs are charged different tax rates based on the following:
  - ***Enrollment Type.*** MCOs are generally taxed at higher rates for Medi-Cal enrollee member months than non-Medi-Cal enrollee member months.

- » ***Enrollment Size.*** MCOs with higher enrollee member months are taxed at lower effective rates.
- » ***Fiscal Year.*** The tax rates generally increase each fiscal year.
- » ***Structure of MCO.*** The MCO tax applies a unique tax rate to non-Medi-Cal enrollment in any MCO that qualifies as an "Alternate Health Care Service Plan," defined as a nonprofit health plan that has high statewide enrollment, that owns or operates pharmacies, and that exclusively contract with a single medical group in all of its geographic areas of operation. Kaiser Foundation Health Plan is the only MCO that qualifies under this definition.

Figure 6 details the existing MCO tax's overall structure.

MCO Tax Package Included Changes to Other Taxes Paid by Some MCOs. The MCO tax package cut other taxes paid by some MCOs and certain affiliated health insurance companies for the period the MCO tax is in effect. Specifically, certain types of income currently subject to the corporation tax is exempted from taxation and the insurance tax (also known as the gross premiums tax) rate is set to zero for certain premium revenue during the period in which the MCO tax is in effect. The administration estimated that these tax reductions would lower corporate and insurance tax revenue—which support the General Fund—by around $400 million per year. Due in part to these tax reductions offsetting the impact of the MCO tax, the administration estimated at the time of enactment that the health insurer industry as a whole would receive an approximately $100 million net benefit annually. Although the health insurance industry as a whole was expected to benefit on net, total state taxes for some MCOs were expected to increase under the MCO tax package.

MCO Tax Package Restored In-Home Supportive Services (IHSS) Service-Hours to Prerecession Levels. IHSS beneficiaries' service hours were reduced across the board by 7 percent in an effort to reduce the General Fund shortfall during the most recent recession. The MCO tax package restored IHSS service hours to prerecession levels for the years the MCO tax is in effect, at an annual General Fund cost of about $300 million. (We would note that the Governor's budget independently proposes an extension of General Fund support for the IHSS service hours restoration.)

STRONG PROSPECTS FOR FEDERAL APPROVAL OF A REAUTHORIZED MCO TAX PACKAGE

Prospects of Renewing MCO Tax After 2018-19 Initially Appeared Uncertain. Following federal approval of the existing MCO tax in 2016-17, there was initial uncertainty among state health policymakers over whether the federal government would approve a similarly structured MCO tax after the expiration of the existing tax. At that time, state policymakers were expecting

Figure 6

Tax Tiers and Rates of the Existing MCO Tax

Member Months[a] (In Base Year[b])	Tax Rate Per Member Month 2016-17	2017-18	2018-19
Medi-Cal Enrollees			
1 - 2,000,000	$40	$42.50	$45
2,000,001 - 4,000,000	19	20.25	21
4,000,001 and above	1	1	1
Non-Medi-Cal Enrollees			
1 - 4,000,000	7.50	8	8.50
4,000,001 - 8,000,000	2.50	3	3.50
8,000,001 and above	1	1	1
AHCSP Non-Medi-Cal Enrollees[c]			
1 - 8,000,000	2	2.25	2.50

[a] A member month is defined as one member being enrolled for one month in an MCO.
[b] The base year is October 2014 through September 2015.
[c] An AHCSP is defined as a nonprofit health plan that has high statewide enrollment, owns or operates pharmacies, and exclusively contracts with a single medical group in all of its geographic areas of operation.
MCO = managed care organization and AHCSP = alternate health care service plan.

revisions to federal rules on health care-related taxes that could have, in the years following 2018-19, prohibited an MCO tax similar in structure to the state's current MCO tax. Such revisions to federal rules, however, were never made. Nevertheless, until recently, the state's prospects for federal approval remained uncertain since the current federal administration had neither approved nor rejected a health insurer tax proposal structured like California's from any state.

Current Federal Administration Recently Approved Michigan's Similarly Structured Tax. In December 2018, the federal government approved a new health insurer tax in Michigan. The new tax on Michigan health insurers is structured very similarly to California's current MCO tax. Like California's MCO tax, Michigan's new health insurer tax (1) is enrollment-based, (2) applies to Medicaid and non-Medicaid enrollment, and (3) and is tiered so that the tax rate varies based on whether a member is enrolled through Medicaid as well as on insurers' Medicaid enrollment numbers. Unlike California's MCO tax, Michigan's health insurer tax is based on annually updated insurer enrollment numbers. In addition to imposing the above new tax, Michigan repealed other state taxes on health insurers, including a one percent tax on insurers' health claims. The repeal of these taxes serves to offset the costs of the new health insurer tax.

Federal Approval of a Reauthorized MCO Tax in California Appears Likely. Following the approval of Michigan's new health insurer tax, we believe that California's prospects of receiving federal approval of a reauthorized MCO tax are strong. The administration has shared that it agrees with this assessment, stating that it is not concerned that the federal government could reject a proposal to extend a similarly structured MCO tax.

FISCAL IMPLICATIONS OF ALLOWING THE MCO TAX PACKAGE TO EXPIRE

MCO Tax Package Generates a $1.5 Billion Net General Fund Benefit . . . The net General Fund benefit from the MCO tax package equals the difference between total MCO tax revenues and the combination of (1) the General Fund portion of the cost to pay MCOs back for the tax amounts that they pay on their Medi-Cal lines of business (the federal government pays the remaining portion of the Medi-Cal share) and (2) the loss of General Fund revenue associated with the reductions to the insurance and corporation taxes.

. . . And Is Estimated to Leave California's Health Industry Overall No Worse Off. The MCO tax package was designed to at least fully offset, on net, the state tax liability of the health insurance industry as a whole. Although the initial net benefit to the industry was estimated at $100 million, estimating the net benefit comes with significant uncertainty, particularly on the corporation tax side. In 2018-19, the most recent estimates show that the MCO tax package reduced the state tax liability of the health insurance industry overall by around $50 million, relative to what its liability would have been absent the MCO tax package. However, under the MCO tax package, certain plans were expected to see their net tax liability decline while others were expected to see their net tax liability increase. Figure 7 (see next page) summarizes the fiscal impact of the MCO tax package—excluding the associated restoration in IHSS service-hours—on the General Fund and the state's health insurance industry.

Expiration of MCO Tax Will Eliminate the Associated General Fund Benefit. In 2019-20, the net impact of the expiration of the MCO tax package on the General Fund is projected to be between $700 million and $800 million. This reduction in available General Fund resources is reflected in the Governor's January budget proposal. We expect the full fiscal impact of the expiration of the MCO tax package—the loss of the full $1.5 billion General Fund benefit—to materialize in 2020-21 or later. The fiscal impact is less in 2019-20 because of delays in when MCO tax revenue is available to offset General Fund costs in Medi-Cal.

ISSUES FOR CONSIDERATION

To Allow the MCO Tax Package to Expire Would Forego a Significant General Fund Benefit. By allowing the MCO tax package to

Figure 7

Net Impact of MCO Tax on the State and California Health Insurance Industry

2018-19 (In Millions)

State Impact	
Total MCO tax revenue	$2,560
Cost of non-federal share for reimbursing Medi-Cal share of tax	-660
Reduced General Fund revenue from insurance and corporation tax changes	-440
Net General Fund Benefit	**$1,460**
Health Insurance Industry Impact	
Total MCO tax liability	-$2,560
Medi-Cal reimbursement to MCOs:	
Federal Funds	1,510
General Fund	660
Reduced tax liability from changes to insurance and corporation taxes	440
Net Health Insurance Industry Fiscal Benefit	**$50**

MCO = managed care organization.

expire, the state would ultimately forego around $1.5 billion in annual revenue. This revenue could support a number of the Legislature's funding priorities.

Unclear Why the Administration Would Not Pursue an Extension of the MCO Tax Package. The administration has not laid out a convincing rationale for why it has not proposed an extension of a tax package. The administration's primary stated rationale is that obtaining federal approval of a reauthorized MCO tax could conflict with the state's negotiations on pending Medi-Cal waiver renegotiations. Two major Medi-Cal waivers expire in 2020, requiring renegotiation with the federal government over the scope and provisions of these waivers going forward. However, it is unclear to us how MCO tax negotiations would negatively impact negotiations over renewal of the two major Medi-Cal waivers.

Renewal of the MCO Tax Package Warrants Serious Consideration. Given the General Fund benefit and lack of significant negative fiscal impact on the state's overall health insurance industry, renewal of the MCO tax package warrants serious consideration by the Legislature. We advise the Legislature to use upcoming budget proceedings to explore the potential trade-offs and risks associated with pursuing renewal of the MCO tax package.

Potential Next Steps

Should the Legislature wish to reauthorize the MCO tax package, a number of steps and decisions would have to be taken. This section describes the major steps and decisions that the Legislature would have to make should it wish to renew the MCO tax package.

Establish New Parameters for a Reauthorized Tax. The parameters of the existing MCO tax package likely would need to be updated under a reauthorized tax. The following are the major parameters that the Legislature may wish to consider for an updated MCO tax package.

- ***Tax Base.*** The tax base of the existing MCO tax is based on historical MCO member enrollment. Using MCO member enrollment as the tax base likely makes sense going forward. However, MCO member enrollment may need to be updated to reflect more current MCO enrollment numbers. As explained below, an update to the MCO member enrollment tax base could have a significant impact on the federal permissibility and revenue-generating potential of other parameters of a reauthorized MCO tax.
- ***Tax Rates.*** As shown earlier in Figure 6, the existing MCO tax has tax rates that generally increase annually. This allowed revenues to grow annually and helped prevent the

General Fund benefit from diminishing as the loss in General Fund revenue from the insurance and corporation tax changes grew over time. Accordingly, the state may wish to update the tax rates to ensure continued MCO tax revenue growth, and by doing so at least maintain the net General Fund benefit. In addition, the tax rates that the state may impose—while maximizing revenue and remaining in compliance with federal rules—depend on how member enrollment is distributed among MCOs in the state. Updates to MCO member enrollment (the tax base) may affect (1) what tax rates the state may permissibly impose, (2) what tax rates maximize the overall General Fund benefit, and (3) how the tax rates affect individual health insurers' overall state tax liabilities. Finally, the Legislature could consider changing how a reauthorized MCO tax is tiered—for example, consolidating the number of tiers for either Medi-Cal or commercial enrollment or modifying the difference between the tax rates that apply to the different enrollment tiers.

- ***Other Tax Policy Changes.*** Lastly, the Legislature would have to decide on whether to maintain or modify the changes to other state taxes imposed on health insurers—the state's insurance and corporation taxes—that were part of the MCO tax package. As previously noted, the administration estimates that changes to these other taxes result in lost General Fund revenue of around $400 million annually while helping to generate a net benefit for the health insurance industry under the whole MCO tax package. However, there is significant uncertainty as to the full fiscal impact of these changes to state taxes on both General Fund revenues and on health insurers' state tax liabilities. Reassessment of the impact of these tax changes may be warranted before potentially reauthorizing this aspect of the MCO tax package in a similar form.

Approve Reauthorizing Legislation. Should the Legislature wish to renew a similarly structured MCO tax package, we would advise the Legislature to use the coming months to evaluate its options around how to structure a reauthorized MCO tax. Doing so would help ensure that the Legislature is able to approve a reauthorized MCO tax package around the same time as passage of the state budget by June 30, 2019. This would allow the state to avoid the potential loss of General Fund savings and assist health insurer operations related to incorporating the tax changes into the premium rates they charge their customers. Any such legislation should direct DHCS to submit the state's proposal to reauthorize the MCO tax to the federal government before October 1, 2019.

EXPANDS COVERAGE FOR INCOME-ELIGIBLE YOUNG ADULTS, REGARDLESS OF IMMIGRATION STATUS

In 2019-20, the Governor's budget proposes to extend full-scope Medi-Cal coverage to income-eligible undocumented immigrants ages 19 through 25, most of whom are currently considered to be uninsured as they only have limited Medi-Cal coverage for emergency- and pregnancy-related services. The administration estimates the net cost of this proposal to be $134 million in 2019-20. The net cost comprises (1) the new full-year cost in Medi-Cal of expanding comprehensive Medi-Cal coverage to a projected 138,000 undocumented adults and (2) projected General Fund savings under a proposed increase in the redirection of county realignment funding for indigent health care services. As discussed below, while there is significant uncertainty around the cost of expanding coverage, we find that the administration's General Fund cost estimate in Medi-Cal is likely too high. Below, we more fully describe and provide our assessment of the Governor's proposal.

Background

Undocumented Adults Currently Ineligible for Comprehensive Medi-Cal Coverage. Medi-Cal eligibility depends on a number of individual and household characteristics, including, for example, income, age, and immigration status. Citizens and certain immigrants with documented status generally qualify for comprehensive, or full-scope, Medi-Cal coverage, while undocumented immigrants generally do not qualify for full-scope Medi-Cal coverage. Rather, those who would be eligible for Medi-Cal but for their immigration status are eligible for what is known as "restricted-scope" Medi-Cal coverage. Restricted-scope Medi-Cal covers emergency- and pregnancy-related health care services. The federal government pays for its portion of undocumented immigrants' restricted-scope Medi-Cal services according to standard FMAP rules.

Full-Scope Medi-Cal Coverage Was Expanded to Otherwise Eligible Undocumented Children in 2015. In 2015, the state expanded full-scope Medi-Cal coverage to undocumented children ages zero through 18. Over 200,000 undocumented children gained full-scope coverage through this expansion at an annual General Fund cost of around $300 million.

Undocumented Immigrants Represent a Significant Portion of the State's Remaining Uninsured Population. Around 1.5 million (40 percent) of the state's estimated 3.5 million uninsured residents are undocumented adults. Most of these adults are believed to have low enough incomes that they currently qualify for—but are not necessarily enrolled in—restricted-scope Medi-Cal. Here, we consider enrollees in restricted-scope Medi-Cal to be uninsured since they only have access to limited Medi-Cal benefits.

Governor's Proposal

Expand Full-Scope Medi-Cal Coverage to Otherwise Eligible Undocumented Adults Ages 19 Through 25. The Governor proposes budget-related legislation that would expand full-scope Medi-Cal coverage to otherwise eligible undocumented immigrants ages 19 through 25. The administration projects that this would expand full-scope Medi-Cal coverage to about 138,000 undocumented young adults in 2019-20. The administration anticipates that the majority of undocumented young adults who would receive full-scope coverage under the Governor's proposal are already enrolled in restricted-scope Medi-Cal coverage.

Net General Fund Cost of $134 Million. On net, the administration estimates the cost of the proposed expansion to be $134 million General Fund in 2019-20. As shown in Figure 8, using the administration's assumptions on caseload and costs, we project that the net General Fund cost of this coverage expansion would grow to over $250 million after 2019-20. Below, we describe the major components of the administration's cost projection.

New Incremental Costs in Medi-Cal. The $194 million projected by the administration for additional Medi-Cal costs reflects the

Figure 8

Multiyear Projection of Net General Fund Cost[a] of Expanding Full-Scope Medi-Cal to Young Undocumented Immigrant Adults

General Fund (In Millions)

	2019-20[b]	2020-21[c]	2021-22[c]	2022-23[c]
Medi-Cal (incremental cost)	$194	$286	$299	$308
In-Home Supportive Services	2	26	40	43
Proposed additional redirection of realignment funding for health	-63	-64	-65	-66
Net Total	**$134**	**$248**	**$274**	**$285**

[a] Numbers may not add due to rounding.
[b] Administration's projection.
[c] LAO projection based on the administration's Medi-Cal and In-Home Supportive Services cost assumptions, including a 3 percent annual growth factor.

incremental General Fund cost of expanding from restricted-scope to full-scope coverage for undocumented young adults. The state currently uses General Fund to pay for the nonfederal share of restricted-scope Medi-Cal coverage for almost 90,000 currently enrolled undocumented young adults. As such, the incremental General Fund cost of expanding full-scope coverage excludes existing General Fund spending. Following 2019-20, costs for expanding full-scope coverage to this population are expected to grow as additional eligible but not currently enrolled individuals sign up for coverage.

Increased IHSS Costs, Mostly in Out Years. In addition to the costs in Medi-Cal, the proposed expansion of full-scope coverage is expected to increase General Fund costs in IHSS under the Department of Social Services' budget. Though modest in 2019-20 at $2.2 million General Fund, we project, based on the administration's assumptions, significantly increasing General Fund costs in IHSS in subsequent years—reaching around $40 million annually by 2021-22. These costs are on top of those in Medi-Cal.

Proposed Redirection of $63 Million in County Health Realignment Funding to Offset General Fund Costs in CalWORKs. Through 1991 realignment, the state provides funding for counties to provide health care services to their low-income populations who otherwise lack health care coverage. Following implementation of the ACA, the number of low-income state residents without health care coverage has decreased dramatically, lowering the cost to counties of providing health care services to their low-income populations. As a result, the state redirected the portion of realignment funding that was historically intended to cover county health care services to instead offset General Fund costs in the California Work Opportunity and Responsibility to Kids (CalWORKs). In conjunction with the proposed coverage expansion, the Governor proposes to redirect additional funding from counties. This proposed redirection is projected to free up $63 million General Fund, partially offsetting the cost of the proposed coverage expansion.

LAO Assessment

Proposed Expansion Would Potentially Reduce the Number of Uninsured Undocumented Californians by More Than 10 Percent. The Governor's proposed expansion would potentially extend full-scope Medi-Cal coverage to up to around 150,000 undocumented young adults in the years after 2019-20. We estimate that this would reduce the number of uninsured undocumented Californians by more than 10 percent, and reduce overall the number of uninsured Californians by around 4 percent. See the box on page 18 for information on the number of uninsured undocumented adults statewide, and the projected enrollment and fiscal impact of expanding full-scope Medi-Cal coverage to all otherwise eligible undocumented adults.

Governor's Fiscal Estimate Appears Somewhat Overstated. There is significant uncertainty in projecting the caseload and cost of the Governor's proposed Medi-Cal expansion. Although the administration's cost estimate appears to be in the range of what is reasonable, it is likely overstated, in particular for 2019-20. First, the estimate includes the simplifying assumption that implementation will occur on July 1, 2019. The state's recent history in implementing the expansion of full-scope coverage to undocumented children shows that it will likely take perhaps an additional half a year before implementation is fully under way. This short and reasonable delay in implementation would result in reduced costs in 2019-20. Second, what appears to be an erroneous assumption in the administration's caseload model leads it to project that 98 percent of eligible young adults would enroll in full-scope coverage within several years. It is our understanding that the administration instead intended to assume that around 90 percent of eligible enrollees would enroll within several years, a reasonable assumption in our view. Correcting this error would likely reduce the ongoing General Fund cost of the Governor's proposed coverage expansion by around $20 million annually.

Caseload and Cost of Expanding Full-Scope Medi-Cal Coverage to All Otherwise Eligible Undocumented Immigrants

Researchers estimate that there are around 1.5 million uninsured undocumented immigrants in California. This makes them one of the largest groups of state residents that continue to lack health care coverage.

Administration Estimates Over 1 Million Undocumented Adults Are Income-Eligible for Restricted-Scope Medi-Cal. The administration recently estimated that 1.35 million undocumented adults ages 19 and up are income-eligible for restricted-scope Medi-Cal coverage. Almost one million of these individuals are currently enrolled in restricted-scope Medi-Cal.

Over $2 Billion General Fund Required in Medi-Cal to Expand Full-Scope Coverage to All Otherwise Eligible Undocumented Adults. Although the Governor's proposed Medi-Cal expansion extends only to undocumented adults ages 19 through 25, the administration has released estimates of what the General Fund cost would be to expand full-scope Medi-Cal coverage to all otherwise eligible adults. To do so, the administration estimates that around $2 billion General Fund would be required in Medi-Cal in 2019-20. Under the administration's assumptions, this would grow to around $2.4 billion annually after 2019-20. Around 1.3 million undocumented adults would gain full-scope coverage under these projections. Importantly, these figures exclude costs in In-Home Supportive Services (IHSS), which would likely grow to be in the hundreds of millions of dollars annually after 2019-20. The figure summarizes the administration's 2019-20 caseload and cost estimates for expanding coverage to the entire otherwise eligible undocumented adult population.

Ongoing Caseload and Incremental Cost Estimate of Expanding Full-Scope Medi-Cal to All Otherwise Eligible Undocumented Immigrants[a]

Ages	Estimated Caseload[b]	General Fund Cost (In Millions)[b,c]
19 through 25	150,000	$280
26 through 64	1,098,000	1,960
65 and up	28,000	100
Totals	**1,276,000**	**$2,340**

[a] LAO projection based on the administration's assumptions.
[b] Numbers may not add due to rounding.
[c] Numbers do not include new projected General Fund costs in In-Home-Supportive Services or the General Fund savings under the proposed redirection of realignment health funding.

Magnitude and Scope of Proposed Redirection of Realignment Funding Raises Questions. In our separate forthcoming brief on 1991 realignment, we analyze the Governor's proposed increase in the redirection of realignment health funding to help offset the cost of the proposed coverage expansion and raise questions about its scope and magnitude. We note that, should the Legislature wish to scale back the proposed increase in the redirection, the net General Fund cost of the coverage expansion could be higher than currently estimated by tens of millions of dollars.

Proposal Presents an Opportunity for the Legislature to Decide Among Its Priorities. Expanding full-scope Medi-Cal coverage to otherwise eligible undocumented adults would represent a sizable investment of the Legislature's ongoing General Fund resources, and result in a significant reduction in the number of uninsured state residents. The Governor's proposal presents the Legislature with at least a couple of decisions to make. First, does the Legislature wish to use

its discretionary ongoing resources on health care coverage expansion, as opposed to funding other legislative priorities? Second, does the Legislature wish to prioritize health care coverage expansion for the same demographic group as the Governor?

There are reasons to support the Governor's approach and reasons to prefer alternative approaches to expanding coverage within Medi-Cal. For example, supporting the Governor's prioritization of young adults, the proposed expansion would align coverage for low-income undocumented adults with the protection under the ACA that compels commercial health insurers to extend coverage to their members' children through age 25. Moreover, this would allow undocumented immigrants to maintain consistent full-scope Medi-Cal coverage all the way from zero through 25 years old, as opposed to having full-scope coverage end at age 19. On the other hand, older undocumented adults may, on average, stand to gain more through the availability of full-scope Medi-Cal coverage. The prevalence of disease grows as people age, thus increasing the need for health care services. Moreover, restricted-scope Medi-Cal arguably covers a greater proportion of the health care services needed by young adults compared to older adults—services for emergencies and related to pregnancy. However, we note that the number of uninsured state residents who would gain health care coverage under an expansion of full-scope Medi-Cal to undocumented elderly adults would be significantly smaller than under the Governor's proposed expansion for young adults.

PRIORITIZES PROVIDER PAYMENT INCREASES WITH PROPOSITION 56 FUNDING

This section provides an overview of the Governor's proposed use of Proposition 56 funding in Medi-Cal, and provides some initial LAO comments. We will provide a broader assessment of the Governor's proposals related to Proposition 56 in Medi-Cal in the coming weeks. In addition, we will specifically assess the Governor's proposal to create supplemental payments for developmental screenings in our budget analysis, *The 2019-20 Budget: Governor's Proposals for Infants and Toddlers With Special Needs*.

BACKGROUND

Proposition 56 Raised State Taxes on Tobacco Products and Dedicates Most Revenues to Medi-Cal on an Ongoing Basis. Medi-Cal began receiving Proposition 56 funding in 2017-18. Funding from Proposition 56 is intended to ensure timely access to quality care within the Medi-Cal program. Proposition 56 funding for Medi-Cal has been used for two main purposes: (1) augmenting the program, such as by increasing Medi-Cal provider payments and (2) offsetting General Fund spending on underlying cost growth in Medi-Cal. Proposition 56 currently provides about $1 billion annually to Medi-Cal. Because tobacco use is projected to continue to decline on an ongoing basis—partially as a result of the new taxes put in place by Proposition 56—revenues from Proposition 56 for Medi-Cal are expected to gradually decline on a year-over-year basis.

Use of Proposition 56 Funding in Medi-Cal

In 2017-18, the Legislature and Governor Brown reached a two-year agreement on how to use Proposition 56 funding in Medi-Cal. As described below and summarized in **Figure 9** (see next page), this agreement—as updated in 2018-19—allocated Proposition 56 funding for Medi-Cal to three distinct purposes: (1) increasing provider payment, (2) offsetting General Fund spending on underlying cost growth in Medi-Cal, and (3) creating a physician and dentist student loan repayment program. (We provide additional detail on the specific allocation of funding for provider payment increases in **Figure 10**, see page 21.)

Figure 9

Use of Proposition 56 Funding in Medi-Cal[a]

(In Millions)

	2017-18	2018-19
Provider payment increases	$253	$821
Provider loan repayment	—	220
Offset to General Fund spending on natural cost growth	711	218
Totals	**$964**	**$1,259**

[a] Funding amounts reflect estimates at the time of the *2018-19 Budget Act*.

Increase Medi-Cal Provider Payments. In the last two years since funding became available, about half of Proposition 56 funding for Medi-Cal has been used to increase Medi-Cal provider payments. A variety of Medi-Cal provider groups or service categories receive payment increases under Proposition 56, including, for example, physicians, dentists, family planning services, and AIDS Waiver Program services. Where appropriate, the provider payment increases apply to both FFS and managed care. Under the 2018-19 spending plan, $821 million in Proposition 56 funding was dedicated to provider payment increases. This was expected to draw down over $1 billion in federal funds, which help to finance the provider payment increases. As shown in Figure 9, funding dedicated to provider payment increases is significantly higher in 2018-19 compared to 2017-18. This increased funding is used to (1) further supplement provider payments that already received increases in 2017-18 and (2) expand the number and kinds of Medi-Cal services that receive payment boosts.

Primarily, the provider payment increases take the form of supplemental payments that are tied to a designated set of Medi-Cal services, such as, for example, a new patient doctor's office visit or family planning services. These supplemental payments are paid on top of the base reimbursement rates that providers receive for the Medi-Cal services they provide. In a couple of instances, however, the provider payment increases took the form of Medi-Cal base rate increases. Supplemental payments provide flexibility as they are easier to reduce or eliminate in the event, for example, of an economic downturn. Making subsequent reductions to Medi-Cal rates, to the contrary, can be more challenging for the state because federal rules that apply to provider rate reductions, but not reductions in supplemental payments, require enhanced state monitoring of the potential effect of a rate reduction on beneficiary access to services.

Offset General Fund Spending on Underlying Cost Growth in Medi-Cal. To date, a significant portion of Proposition 56 funding for Medi-Cal has been used to offset General Fund spending on underlying cost growth in Medi-Cal. In 2018-19, $218 million in Proposition 56 funding was used for this purpose. This represents a significant reduction from the $711 million in Proposition 56 funding that offset General Fund expenditures in Medi-Cal in 2017-18.

Establish a Physician and Dentist Student Loan Repayment Program. In the 2018-19 spending plan, $220 million in Proposition 56 funding from the previous year was dedicated to create a physician and dentist student loan repayment program. The program—financed with one-time funding but expected to implement over multiple years—will help repay the student loans of physicians and dentists who serve significant numbers of Medi-Cal patients.

Implementation Update

Implementation of the Proposition 56 provider payment increases has met with some, generally anticipated, delays. Often these delays relate to the time line of federal approval of the provider payment increases. (Federal approval is required since Proposition 56 funding is matched with federal Medi-Cal funding to fully finance the payment increases.) The 2017-18 provider payment increases were implemented that same fiscal year and have continued to be paid through 2018-19. The

2018-19 provider payment increases—which are on top of the 2017-18 increases—have generally either recently been implemented or are soon to implement over the next couple of months. In terms of overall funding, updated estimates of Proposition 56 spending on provider payments in the Governor's January budget are relatively consistent with projections from the *2018-19 Budget Act.*

GOVERNOR'S PROPOSAL

The Governor's budget proposes to extend and expand upon the previous two-year agreement on the use of Proposition 56 funding in Medi-Cal. For 2019-20, the proposal would spend just over $1 billion in Proposition 56 funding (more than $3 billion in total funds) on provider payment increases. Below, we outline the Governor's proposal. Figure 10 summarizes the Governor's proposed use of Proposition 56 funding in Medi-Cal.

Makes Most Provider Payment Increases Permanent. The Governor has stated an intent to make most of the provider payment increases—the existing as well as certain new supplemental payment programs—permanent and ongoing.

Eliminates the General Fund Offset. In 2019-20, the Governor proposes to eliminate the General Fund offset, which in 2018-19 is $218 million. This proposal results in higher General Fund costs in Medi-Cal in 2019-20 of an equivalent amount. The Governor's budget allocates this funding to additional provider payment increases.

Figure 10

Governor's 2019-20 Budget Dedicates All Proposition 56 Funding for Medi-Cal to a Variety of Provider Payment Increases

(In Millions)

	2018-19		2019-20	
	Proposition 56 Funds	Total Funds	Proposition 56 Funds	Total Funds
Existing Provider Payment Increases:				
Physician services	$409[a]	$1,299	$456	$1,387
Dental services	194	510	217	547
Women's health	54	203	42	160
Home health services	27	57	31	65
Intermediate Care Facilities for the Developmentally Disabled	14	29	13	28
Pediatric day health care facilities	6	12	7	14
AIDS Medi-Cal Waiver Program	3	7	3	7
Freestanding pediatric subacute care facilities	3	6	1	2
Program for All-Inclusive Care for the Elderly	5	5	—	—
Community-Based Adult Services programs	2	2	—	—
Subtotals	($717)	($2,130)	($770)	($2,209)
New Proposed Provider Payment Increases:				
Value-based payments	—	—	$180	360
Developmental and trauma screenings	—	—	53	105
Medi-Cal family planning	—	—	50	500
Subtotals	(—)	(—)	($283)	($965)
Subtotals, All Provider Payment Increases	**($717)**	**($2,130)**	**($1,052)**	**($3,174)**
Offset to General Fund spending on Medi-Cal cost growth	$218	N/A	—	N/A
Grand Totals, Proposition 56 Spending in Medi-Cal	**$935**	**$2,130**	**$1,052**	**$3,174**

[a] Estimated Proposition 56 funding for these supplemental payments has been revised significantly downward in the Governor's January budget relative to the *2018-19 Budget Act.* However, total funding for these supplemental payments is actually higher than previously estimated. As such, this change results from an updated estimate of the federal share of cost for these payments—an update that is fiscally beneficial to the state.

Establishes New Supplemental Payment Programs. The Governor's budget proposes to use $283 million in Proposition 56 funding to establish new supplemental payment programs. At the time of this publication, many of the details of the new proposed programs remain in development. The following bullets provide basic background on these new proposed supplemental payment programs.

- ***Value-Based Payment Program.*** The Governor proposes using $180 million in Proposition 56 funding ($360 million total funds) to create a value-based payment program to improve the quality and efficiency of care within Medi-Cal managed care plans. While details for the program remain under development, the intent is to establish incentive payments for managed care plans and their network physicians that will reward those that meet predetermined performance benchmarks. According to the administration, these payments are intended to improve care in three distinct focus areas: (1) chronic disease management, (2) pre- and post-partum care, and (3) behavioral and physical health integration.
- ***Payments to Encourage Timely Developmental and Trauma Screenings.*** The Governor's budget includes $53 million in Proposition 56 funding ($105 million total funds) to expand physician screenings for (1) appropriate childhood development and (2) early identification of trauma. Of the total amount of proposed Proposition 56 funding, $30 million is for developmental screenings and $23 million is for trauma screenings. The funding would provide for a $60 supplemental payment for each developmental screening and either a $6.50 or a $23 supplemental payment for trauma each screening. Whereas developmental screenings are currently required and funded in Medi-Cal, the introduction of trauma screenings would be largely new to the program.
- ***Extends Family Planning Payments to Broader Medi-Cal Program.*** Currently, Proposition 56 funding is used to provide supplemental payments for family planning services within the Family Planning, Access, Care, Treatment Program (Family PACT) that is operated within Medi-Cal. Family PACT serves state residents with incomes that are low but nonetheless too high for them to qualify for Medi-Cal. The Governor's budget proposes to provide similar supplemental payments within the broader Medi-Cal program. $50 million in Proposition 56 funding is allocated for these payments, which, with an enhanced federal share of cost, will provide for $500 million in supplemental payments for these Medi-Cal family planning services.

State Operations Resources Requested for Value-Based Payment Program. To develop and implement the value-based payment program, the Governor's budget proposes 18 new positions at DHCS at an annual cost of $1.5 million in Proposition 56 funds ($3 million in total funds).

PRELIMINARY ASSESSMENT AND SELECTIVE RECOMMENDATIONS

In the coming weeks, we will release more comprehensive analyses of the Governor's proposed use of Proposition 56 funding in Medi-Cal. In those analyses, we will further analyze and provide recommendations related to the Governor's overall package of proposals on the use of Proposition 56 funding in Medi-Cal. Below, we provide preliminary issues for consideration.

Proposed Funding Levels for Provider Payment Increases May Not Be Sustainable on an Ongoing Basis. The Governor's budget proposes to use $1.05 billion in Proposition 56 funding on provider payment increases in 2019-20. Proposition 56 revenues dedicated to Medi-Cal are projected to be $1.02 billion in 2019-20, and to decline on annual basis thereafter. Moreover, scheduled changes in the FMAP for certain populations will increase the state's share of cost for Medi-Cal. This will require the state to pay for a somewhat higher share of the total cost of the Proposition 56 provider payment increases in the coming years. Accordingly, unless the administration's current spending projections are too high or its revenue projections overly

cautious, we would project annual shortfalls of Proposition 56 revenue for Medi-Cal compared to Proposition 56 costs in Medi-Cal. Balances in the Proposition 56 fund account could cover these annual shortfalls, but likely only on a temporary basis, after which General Fund could be needed. We thus advise that the Legislature take into account the long-term sustainability of any augmentations to Medi-Cal funded through Proposition 56.

Making Provider Payment Increases for a Limited Term Would Provide an Opportunity to Assess Their Impact. To date, no analysis has been released showing that the existing Proposition 56 provider payment increases have been effective in improving access to quality care in Medi-Cal. Moreover, given implementation delays and other issues, it is unlikely that any information provided by the administration will be able to definitively show a positive effect from the existing payment increases on access and quality. Accordingly, more time and experience under the provider payment increases would be needed to assess their effectiveness. The Legislature might consider making the provider payment increases—if extended—limited term to allow further assessment of their impact.

More Details Needed for Legislature to Assess New Proposed Supplemental Payment Programs. At this time, the administration has not provided very much detail on the other new proposed supplemental payment programs. While, conceptually, a new value-based payment program may have significant potential to drive quality improvements within Medi-Cal, the details around how the program would be structured will be crucial to its success. While expanding the use of trauma screening could improve patient-provider relationships and referral to other supports and services, it is unclear at this time how the results of the trauma screening will ultimately affect Medi-Cal beneficiaries' treatment plans and eligibility for additional services. Improved screening for developmental disabilities is a worthy goal. However, it is unclear whether supplemental payments reflect the most cost-effective approach to improving the identification of children in need of services. Finally, while equitable payment across the various Medi-Cal delivery systems may be a worthwhile goal, the administration has not presented evidence of access issues affecting the Medi-Cal provision of family planning services, thereby justifying payment increases. Using the upcoming budget process to gather additional information from the administration on how the new proposed supplemental payment programs will be structured and how they will ultimately improve access and care within the Medi-Cal program could help the Legislature in its decision on whether to approve these new payment programs.

IMPROVING MEDI-CAL FISCAL ESTIMATES AND BUDGET TRANSPARENCY

With proposed General Fund support of nearly $23 billion in 2019-20, Medi-Cal is a high priority for the Legislature's budgetary oversight. However, several features of the Medi-Cal program make its budget extremely complex, difficult for external stakeholders to track, and challenging to predict. In this section, we describe recent challenges in accurately projecting Medi-Cal expenditures and the major underlying sources of budgeting uncertainty. We also provide our assessment of proposals by the Governor to increase staffing at DHCS to improve estimates of Medi-Cal spending and more effectively manage the program's budget.

MEDI-CAL EXPENDITURES HAVE BECOME INCREASINGLY DIFFICULT TO PROJECT

Significant, Unanticipated Changes to Medi-Cal Budget Have Become Routine. In recent years, the Legislature has been confronted with multiple significant, unanticipated changes in the Medi-Cal budget. Estimates of future Medi-Cal

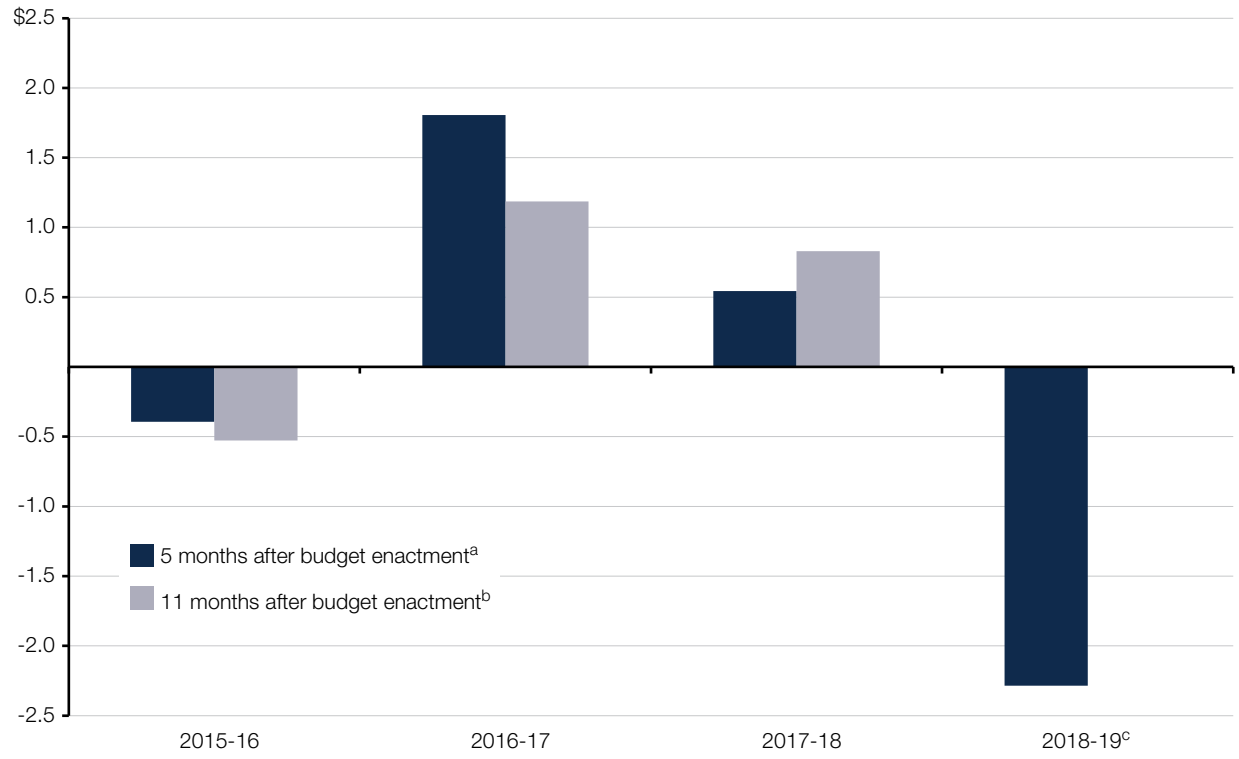
costs can change dramatically from the time the Governor's budget is introduced in January to the time of the May Revision and budget enactment. Estimates of Medi-Cal spending also frequently shift significantly after the budget is enacted. Figure 11 shows the change in estimated General Fund Medi-Cal spending relative to the respective budget acts for each of the fiscal years from 2015-16 through 2018-19, at 5 months and 11 months after budget enactment. As shown in the figure, revised estimates have varied from budget act appropriations by several hundred million, or in some cases billions, of dollars. Of particular note, the *2017-18 Governor's Budget* identified a $1.8 billion *upward* adjustment in 2016-17 Medi-Cal General Fund costs. (This amount of the increase was revised downward to $1.2 billion a few months later.) The recently released *2019-20 Governor's Budget* identifies a $2.3 billion *downward* adjustment in 2018-19 Medi-Cal General Fund costs.

Medi-Cal Budget Uncertainty Hinders Legislative Decision Making. These unanticipated adjustments are large in terms of the Medi-Cal

Figure 11

Revised Estimates of Medi-Cal Spending Often Differ Significantly From Budget Act Assumptions

Change in Estimated Spending Relative to Budget Act (General Fund, In Billions)



[a] Estimates of Medi-Cal spending are revised 5 months after budget enactment as part of preparing the Governor's budget proposal for the following fiscal year.

[b] Estimates of Medi-Cal spending are further revised 11 months after budget enactment as part of preparing the May Revision for the following fiscal year.

[c] An additional revised estimate of Medi-Cal spending in 2018-19 will be available in May 2019.

budget—the $1.8 billion upward adjustment in the *2017-18 Governor's Budget* represented a 10 percent increase in estimated Medi-Cal General Fund spending for the year. They are also large in terms of the broader state budget. At the time of the release of the *2017-18 Governor's Budget*, the upward adjustment in Medi-Cal spending in 2016-17 was cited as one of the main factors leading to a projected budget problem in 2017-18. This required the Governor and Legislature to identify ways to constrain spending to achieve a balanced budget. Such large, unanticipated changes in estimated Medi-Cal spending can interfere with the Legislature's ability to formulate and pursue longer-term fiscal plans in alignment with its priorities, given the potential for these priorities to be displaced by changes to base funding requirements in Medi-Cal.

Medi-Cal Budget Complexity Hinders Legislative Oversight. The significant complexity of the Medi-Cal budget also creates challenges for the Legislature to independently oversee operations of the program. This is particularly true because often information that would be needed to understand and track the complex operations of the Medi-Cal budget is not publicly available or easy to obtain (or for the department to provide).

Underlying Sources of Budgeting Complexity

There are a few key sources of complexity in the Medi-Cal budget, as discussed below.

In Contrast to Other Programs, Medi-Cal Is Budgeted on a Cash Basis. Most state departments and programs are budgeted on an "accrual" basis, which means that spending is largely accounted for in the fiscal year in which the activity that the spending supports takes place. As part of the 2003-04 budget package, the state shifted the Medi-Cal budget to a "cash basis" for budgeting, which means that spending is accounted for in the fiscal year in which it leaves the state's cash accounts. This action was taken primarily to achieve one-time General Fund savings (estimated at about $930 million at the time), but contributes to the complexity of the Medi-Cal budget in important ways. Cash budgeting means that the timing of payments, particularly those that take place around the end of a fiscal year, significantly affect the level of Medi-Cal spending in any given fiscal year. The timing of payments under cash budgeting can in some cases lead to DHCS having insufficient cash available at the end of a fiscal year. Cash budgeting also makes oversight of the Medi-Cal budget challenging, since outside stakeholders, including the Legislature, have limited insight into the timing of payments.

Medi-Cal Budget Is Interdependent With Several External Actors. Another key source of complexity in the Medi-Cal budget is the program's interdependence with other government agencies and private parties. Some key interdependencies include:

- ***The Federal Government.*** The federal government provides the majority of funding for the Medi-Cal program. The Medi-Cal program is dependent on various federal approvals for things like rates paid to managed care plans and waivers of federal Medicaid rules to implement state policies. In any given year, DHCS has several applications for approval pending with the federal government. The timing of federal approval can significantly affect the timing and amount of spending in Medi-Cal.
- ***Providers.*** Medi-Cal providers also play a key role in funding the Medi-Cal program. Public entities, such as county hospital systems, transfer funds to the state which are then used to draw down additional federal funding for Medi-Cal services. Other providers, such as skilled nursing facilities and hospitals, pay a QAF that is similarly used to draw down additional federal funding for Medi-Cal. Because of these relationships, the state is collecting funds from and distributing funds to a large number of providers on varying schedules, significantly increasing the complexity of Medi-Cal finances.
- ***Other State Departments.*** DHCS also has significant interactions with other state departments in its administration of Medi-Cal. Several major state programs, including personal care services in the IHSS program, administered by the Department of Social

Services, and many services provided by the Department of Development Services, receive federal Medicaid funding. As the designated single state agency for purposes of federal Medicaid funding, DHCS is involved with managing the flow of federal funds for these services to other state departments.

Complexity Has Increased as Medi-Cal Program Has Grown. Since the implementation of the ACA, the size of the Medi-Cal program, both in terms of caseload and spending, has grown significantly. Relative to 2012-13, the year before eligibility for Medi-Cal benefits was significantly expanded under the ACA, the Medi-Cal caseload in 2019-20 will have increased 67 percent and total spending from all funds will have more than doubled. With this growth, complexity and uncertainty in budgeting have increased. The ACA added new complexities to the program, such as by providing enhanced federal sharing ratios for certain populations. These higher sharing ratios allowed the state to provide coverage to these populations at a lower state cost than for other populations, but tracking the appropriate sharing ratio of federal funding for different populations has led to additional workload and complexity for DHCS. The growth in the Medi-Cal program also made the Medi-Cal budget more difficult to manage as preexisting complexities are magnified over a larger amount of total spending. In the nearby box, we provide examples of how the factors described above can particularly affect certain components of the Medi-Cal program.

GOVERNOR HAS TWO PROPOSALS TO IMPROVE MANAGEMENT OF THE MEDI-CAL BUDGET

Increase DHCS Staffing to Improve Fiscal Estimates and Cash Monitoring

To address concerns about DHCS's ability to estimate Medi-Cal spending and monitor cash flow, the Governor proposes to provide 25 permanent positions and $3.8 million total funds ($1.8 million General Fund) in 2019-20 and ongoing. As proposed by the Governor, these resources would be allocated to four main purposes.

Improved Monitoring of Cash Flows. Under the Governor's proposal, four of the positions would be dedicated to improving and centralizing the department's cash flow monitoring functions. These positions would be tasked with coordinating among various units at DHCS that separately track different components of the department's cash flow.

Increased Reconciliation of Actual Spending to Previous Estimates. Next, 11 of the positions would be dedicated to reconciling actual spending and cash flows to estimates of spending developed as part of the state's budget process. These positions would also make changes to improve the departments spending estimates, such as better aligning the department's budgeting methodologies with how managed care rates are set.

Improved Processing of Payments and Collections. Another nine of the positions would provide additional support to key payment and collection processes, including managed care rate development and payment, drug rebate reconciliation, and collections of provider fees.

Additional Coordination Among DHCS Units. Finally, the proposal would establish a new Chief Financial Officer position at DHCS that would provide consolidated leadership for budgeting and accounting functions and would help coordinate among various DHCS units on fiscal issues.

Create New Special Fund to Smooth Impact of Drug Rebates on Medi-Cal Budget

The Governor additionally proposes to create a new special fund into which drug rebates would be deposited before being transferred to the General Fund. Under the Governor's proposal, in years where an unusually large amount of rebates are collected, the state would hold a portion of rebate proceeds in the special fund. In other years, when an unusually low amount of drug rebates is collected, rebates revenue held in the fund would be transferred to the General Fund. This would serve to smooth the impact of drug rebates on the Medi-Cal budget.

LAO ASSESSMENT OF GOVERNOR'S PROPOSALS

Governor's Staffing Proposal Has Merit. In our view, recent challenges with projecting Medi-Cal expenditures represent a significant concern that warrants the Legislature's attention. Based on our review of the proposal, the requested resources would meaningfully improve the department's ability to estimate Medi-Cal spending and monitor cash flow.

Increased Transparency for Legislature and Other External Stakeholders Should Also Be a Priority. At the same time, we believe that improving the ability of the Legislature and other external stakeholders to understand and track Medi-Cal spending is another high priority that should be addressed with this proposal. There are many changes related to the presentation of Medi-Cal estimates and the availability of public information about program operations that would increase the transparency of the Medi-Cal budget and allow for greater oversight by outside stakeholders. Many of these changes will take time and planning. Others may be more achievable in the near term. For example, given the significant emphasis of the proposal on monitoring cash flow and reconciling actual expenditures to estimates,

Examples of Medi-Cal Program Components Particularly Subject to Budgeting Uncertainty

Certain components of the Medi-Cal program are particularly subject to budgeting complexity, and have significantly contributed to the major adjustments to estimated Medi-Cal funding in recent years. Below, we describe three examples.

Managed Care Payments. Managed care payments introduce complexities into the Medi-Cal budget in a few key ways. First, the state pays managed care plans each month based on over a thousand individual rates, each of which corresponds to a type of Medi-Cal beneficiary in a particular county or region covered by a particular managed care plan. Each of these individual rates must be submitted for approval to the federal government, and delays in approval of these rates create uncertainty about the timing and amount of managed care payments.

Hospital QAF. The hospital Quality Assurance Fee (QAF) program, as described earlier, uses fees paid by private hospitals to draw down additional federal funding to support higher Medi-Cal rates paid to the hospitals. The hospital QAF involves significant amounts of funding—the program is currently projected to provide $8.4 billion in total additional payments to hospitals (including the fees paid by hospitals) and offset $1.1 billion in General Fund costs in Medi-Cal in 2019-20. Because most Medi-Cal beneficiaries are enrolled in managed care, the state pays a significant share of hospital QAF payments through managed care rates. Federal regulations in 2016 related to managed care in Medicaid required the state to significantly change how hospital QAF payments are made through managed care in ways that increased program complexity.

Drug Rebates. The state receives rebates from drug manufacturers that lower the net price it pays for prescription drugs. When these rebates are received, the state keeps a share of the rebate and returns a share of the rebate to the federal government, since some federal funds were used to pay for the drugs. In the past, the state has struggled to track the amount of federal rebates due to the federal government, specifically when the federal government pays for a higher share of the cost of drugs for certain populations. Recently, the state has returned insufficient shares of rebates to the federal government, leading to unexpected increases in General Fund costs in later years when the federal government requires that its full share of rebates be paid. The timing of when the state will receive drug rebates may also be difficult to predict, which contributes to the uncertainty related to the General Fund funding requirements of Medi-Cal.

some form of regular public update on spending relative to budget estimates would seem to be an appropriate and reasonable outcome of providing these additional resources.

Additional Structural Changes Should Be Considered Over Longer Term. The administration has indicated that the proposals we have described represent a first step toward better managing the Medi-Cal budget, and that additional, more structural changes will be considered in the future. In our view, more structural changes to reduce the complexity of the Medi-Cal budget and limit unanticipated changes in annual costs should be explored. Examples of such changes could include:

- Modernize information technology (IT) systems that would automate and streamline processes that are currently manual and labor intensive.
- Redesigning the department's Medi-Cal estimating methodology to better match program operations.
- Potentially reverting to an accrual budget for the Medi-Cal program. While we believe this is an alternative that should be explored, we note that switching Medi-Cal back to an accrual basis of budgeting would, on its own, be a complex endeavor, and improved budget transparency and oversight would not be guaranteed. The program has grown significantly since the switch to cash budgeting in 2003-04. The increased size of the program and other changes may mean that the state could face many of the same challenges under an accrual budget as it faces today with a cash budget. Additionally, switching back to an accrual budget would involve a significant one-time cost as large payments, deferred in previous years to achieve savings, would be accelerated to match with the year in which the services and activities they fund occur. The amount of this one-time cost was estimated at roughly $2 billion in 2016-17, and could be larger today.

Drug Rebate Special Fund Concept Has Promise. The concept of using a special fund to smooth volatility in drug rebates is a promising one, provided that information about amounts deposited and withdrawn from the special fund is transparently outlined in budget documents for external stakeholder review. The concept of using a special fund to smooth funding volatility could also have broader application in other Medi-Cal program components, and could be an additional option to future changes to improve the management of the Medi-Cal budget.

RECOMMENDATIONS

Approve Requested Positions and Creation of Drug Rebate Special Fund. To strengthen the department's ability to oversee and manage the Medi-Cal budget, we recommend that the Legislature approve the positions as requested in the Governor's proposal. We also recommend that the Legislature approve the Governor's proposal to create a special fund to smooth the impact of drug rebates on the Medi-Cal budget.

In the Short Term, Require DHCS to Share Key Information Gained From Improved Monitoring With Legislature. However, we additionally recommend that the Legislature require, in connection with approving these positions, that DHCS share key information gained from improved monitoring of the Medi-Cal budget with the Legislature. In the near term, regular updates on cash flows that would compare actual spending to estimated budget amounts, would be a reasonable first step.

Require DHCS to Report to Legislature With Plan For Longer-Term Structural and Systems Changes to Promote Sound Estimates and Budget Transparency. Even with approval of the changes proposed by the Governor, the Medi-Cal budget will likely continue to be challenging to project and subject to significant uncertainty. The DHCS has indicated that it intends to continue assessing possible long-term solutions to address these challenges. To continue moving toward solutions to these issues and to ensure appropriate legislative oversight, we recommend that the Legislature require DHCS to develop and present to the Legislature a longer-term plan with structural and systems changes that would further promote sound estimates and budget transparency in

Medi-Cal. Such a plan would look at such changes as IT system modernizations (some of which may already be in process), the implications of moving Medi-Cal back to an accrual budget, and the potential use of special funds or other reserves to smooth unanticipated swings in Medi-Cal spending that can be disruptive to the Legislature's budgetary decision-making and long-term planning.

LAO PUBLICATIONS

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

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