



## Health Access California Perspective: Proposed Medi-Cal Section 1115 Waiver

Health Access California has reviewed the draft concept paper on the Medi-Cal Section 1115 waiver offered by the California Department of Health Care Services (DHCS) on October 19, 2009. Health Access California was an active participant in the debate over the previous waiver negotiated in 2005.

Health Access California has two primary goals for the Section 1115 waiver: first, to reinvest any savings resulting from improved efficiency in health care and second, to expand coverage as a bridge to implementing national health reform in California.

Health Access proposes a number of steps designed to smooth the cost curve of implementation and maximize federal revenue, particularly in 2013 and 2014, through early implementation of federal health reform. In our discussions with the Obama Administration officials, we have learned that the Obama Administration is committed to early implementation of national health reform.

### **Medi-Cal Waiver: A Bridge to Health Reform?**

If health reform is enacted at the national level, it will be implemented during the term of the 1115 waiver, which would run from 2010 to 2015. Many of the key elements of health reform would be implemented in 2013.

Health Access California strongly supports H.R. 3962, the *Affordable Health Care for America Act*, as it passed the House of Representatives on November 7, 2009. We have reviewed the relevant elements of the draft legislative language of H.R. 3962 as well as the bills coming from the Senate Finance Committee and Senate Health, Education, Labor, and Pensions (HELP) Committee.

Savings from improved efficiency should be invested in expanding coverage: Health Access proposes that expansions of Medi-Cal coverage should be triggered in advance of 2013 as revenues become available, due to improvements in the economy, ballot measures, or other sources.

The maximum federal match is available in the first two years of implementation of national health reform, specifically 2013 and 2014. The Section 1115 waiver creates an opportunity for California to be ready to maximize federal revenue in those years.

### **Early Implementation of Federal Health Reform: Smoothing the Cost Curve, Maximizing Federal Revenue**

Early implementation of federal health reform should be designed to smooth the cost curve of expanded coverage by mitigating the impact of pent-up demand by previously uninsured populations. Health Access proposes a series of steps to address pent-up demand of previously uninsured groups in 2010-2012 in order to help smooth the cost curve in 2013-2015.

### Key Elements of Proposed Health Reform for the 1115 Waiver

While national health reform has not yet been enacted, key elements of the major proposals are known. Among those key elements that are relevant to the Medi-Cal program and the Section 1115 waiver:

#### ***Medicaid Changes***

- Medicaid expansion to 133% FPL (Senate)/150% FPL (House), including childless adults: 1.6 million (Senate) to 1.8 million (House) Californians newly eligible
- Enhanced federal match for newly eligible populations: Childless adults and parents above 100% FPL
  - Enhanced FMAP highest in 2013, but declining over time:
    - Senate: 87.3% in 2013 to 82.7% in 2019 (Finance)
    - House: 100% FMAP in 2013 and 2014, 91%FMAP (House) as of 2015
  - At net cost of \$229 million (House) to \$856 million (Senate).
- Medicaid enrollment improvements (both House and Senate):
  - Elimination of asset test except for long term care
  - Auto-enrollment encouraged/required
- Prescription drug rebates increased from 15.6% to 23.1%, savings estimated at \$300 million annually.
- Five-year pilot program for medical homes (House)
- Maintenance of effort requirement for eligibility until 2013 (both House and Senate)
- Other Medicaid changes and improvements

#### ***Exchange with Affordability Credits***

- Affordability Credits: Eligible to individuals 133%-400% FPL without affordable employer coverage eligible, and based on sliding scale for both premium and cost sharing. House more generous than Senate.
- Definition of “affordable” employer coverage: as a percent of income for premium, nature of benefit package: House more consumer friendly than Senate.
- State operation of exchange: permitted

#### ***CHIP (Healthy Families)***

- Maintenance of effort until 2013
- House: eliminates CHIP effective 2014, children enrolled into Exchange 1/1/14.
- Senate Finance: maintains CHIP but does not lift cap on funding

California must be ready to take advantage of the enhanced federal match (up to as much as 100%) on Day One of health reform, January 1, 2013. Take-up of Healthy Families was slowed in the late 1990s due to unnecessary barriers to enrollment. California should not repeat those mistakes – we will pay a high price in lost federal revenues because California will get a higher federal match in the beginning years 2013-14 (100% in the House version, 87% in the Senate Finance proposal) than in the later years (91% in the House, 82.3% in Senate Finance).

***Health Access proposes the following changes as a bridge to national health reform:*****① *Expand Medi-Cal Coverage to Targeted Populations***

Health Access proposes that in 2010-2012 California expand Medicaid coverage to targeted populations as revenue is available, either from savings realized through the waiver, from an improving economy, from ballot measures or from other sources.

Specific populations that could be targeted include:

- Low-income unemployed, using the UI/DI system as a gateway for enrollment;
- Medi-Cal eligible young adults aging out of coverage, including foster youth;
- Parents who are otherwise Medi-Cal eligible but whose children have aged out of Medi-Cal coverage; and
- As revenue becomes available, childless adults starting with those with the lowest incomes first.

**② *Establish Auto-Enrollment for Infants in 2010***

Health Access proposes that any infant born to a parent that is uninsured or on Medi-Cal should be deemed eligible and automatically enrolled in Medi-Cal at birth. Any infant that is born to a parent covered by the Access for Infants and Mothers (AIM) program should be automatically enrolled in Healthy Families at birth. H.R. 3962 provides auto-enrollment of uninsured infants into Medicaid. Given that any infant born in this country meets citizenship requirements as a result of the United States Constitution, automatic enrollment will assure health coverage during the critical first months of life. This approach is administratively efficient because it obviates the need for verification of citizenship under the Deficit Reduction Act of 2005 (DRA). It would also eliminate the county-by-county variation in enrollment of infants. The waiver should provide for auto-enrollment of infants upon approval of the waiver. While technically some infants are currently eligible for Medi-Cal, unnecessary barriers impede enrollment of infants in Medi-Cal or Healthy Families: the burden should be on the government, not the parent, to make enrollment happen. That's what auto-enrollment is.

**③ *Coverage Initiative Successors as a Gateway for Enrollment of Childless Adults***

Health Access proposes that the Coverage Initiatives currently in place in ten counties be revised and extended to serve as a gateway to enrollment of childless adults into Medicaid when it is expanded to cover childless adults in 2013. Today, 100,000 Californians are enrolled in the Coverage Initiatives: the Coverage Initiatives are a good means of smoothing the cost curve by addressing pent-up demand in advance of expanding Medi-Cal to childless adults. Indeed, those who have signed up for the co Coverage Initiatives are disproportionately those with significant health care needs.

Enrollment in the Coverage Initiatives needs to be further increased both to smooth the cost curve of pent-up demand and to create a gateway to fast enrollment in Medi-Cal coverage for childless adults in 2013.

The Coverage Initiatives are designed to serve childless adults: Health Access is committed to working with DHCS, the counties, and the public hospitals to create successors to the Coverage Initiatives that transition to full Medi-Cal coverage for childless adults in 2013.

Health Access suggests that since the counties will be providing the non-federal match through Certified Public Expenditures, the county hospital and health system should be the anchor of the provider network under the successor to the Coverage Initiatives. This approach has already been demonstrated by Healthy San Francisco.

We note that while not all counties participate in the Coverage Initiatives, more than 80% of Californians reside in counties that do. Health Access is also interested in exploring how the 34 County Medical Services Program (CMSP) counties and other counties without Coverage Initiatives can be ready on Day One for the childless adult expansion.

#### ④ *Prescription Drug Discount Program as a Gateway for Childless Adults in 2010*

In 2006, Governor Schwarzenegger signed into law a prescription drug discount program to provide access to prescription drug discounts for the uninsured. The prescription drug discount program can serve as a gateway for enrollment of childless adults into Medi-Cal (and the Exchange) in 2013 by identifying uninsured adults in 2010-2012.

Health Access California was the sponsor of the measure that created the prescription drug discount program and has supported its implementation. We suggest that California take a small share of the savings to the General Fund resulting from the improved Medicaid drug rebate (which increases from 15.6% to 23.1%) to fund the one-time, initial implementation cost of \$5 million. As best we can determine, the increased Medicaid drug rebate is effective immediately so this can be implemented in 2010-11.

The prescription drug discount program should also be modified in 2012 to serve as a gateway to enrollment in either Medicaid or the Exchange for those eligible for it. Persons who take advantage of the drug discount should be auto-enrolled into either Medi-Cal or the Exchange, depending on income.

#### ⑤ *“Frequent Flyers” Program in 2010*

A series of demonstration projects have indicated that a small number of individuals use the emergency room with much greater frequency than other uninsured individuals. The cost of these “frequent flyers” affects not only Medi-Cal but also other human services, including mental health and substance abuse services. Early implementation of a frequent flyers program would mitigate pent-up demand for care while relieving the strain on emergency rooms in advance of coverage expansions.

#### ⑥ *Simplify Eligibility Determinations in 2011: Initial Income Test, Self-Certification of Income*

Health Access California supports the proposal of Western Center on Law and Poverty and others to create a simplified initial income test that would not expand or reduce current eligibility thresholds but that would allow simplified eligibility determinations for the vast majority of those eligible for Medi-Cal.

Health Access California also supports self-certification of income. Preliminary data for pilots on self-certification done in Orange and Santa Clara Counties indicated that the pilots worked well. We suggest both should be implemented in 2011 as part of the waiver and in preparation for health reform.

⑦ ***Eliminate Asset Test for Most Medicaid-Eligible in 2011***

Both H.R. 3962 and the Senate proposals eliminate the asset test for those Medicaid beneficiaries who are not long-term care eligible. Health Access California supports the proposal of Western Center on Law and Poverty and others to eliminate the asset test effective in 2011.

⑧ ***Eliminate the Churning of Coverage by Creating Default to Re-Enrollment in 2012***

To quote Western Center, *et al.*,

“Churning” is the process whereby *eligible* beneficiaries are terminated from Medi-Cal due to confusion or paperwork requirements, only to re-enroll shortly thereafter, often with worsened health conditions and a need for more invasive, more expensive, and more amounts of health care.

A 2005 report by the California HealthCare Foundation found that approximately 20% of children in Medi-Cal churn. Given that the barriers to enrollment and re-enrollment are less for children than for adults, we would expect that churning of adults would be higher than for children. Re-enrollment of children costs \$2,000 per child. Costs for adults may be higher because of the additional barriers to enrollment.

The very high number of Medi-Cal beneficiaries using the emergency room (30% in a PPIC analysis of OSHPD data) suggests that adults who are otherwise eligible either churn off coverage or never enroll because of barriers to enrollment. (PPIC, however, failed to take the next step in the analysis by determining the portion of the Medi-Cal beneficiaries that were made eligible retrospectively as opposed to those who were covered by Medi-Cal when they came into the emergency room.)

In a health reform construct that relies upon an individual mandate to assure continuous coverage, churning increases both administrative costs and health services costs while undermining individual compliance with the mandate. To minimize churning in Med-Cal, Health Access proposes that in 2011-12, Medi-Cal convert to a system of defaulting to re-enrollment rather defaulting to disenrollment as in the current system.

## Existing Medi-Cal Managed Care Is Problematic at Best

Health Access California is deeply troubled by the existing Medi-Cal managed care program. When Medi-Cal managed care was created in the early 1990s, the stated goal was to create a medical home for the parents and children covered by mandatory managed care. The implementation of Medi-Cal managed care ravaged California's safety net of public hospitals, contributing to the closure of numerous county hospitals and the near-closure of the Los Angeles County hospital system.

Health Access has several questions for the DHCS about the existing Medi-Cal managed care program:

- Can DHCS document that most Medi-Cal beneficiaries enrolled in Medi-Cal managed care have a usual source of care that is not a hospital emergency room? The trend on HEDIS measures suggests that only about half of pregnant women and infants receive appropriate care—and only a third of adolescents. Can the Department determine the impact of churning due to disenrollment and re-enrollment on usual source of care?
- Are all contracting Medi-Cal managed care plans currently identifying children at risk for chronic conditions such as asthma and diabetes and providing chronic care management for such conditions that is culturally competent? What about asthma, diabetes, hypertension and other chronic conditions prevalent among low-income parents?
- Can the Department demonstrate that existing managed care plans have adequate networks, including specialists? Reliance on Knox-Keene standards alone is not sufficient given that Medicaid, Medi-Cal and Medi-Cal managed care contracts impose requirements on providers that are in addition to those required under Knox-Keene. Anecdotal evidence as well as HEDIS data suggests that Medi-Cal managed care provider networks are not sufficient. The Department states that “existing managed care plans provide a coordinated system of care for many Medicaid beneficiaries”. Can the Department demonstrate that beneficiaries have timely access to an adequate network of providers?
- Can Medi-Cal managed care plans document that beneficiaries have access to care in the language that the individual or the parent speaks? This has been a contract requirement since the initiation of Medi-Cal managed care yet we continue to hear complaints from consumers and providers about the lack of language access.

Mandatory Medi-Cal managed care for children and parents is a mature program, implemented more than fifteen years ago. It should be possible to answer these questions before expanding the program further.

## Basic Consumer Protections for Californians

### A Sufficient Rate Methodology to Assure Adequate Reimbursement

The DHCS concept paper does not mention development of a rate methodology for the proposed organized delivery system. This is especially troubling given the vulnerable population of low-income seniors and persons with disabilities: adequate reimbursement of providers is essential to assuring adequate and timely access to care.

A one-time actuarial analysis, such as the Mercer analysis conducted in 2007, is not a rate methodology. That analysis is now very dated, relying on data from 05-06 at best. Trending forward using medical Consumer Price Index or other general price indices is not sufficient to provide adequate funding for care, particularly for seniors and persons with disabilities with greater health care needs.

Medi-Cal is an under-funded program with inadequate reimbursement for providers. One of the reasons that mandatory Medi-Cal managed care for seniors and persons with disabilities has not been implemented in California is that every review of the concept has come to the same conclusion: in order to provide an adequate array of services, spending would *increase*, not decrease.

Bending the cost curve downward is a laudable goal but it should be accomplished by improving coordination of care, not creating a mandate to deny and delay care for fragile populations in order to achieve cost savings.

### **Putting Consumer Protections in Statute**

One of the most troubling aspects of the existing Medi-Cal managed care program is that few consumer protections are incorporated in the statute. While some consumer protections are incorporated in the existing regulations, most of the requirements are incorporated in the contracts between the managed care plans and the Department: in that instance, the consumer has a choice of relying on the HMO or the Department which is attempting to find cost savings.

Further, the existing Medicaid regulations have never been updated to reflect the many changes in regulation of managed care between 1995 and 1999. In some instances, the provisions of Medi-Cal managed care are not as consumer friendly as the protections provided to those with individual or employer-based coverage regulated under the Knox-Keene Act.

Health Access has offered detailed comments on proposed legislation in prior years designed to assure that consumer protections are codified in statute. (See attachment.)

### **Safety Net for Remaining Uninsured**

Health Access appreciates the acknowledgement of the central role of public hospitals in serving both Medi-Cal recipients and the uninsured.

The UCLA Center for Health Policy Research estimates that under national health reform, 93% of Californians will be eligible for coverage. However, this estimate assumes that all of those who are eligible will enroll and remain enrolled in coverage. In a multi-payer system, a more realistic assessment should take into account that some of those who are eligible will not enroll even in the context of an individual mandate.

California will continue to have a disproportionate number of uninsured, both because of immigration and because of the disproportionate presence of other persons likely to be uninsured in any system, such as those who are homeless or who have a dual diagnosis.

### **Other Key Concerns About the Medi-Cal Waiver**

## Medical Homes and the Inclusion of Community Clinics and County Hospital Systems

Health Access remains open to exploring the concept of medical homes as the locus of care for seniors and persons with disabilities in Medi-Cal. However, we were extremely troubled by the discussion at the initial stakeholder meeting on November 2, 2009, in which Medicaid Director Toby Douglas said that if a medical home was not an HMO, that the medical home would contract with an ASO, which we understand to be an Administrative Services Organization or something like that. ASOs are not regulated or licensed by the State of California. They are not subject to the many consumer protections, including financial solvency, required under the Knox-Keene Act. Reliance on such unregulated entities would put the care of consumers at greater risk, not lesser risk. If a medical home is simply an unregulated HMO, this approach puts seniors and persons with disabilities at considerable risk.

California has a long, sorry history of entities accepting financial risk without adequate reserves while putting care at risk by denying and delaying care or simply failing to provide care at all. The Knox-Keene Act was created because some early health plans literally sent the capitation payments to the Bahamas without contracting with doctors or hospitals. In the mid-1990s, the delegated medical model involved medical groups each responsible for the care of tens of thousands of Californians but not sufficiently financially prudent to have audited financials, a rather modest standard, much less adequate reserves. They were also guilty of every bit of bad behavior in terms of denying and delaying care that any HMO or health insurer has ever been accused of.

Some stakeholders have proposed that all entities that operate medical homes be required to be at risk. Health Access opposes this. It excludes community clinics, county clinics, and county hospital systems from operating as medical homes even though these entities are now the primary source of care for seniors and persons with disabilities who rely on Medi-Cal.

The insistence of the Medi-Cal program on relying on entities willing to accept risk has biased the program toward large, for-profit vendors, such as McKesson rather than community clinics and county health systems. This has precluded the expansion of pilot projects on disease management and care coordination that were originally funded by foundations and that should have been or should be the basis for disease management programs.

## Reducing Racial and Ethnic Disparities

Health Access is disappointed that the DHCS concept paper does not take advantage of the opportunity presented to reduce racial and ethnic disparities in the provision of care. It is well documented that the Medi-Cal population is disproportionately made up of persons of color. Assuring that care is culturally competent and linguistically accessible should be a basic tenet of the waiver proposal. Yet we find not one mention of these objectives. Perhaps this should not be surprising given that Medi-Cal managed care is unable to document that it meets the longstanding contractual obligation to provide care in the language spoken by the patient.

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Health Access California is a statewide coalition of consumer, labor, ethnic, senior, faith, and other organizations that has been dedicated to achieving quality, affordable health care for all Californians for over 20 years. Please visit our website and read our daily blog at [www.health-access.org](http://www.health-access.org).

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