HEALTH ACCESS
CALIFORNIA

May 8, 2015

Andy Slavitt, Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: California's Section 1115 Medicaid Waiver Request: Medi-Cal 2020

Dear Administrator Slavitt:

On behalf of Health Access California, the statewide health care consumer advocacy coalition, we write in strong support of the state's "Medi-Cal 2020 Waiver" renewal request (submitted March 27, 2015), and we urge you to work with the state toward timely approval of a waiver renewal.

We believe a new waiver is essential for California to solidify the significant progress it has made implementing the Affordable Care Act (ACA); to take important and needed steps forward in ensuring safety-net care for the remaining uninsured; to transform the Medi-Cal program to improve outcomes, quality, and equity; and to coordinate and integrate health care with a range of other human services for improved overall health.

Health Access served on the 1115 Waiver stakeholder advisory committee for the prior waiver and on three of five different Medi-Cal waiver renewal stakeholder workgroups and was active in participating in other stakeholder processes as well. We very much appreciate the state's responsiveness to feedback from community and consumer advocates and key stakeholders who serve the Medi-Cal population, from safety-net providers to the counties which provide an array of health, behavioral health and human services to low-income Californians.

California's Commitment to the Success of the Affordable Care Act

A new Medicaid waiver is essential to continue California's efforts to implement and improve upon the ACA. California, through two governors, has remained committed to the success of the ACA. California's commitment to the Affordable Care Act has been a key driver for the success of the ACA nationally.

Today more than 4 million Californians have coverage through the new options of the ACA, and more than 60% of previously uninsured adults were covered as early as July 2014. Much of our success with enrollment, retention, and other reform initiatives to date is tied directly to provisions in the Bridge to Reform waiver—specifically to the role of the counties in maximizing enrollment and reinvesting any savings from delivery system reforms into care and, in some counties, coverage for the remaining uninsured.

Using county dollars to match federal dollars, the counties, enrolled more than 600,000 Californians in the Low Income Health Programs—and from there most of these Californians were seamlessly transitioned to full-scope Medi-Cal at the stroke of midnight on January 31, 2014.

With the backing of health and community groups, providers, insurers, and policymakers from around the state, Governor Brown made the commitment to expand Medi-Cal to the maximum extent possible, despite serious concerns about ongoing budget liabilities to the state arising from the uncertainties surrounding the Affordable Care Act. Governor Brown stood by that commitment despite the dire budget situation in which California found itself when he became Governor in 2010.

And despite coming out of a tough budget, California has since made key investments to fulfill and further the intent of the Affordable Care Act by streamlining and simplifying enrollment and renewal for those previously eligible; maximizing the expansion of Medi-Cal; and augmenting Medi-Cal mental health services while partially restoring dental benefits cut during the recession. As noted above, the counties' role in funding the non-federal share of the Medicaid program is the cornerstone of the state's success to date with Medi-Cal reform and the ACA. Medi-Cal 2020 embraces the federal-state-*county* partnership that is at the heart of the state's Medicaid transformation.

When the Bridge to Reform waiver was granted, California had over six million uninsured, literally more than Massachusetts had people. Thanks to our commitment to the ACA, the number of uninsured has been cut in half. Our level of uninsurance is now where the proportion of uninsurance was in Massachusetts before they began their reform efforts under then Governor Romney. A robust waiver renewal is critical, because it is not realistic to expect that in a single five year period California would make it all the way from a health system characterized by high levels of uninsurance and a strained Medicaid system to a fully reformed and transformed health care system. California needs more time, and more help, to achieve these critical waiver goals.

California Seeks to Share Savings from a Fully Realized Transition to Managed Care from a Fee-For-Service Baseline

We support the state's request for California to share in the savings generated by our efficiencies in the Medi-Cal program. California's Medicaid program continues to provide care to nearly 12 million Americans at a low per-person per month rate compared to other Medicaid programs.

We support the state's request to use a fee-for-service baseline. Among the transformative elements of the Bridge to Reform waiver was a major shift from fee-for-service to managed care. For more than 20 years, low-income parents and children in urban counties have been enrolled in Medi-Cal managed care, but populations with more complex and expensive needs remained for the most part in fee-for-service. Over the course of the last waiver, the following populations have transitioned or begun to transition to Medi-Cal managed care:

- Seniors and persons with disabilities

- Many dual eligibles covered by both Medicare and Medi-Cal
- The CHIP population, previously enrolled in Healthy Families
- Rural populations.
- Childless adults newly eligible under the Affordable Care Act.

In 2014, 9.7 million Californians were enrolled in Medi-Cal managed care, more than the entire population of New Jersey. In 2010, fewer than half that number were enrolled in Medi-Cal managed care, mostly healthy kids and parents, rather than the more complicated and expensive populations of seniors and persons with disabilities. Even childless adults who tend to be in their late 40s and 50s, as opposed to the young parents enrolled in Medi-Cal managed care previously, are a more complex and expensive population than young parents and essentially healthy children. (Children with special needs were carved out of Medi-Cal managed care).

We note that the previous waiver was based on a fee-for-service baseline. Given the very recent, and in some instances not yet completed, transitions of the more medically fragile populations to Medi-Cal managed care, a fee-for-service baseline is justified.

The Need for a Smarter Safety-Net for the Remaining Uninsured

We strongly support the Medi-Cal 2020 proposal for a Public Safety Net Global Payment for the Remaining Uninsured.

Even after full implementation of the ACA and maximizing the ACA coverage expansions, California and its health care safety net will be left with an estimated three million remaining uninsured. The public safety net system provides a disproportionate share of the care to the uninsured and to the Medi-Cal population. We therefore strongly support the proposal to combine Disproportionate Share Hospital funding with continued Safety Net Care Pool funding as this will allow California's county hospital and health care systems to provide primary and preventive care as well as necessary hospital care for the remaining uninsured. Based on California's experience with the Low Income Health Programs, it takes several years before emergency room use declines as patients become established in medical homes and begin to control any chronic conditions.

Health Access has worked county-by-county on their safety-net policies, and such a county funding construct would incentivize counties to re-orient their medically indigent programs to the remaining uninsured, but also to offer a smarter safety-net that emphasizes primary and preventive care, a medical home, and assistance at the right place and right time—preempting visits to the emergency room. Several counties are already moving in this direction—such a construct would help solidify this shift and provide the right incentive structures to motivate others counties to move in the same direction.

To help strengthen these areas of the waiver renewal, we propose the following for consideration in the final negotiations on Medi-Cal 2020:

- **The points system in Public Safety Net Global Payment structures should risk adjust for socio-economic status.** The points system should be flexible enough to reward plans and providers for progress relative to patients' starting point.
- **Tie Pay for Performance (P4P) incentives more directly to equity benchmarks**, from data collection, better patient outcomes, to engagement in population health initiatives. P4P structures should be tied to equity-related goals, including disparities data collection and meaningful use of that data.
- **Payment incentives** should be anchored in a medical home approach to care. Here payment incentives might need to reward for efforts possibly through the use a point system (or offer a menu of possible initiatives, depending on local interests or capacities).

Improved Incentives in Medi-Cal Including Health Equity

We support the state's proposed incentives to shift Medi-Cal to a more resolute focus on outcomes, cost effectiveness, quality, and equity. With Medi-Cal now responsible for the care of 12 million Californians, Medi-Cal can drive improvements not just with its substantial patient base but system-wide, improving the system for the state as a whole.

The state's waiver renewal is appropriately structured around the people with the most to gain from the proposed Medi-Cal transformation: the eminently diverse populations that are enrolled in the program. Right now people of color comprise 75-80% of Medi-Cal beneficiaries. This and related facts provide the justification to articulate waiver goals and without apologies in terms of a "quadruple aim," with health equity as a fourth goal woven through the next waiver's triple aim initiatives. Again, other states will benefit if one state (at least) is using the Medicaid 1115 waiver as a jumping off point to systematically address disparities and improve population health.

Access to Care in the Medi-Cal Program

The waiver renewal's proposed payment incentives discussed above are more urgent given the context of a Medi-Cal program that has historically low rates, for both fee-for-service and Medi-Cal managed care. We have made progress in this area, and Medi-Cal 2020 can help advance further improvements—not just more money for providers, but payments tied to outcomes.

For more than twenty years, Health Access has listened to the California Medi-Cal program tout the virtues of Medi-Cal managed care because of the protections of California law, in particular the Knox-Keene Act. In response to concerns from advocates, providers and individual consumers have complained about lack of access in Medi-Cal managed care, the Brown Administration is beginning to address these issue, but much more is needed to be done.

Specifically, Governor Brown signed SB964 into law in 2014, which requires annual monitoring of network adequacy and timely access for Medi-Cal managed care networks and requires that such monitoring be done separately for Medi-Cal managed care from commercial networks. California law sets standards for network adequacy in terms of geographic proximity for primary care providers and hospitals as well as time-elapsed standards for primary care, specialty care, and other types of care. The Brown Administration has also begun to do geo-access mapping of providers to patients, allowing a more granular view of access by discrete geographies on an annual basis. Included in this monitoring is language access.

SB964 requires separate monitoring of Medi-Cal managed care network so that a major carrier, such as Anthem Blue Cross or HealthNet, which has both commercial lives and Medi-Cal managed care lives, cannot hide any inadequacy of the Medi-Cal managed care networks behind a more fulsome network for commercial lives. In implementing this law, the Brown Administration has recognized that timeliness of access and adequacy of networks require scrutiny of providers who accept patients with a variety of coverage sources but may treat those patients differently depending on their coverage: for example, a provider may happily accept additional commercial lives but limit their Medi-Cal managed care lives to 10% of their total patient load. As a result of SB964, the California Department of Managed Health Care has gone from monitoring fewer than five hundred networks to monitoring almost 5,000 networks—separately,

We credit Governor Brown and his administration for their efforts to make real the promise of Medi-Cal managed care, but certainly there is more to do to assure access to care for those in Medi-Cal. Further efforts are underway to improve the accuracy of provider directories and assure that the information in provider directories matches network adequacy reporting and does so separately for Medi-Cal managed care networks.

As consumer advocates, we are deeply concerned about lack of timely and appropriate access for the Medi-Cal population. We recognize concerted efforts at the national level to re-orient the health care system to greater use of primary care, as evidenced by the primary care rate bump for Medicaid included in the Affordable Care Act. We specifically see specific issues with access to specialty care, and we are advocating to assure that those enrolled in Medi-Cal have timely access to cardiologists, neurologists, gastroenterologists, orthopedic care, oncologists and other specialists, including pediatric specialists. We hope a waiver can help advance these goals.

Integration and Coordination with Human Services

We support the several proposals in the Medi-Cal 2020 concept paper to facilitate and encourage health care services be better integrated and coordinated with a broader set of human services, from behavioral care to housing supports. We offer additional comments on these goals:

- Whole Person Care
  We are particularly excited about the Whole Person Care elements of the proposal. While it makes sense to start with pilots, we believe these pilots should target the most

vulnerable, highest risk groups, and others most likely to benefit. We have also asked that governance around Whole Person Care Pilots include consumer groups representing patient target populations (or patients/families for some). Closely related to governance is the need for transparency and "community dashboarding" on the achievement of whole person pilots over time.

- Care across silos
  Medi-Cal 2020 is about reaching across silos to housing, corrections, county mental health. Again, one of the reasons why we are so focused on adequate funding for the safety net is because the counties may be in the best position to model this practice for other entities in the state and for the waiver overall.

- Medical Home
  An effective medical home stretches outside the clinical settings of care to the community supports needed to help patients benefit from care or improve their overall health. Again, the counties have taken this concept further than any other entity in the state—with efficiencies and hard savings to show for those efforts.

You can find additional context for our interest in a robust waiver renewal in our paper "Medi-Cal Reform 2.0: Health Access Priorities for California's Next Medicaid Waiver." http://health-access.org/images/pdfs/Medi-CalWaiverIssueBrief_DiscussionDraft1-12-15FinalPublish.pdf.

Thank you for your efforts on behalf of Medicaid beneficiaries. Just as we have enjoyed working with state officials on the concepts for Medi-Cal 2020, we are happy to discuss these issues and be of help in any way to you and other CMS officials as the renewal process moves to the negotiation stage. Thanks for your consideration.

Sincerely,

Anthony Wright
Executive Director

cc:
Secretary Diana Dooley, Health and Human Services Agency
Mari Cantwell, Medicaid Director, Department of Health Care Services
Senate President Pro Tempore Kevin De Leon
Assembly Speaker Toni Atkins