

Executive Summary

May 2005

GOVERNOR'S PLAN TO RESTRUCTURE MEDI-CAL IS FINANCIALLY RISKY AND COULD UNDERMINE ACCESS TO AFFORDABLE HEALTH COVERAGE

Governor Schwarzenegger has proposed a multi-pronged plan to restructure the Medi-Cal Program, which provides health coverage to 6.6 million Californians with low incomes and limited resources. The Administration plans to seek waivers, including two Section 1115 waivers, from the federal government to implement key components of the plan. The restructuring plan could have a range of impacts, including threatening California's financial ability to provide Medi-Cal services by capping federal funding for certain Medi-Cal services and beneficiaries. This report analyzes five components of the plan, including proposals to impose premiums, restructure the safety-net hospital financing system, and shift more Medi-Cal beneficiaries into managed care.

KEY FINDINGS

This report finds that:

- **Section 1115 waivers would cap federal funding for certain Medi-Cal services and beneficiaries.** The Administration would have to obtain a Section 1115 waiver to impose premiums on more than 500,000 Medi-Cal beneficiaries and is planning to proceed under Section 1115 to restructure the state's safety-net hospital financing system. In both cases, the federal government would provide no more than a fixed *amount* of funds for the beneficiaries or services subject to the waiver – regardless of California's actual expenditures – rather than paying a fixed *percentage* of Medi-Cal costs. Currently, the federal government pays half the costs of Medi-Cal expenditures, whether such costs are higher or lower than projected.
- **Section 1115 funding caps would shift more of the financial risk for Medi-Cal from the federal government to California.** Section 1115 funding caps would restrict California's ability to meet its residents' needs in the event of an unanticipated occurrence such as an epidemic, a natural disaster, or the availability of a new drug or technology. If one or more of these events occurred, federal funds would not automatically increase to cover the costly hospital services or the needs of beneficiaries subject to the caps. Consequently, California would have to pay all the costs that exceed the caps or reduce costs by scaling back benefits,

increasing beneficiaries' out-of-pocket costs, and/or reducing reimbursement rates paid to Medi-Cal providers.

- **The Governor's proposal to impose premiums on more than 500,000 Medi-Cal beneficiaries could reduce enrollment of eligible persons in Medi-Cal and increase other state costs.** More than 90,000 children and adults without disabilities, elderly individuals, and people with disabilities could lose Medi-Cal coverage under this proposal. While the state may realize short-term savings due to lower Medi-Cal enrollment, costs would likely be shifted to other parts of California's health care system to the extent that individuals who leave Medi-Cal seek alternative sources of care, such as in clinics or emergency rooms.
- **The Governor's proposed restructuring of the current safety-net hospital financing system could have a significant impact on hospitals' ability to serve the state's Medi-Cal and uninsured populations.** The federal government has raised several concerns with the state's hospital financing proposal. The outcome of the negotiations with the federal government will be critical to California's safety-net hospitals and to the state's health care system.
- **The Governor's proposal to cap adult dental benefits at \$1,000 per year could prevent some beneficiaries from obtaining appropriate and timely dental care and increase Medi-Cal costs per beneficiary.** The state may realize short-term General Fund savings due to lower dental benefit costs. However, capping dental benefits could increase other Medi-Cal health care expenditures. For example, untreated dental needs could lead to other health problems that would require more costly Medi-Cal services.
- **The Governor's proposal to shift more than 800,000 Medi-Cal beneficiaries, including children and people with disabilities, to Medi-Cal managed care plans poses significant implementation issues to ensure that beneficiaries, particularly seniors and people with disabilities, maintain access to services.**
- **The Governor's proposal to allow a centralized contractor to process certain Medi-Cal applications for children would not result in faster enrollment and could add new administrative requirements that would increase costs.**
- **California can improve the Medi-Cal Program without negatively affecting beneficiaries.** For example, California could simplify Medi-Cal eligibility rules to reduce the paperwork burden on Medi-Cal beneficiaries and counties.

Budget Brief

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BACKGROUND

In January 2005, Governor Schwarzenegger released a proposal to restructure the Medi-Cal Program, which provides health coverage to 6.6 million Californians who have low incomes and meet other eligibility criteria. The Governor proposes to restructure the program "in order to advance the twin imperatives of maintaining health care coverage to eligible Californians, while containing costs and maximizing operational efficiencies."¹

Key Components of the Governor's Restructuring Plan

This report examines key components of the Governor's Medi-Cal restructuring plan, including proposals to:

- Impose monthly premiums on more than 500,000 children and adults without disabilities, seniors, and people with disabilities;
- Restructure the state's safety-net hospital financing system;³
- Establish an annual cap of \$1,000 for dental services for adults, except for services required by the federal government;
- Expand the use of managed care for children, families, elderly individuals, and people with disabilities; and
- Process certain Medi-Cal applications for children through a centralized contractor, rather than through county welfare offices.

The Governor's Proposals Could Have a Range of Impacts

In assessing the Governor's proposal, the state should weigh the potential impacts of each component on the state's overall health care delivery and financing system. For example, the waiver required to implement premiums could shift more of the financial risk for Medi-Cal from the federal government to California, since the waiver would cap the amount of federal funds that California receives for Medi-Cal beneficiaries subject to the waiver. Currently, the federal government pays half the cost of Medi-Cal expenditures, whether such costs are higher or lower than projected.

What Is Medi-Cal?

Medi-Cal is California's version of Medicaid, a federal-state program that provides health coverage to individuals and families who have low incomes. Medi-Cal provides health care services to children, parents, elderly and blind persons, and people with disabilities who receive public assistance or meet income and other eligibility criteria. Federal law requires states to provide coverage to certain groups, including children and pregnant women who meet income guidelines and Supplemental Security Income recipients. California's Medi-Cal Program also covers some families and individuals with incomes that exceed minimum federal guidelines. State Medicaid programs must provide a core set of benefits, such as doctor visits, hospital care, nursing home care, and laboratory services. California offers more than 30 additional benefits, including prescription drugs and dental services for adults. The federal government matches state spending for these so-called "optional" benefits. Medi-Cal will provide health coverage to nearly one out of five Californians – an estimated 6.6 million individuals – in 2004-05. Medi-Cal will cost an estimated \$34.1 billion (\$12.9 billion in General Fund dollars) in 2005-06. However, California's costs per beneficiary are the lowest in the nation. Medi-Cal spending, including state and federal funds, averaged \$2,068 per beneficiary in federal fiscal year 2000, compared to the national Medicaid average of \$3,762. California ranked 51st out of 51 Medicaid programs in spending per beneficiary.²

Moreover, the various components of the proposal could have multiple impacts on certain Medi-Cal beneficiaries. For example, elderly individuals and people with disabilities could face limits on dental benefits, new premiums, and a change in their relationship with health care providers due to the expansion of managed care. The combined impact of these changes could have negative consequences for vulnerable individuals.

Restructuring Proposal Would Result in a Loss of Federal Funds

California would lose one dollar in federal funds for every dollar cut from Medi-Cal for federally eligible expenditures. The managed care expansion, annual limit on dental services for adults, and new premium requirements could result in the loss of \$129.8 million in federal funds in 2008-09. This would double the impact of the proposed General Fund reduction on local economies and the state's health care system.

SEVERAL COMPONENTS OF THE GOVERNOR'S MEDI-CAL RESTRUCTURING PROPOSAL WOULD REQUIRE FEDERAL WAIVERS

Several components of the Medi-Cal restructuring proposal cannot be accomplished without waiving federal Medicaid rules.⁴ Changes requiring a waiver include imposing premiums, expanding managed care, and restructuring the state's safety-net hospital financing system, each of which is discussed in detail later in the report.

Administration Will Seek Waiver Authority Under Section 1915(b) and Section 1115 of the Social Security Act

Documents released by the Administration in March 2005 indicate that it will seek waiver authority under Section 1915(b) of the Social Security Act to expand managed care, but will seek broader waiver authority under Section 1115 of the Social Security Act to restructure the safety-net hospital financing system.⁵ Imposing premiums would require a waiver under Section 1115.

The Administration has provided different timetables for each component of the restructuring proposal that requires a waiver of federal rules. This suggests that the Administration will seek three separate waivers. Understanding the scope of and statutory authority for these waivers is critical to analyzing the potential impacts of the Governor's Medi-Cal restructuring proposals.⁶

Section 1915(b) Waivers

Section 1915(b) waivers are narrow in scope. In general, these waivers allow states to require Medicaid beneficiaries to enroll in managed care or, in the case of California's current selective contracting waiver, require beneficiaries to use specific providers.⁷ However, these waivers do not allow states to restrict eligibility or services in any other way, and states cannot use Section 1915(b) waivers to provide services to individuals who are not eligible for coverage under existing Medicaid rules.

The Balanced Budget Act of 1997 allows states to require some Medicaid beneficiaries to enroll in managed care plans without obtaining a federal waiver. However, a waiver is required for mandatory enrollment of most children with special health care needs, children in foster care and adoption assistance programs, and beneficiaries who are dually eligible for Medicaid and Medicare. California would have to obtain a Section 1915(b) waiver to implement the managed care expansion, since the Governor's proposal would require at least some children with special needs, as well as some seniors and people with disabilities who are eligible for Medicare, to enroll in managed care.

Section 1115 Waivers

Section 1115 of the Social Security Act allows the Secretary of the US Department of Health and Human Services (HHS) to waive federal rules so that states may receive federal Medicaid funds for expenditures that are not otherwise permitted under federal law. For example, states may cover populations or offer services that are not allowable under the Medicaid statute, such as expanding coverage to single adults without children, under a Section 1115 waiver. While the HHS Secretary generally has broad authority in granting Section 1115 waivers, some federal requirements may not be waived.⁸ Section 1115 waivers generally apply for five years and may be renewed.

A SECTION 1115 WAIVER WOULD CHANGE THE WAY FEDERAL FUNDS ARE PROVIDED FOR CERTAIN MEDI-CAL SERVICES AND BENEFICIARIES

Under the standard Medicaid Program, the federal government guarantees that it will pay a percentage of a state's Medicaid costs, regardless of whether those costs are higher or lower than projected. The Federal Medical Assistance Percentage (FMAP) for California's Medi-Cal Program is currently 50 percent, meaning the federal government pays half the costs of Medi-Cal.¹²

However, federal Medicaid funding for certain Medi-Cal services and beneficiaries would be capped under a Section 1115 waiver:

- A Section 1115 waiver to restructure the state's safety-net hospital financing system would require California to accept a cap on federal funds available for inpatient hospital services; and

- A Section 1115 waiver to impose premiums on certain Medi-Cal beneficiaries would require California to accept a cap on federal funds for the beneficiaries subject to the premiums.

In both cases, the federal government would provide no more than a fixed *amount* of funds for the beneficiaries or services subject to the waiver – regardless of California’s actual expenditures – rather than paying a fixed *percentage* of Medi-Cal costs.

Section 1115 Medicaid Waivers: A Four-Step Process

The Section 1115 federal Medicaid waiver process generally includes four steps:⁹

- A state submits a waiver concept paper to the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid, for informal feedback. During this period, the state is required to initiate a process that guarantees public input into the waiver design.¹⁰ The Administration convened a series of public workshops in the spring of 2004 to review and gather feedback on its Medi-Cal restructuring proposal.¹¹ Despite the delay in submitting the waiver, the Administration may rely on the public workshops as the required public process for the waiver.
- The state submits a formal waiver application to CMS for review and approval. State and federal officials negotiate the terms and conditions of the waiver, including any modifications to the waiver application required by the federal government. These negotiations include determining how the state will guarantee “budget neutrality” – that is, assuring that federal spending on the state’s Medicaid program under a waiver will not exceed what it would otherwise have been in the absence of the waiver (this issue is discussed in more detail below). The CMS is not required to make a decision on the waiver within a particular period.
- Upon formal approval, the federal government works with the state to ensure the state’s readiness to implement the waiver.
- The state implements the changes allowed by the waiver. Both the federal and state governments are required to evaluate and report on the impact of the waiver, as well as the public policy value of the waiver demonstration project.

The Section 1115 “Budget Neutrality” Requirement

The Office of Management and Budget (OMB) and the Centers for Medicare and Medicaid Services (CMS) require states seeking a Section 1115 waiver to show that the proposed changes would be “budget neutral” for the federal government.¹³ In other words, over the customary five-year waiver period, federal Medicaid expenditures for the beneficiaries or services subject to the waiver may not exceed what the federal government would have spent absent the waiver.¹⁴ In contrast, to obtain a Section 1915(b) waiver to expand managed care, the state will only have to show that the rates it would pay to managed care organizations are actuarially sound.¹⁵

Budget Neutrality and the Governor’s Safety-Net Hospital Financing Proposal

The Schwarzenegger Administration has proposed an “aggregate cap” on federal funding for hospital services as part of the Section 1115 waiver to restructure the state’s safety-net hospital financing system. The cap would increase by a predetermined amount each year based on the annual Medicaid growth rate specified in the President’s budget. However, this cap would not

be automatically adjusted for higher-than-anticipated enrollment in Medi-Cal or for higher-than-anticipated use of hospital services.¹⁶

Budget Neutrality and the Governor's Premium Proposal

In order to obtain a Section 1115 waiver to impose premiums on certain Medi-Cal beneficiaries, the state would have to agree to receive a fixed amount of federal funds for each Medi-Cal enrollee included in the waiver. This "per capita cap" on federal funding would automatically adjust for higher-than-expected increases in Medi-Cal enrollment, and the per capita allotment would increase by a predetermined sum each year to allow for increases in medical costs.¹⁷ However, a per capita cap could discourage California from covering certain individuals, such as elderly individuals or people with disabilities, who have high health care costs and may need the most assistance.¹⁸

THE SECTION 1115 BUDGET NEUTRALITY REQUIREMENT POSES FINANCIAL RISKS FOR CALIFORNIA

Combining an aggregate limit on federal funds for safety-net hospital expenditures with a per capita limit on federal funds for expenditures for beneficiaries subject to premiums would pose serious risks for California, because a large portion of Medi-Cal expenditures would be subject to caps on federal Medicaid funds. This would leave the state at risk if costs exceed the negotiated caps.

Caps Would Increase Funding Pressures on California If Medi-Cal Costs Are Higher Than Anticipated

Budget neutrality caps would restrict California's ability to meet its residents' needs in the event of an unanticipated occurrence such as an epidemic, a natural disaster, or the availability of a new drug or technology – or simply because health care costs rise more quickly than expected. If one or more of these events occurred, federal funds would not automatically increase to cover the hospital services or the needs of the Medi-Cal beneficiaries subject to the caps. Consequently, California would have to pay all of the costs that exceed the caps or reduce costs by scaling back benefits, increasing enrollees' out-of-pocket costs, and/or reducing reimbursement rates paid to Medi-Cal providers.¹⁹ The Administration proposes to include "thresholds" for "unanticipated changes" in Medi-Cal caseload or service usage that would trigger negotiations to modify the budget neutrality cap in the hospital financing waiver. However, there is no guarantee that such "thresholds" would be included or that sufficient additional federal funds would be provided.

A Section 1115 waiver to impose premiums on certain Medi-Cal beneficiaries would presumably generate state and federal savings. However, a per capita cap on federal funding presents risks to California, because per capita Medi-Cal costs for beneficiaries subject to premiums could exceed the cap during the waiver period. For example, the development of expensive drugs or other technological breakthroughs could drive up Medi-Cal costs to unanticipated levels. In addition, to the extent that premiums cause healthier individuals to leave Medi-Cal, per person costs would increase and possibly exceed the per capita federal funding cap.²⁰ These risks would be compounded by the aggregate limit on federal funding for safety-net hospital expenditures that would be required under a Section 1115 waiver.

California Would Be Penalized for Its Low Per Enrollee Spending on Medi-Cal

The per capita cap associated with imposing premiums on Medi-Cal beneficiaries and the aggregate cap associated with restructuring the state's safety-net hospital financing system would penalize California for its historically low Medi-Cal expenditures. Specifically, budget neutrality caps are calculated based on a state's historical Medicaid spending. States that spend more per enrollee on their Medicaid programs would likely have a higher cap than states that spend comparatively less. In 2002, California's Medicaid spending per beneficiary was the lowest in the nation. The state has subsequently reduced Medi-Cal expenditures due to the current budget crisis.²¹

California's extremely low per beneficiary spending levels would serve as the basis of budget neutrality caps and would cause the caps to be set lower than if the state had spent more on Medi-Cal in recent years. It would be difficult for California to increase reimbursement rates for providers or make other improvements without breaching the caps.²² In fact, low provider reimbursement rates have limited physicians' participation in Medi-Cal, which has, in turn, restricted Medi-Cal beneficiaries' access to physician care. If unanticipated events cause Medi-Cal spending to exceed the caps, there would be little or no room to make changes to address the shortfall other than cutting benefits, eligibility, or provider reimbursement rates.

IMPOSING PREMIUMS COULD REDUCE MEDI-CAL ENROLLMENT AND INCREASE OTHER STATE HEALTH EXPENDITURES

One component of the restructuring proposal would require more than 500,000 beneficiaries to pay premiums to remain enrolled in Medi-Cal. This proposal, as noted above, would require a Section 1115 waiver. However, many poor families and individuals lack the discretionary income needed to pay for a larger share of their health care costs. Consequently, this proposal could reduce Medi-Cal enrollment. Individuals who leave Medi-Cal could then have difficulty in obtaining appropriate and timely health care.

While the state may realize short-term savings due to lower Medi-Cal enrollment, imposing premiums on hundreds of thousands of Medi-Cal beneficiaries could increase health spending in other areas. For example, costs would likely be shifted to other parts of California's health care system to the extent that individuals who leave Medi-Cal seek alternative sources of care, such as in clinics or emergency rooms.

Current Federal and State Premium Requirements

Federal law allows states to require certain Medicaid beneficiaries to pay for a portion of the cost of their health care through premiums. Premiums are amounts paid at regular intervals, such as monthly, to maintain health coverage. While most Medicaid beneficiaries are exempt from premiums, states may require some individuals, including people with disabilities who are employed, to pay premiums.²³ Currently, premiums are not widely used in the Medi-Cal Program. The state assesses premiums on a small number of adults with disabilities, ranging from \$20 to \$250 per month for individuals to \$30 to \$375 per month for a couple.²⁴

The Governor Proposes to Impose New Premiums

The Governor proposes to impose new Medi-Cal premiums on children and adults without disabilities with incomes above the federal poverty level (FPL) and on seniors and people with disabilities with incomes above the Supplemental Security Income/State Supplementary Payment (SSI/SSP) level.²⁵ Exceptions would include American Indians, Alaskan Natives, individuals who pay a share of cost for their health care, infants under age 1, and certain working families enrolled in CalWORKs.²⁶ Premium payments would be \$4 per month for each child or adult under age 21 and \$10 per month for other adults, with a monthly cap of \$27 per month per family.²⁷ The state would terminate Medi-Cal coverage if a beneficiary does not pay the required premium for two consecutive months.

These premiums would affect 460,000 children and adults without disabilities and 90,000 seniors and people with disabilities. The Administration estimates that the state would collect \$42.7 million in new premium payments under the proposal. In addition, the Administration estimates the state would save \$4.9 million in 2006-07, increasing to \$22.1 million in 2008-09. Savings would result from premiums collected and from beneficiaries losing coverage due to missed premium payments.

More Than 90,000 Children and Adults Without Disabilities, Elderly Individuals, and People with Disabilities Could Lose Coverage Under the Governor's Proposal

Nearly 92,000 low-income children and adults without disabilities and nearly 3,000 low-income seniors and people with disabilities could lose coverage under the Governor's proposal.²⁸ The Administration argues that, "Premium requirements exist throughout private health insurance and public programs that serve low-income populations, such as Healthy Families..."²⁹ However, research and data show that:

- **Low-income families have difficulty paying premiums.** While premiums are common among families with private health insurance, imposing premiums on low-income individuals can have serious consequences. Research on the impact of premiums finds that participation of low-income individuals in health care programs "falls off sharply as the premium amount increases."³⁰

People with low incomes already bear out-of-pocket medical costs that consume a significant portion of their incomes. Nationally, for example, low-income families spent 7 percent of their income on health care in 2000.³¹ A recent survey of low-income families in three US cities found that many families, even those who are insured, "have large unpaid medical bills mostly from one-time and unexpected medical problems." Moreover, Medicaid beneficiaries tend to be in poorer health than are individuals with employer-sponsored health insurance. More than half of non-elderly adult Medicaid beneficiaries live with at least one chronic condition, compared to less than one-third of persons with employer-sponsored coverage.³²

- **Many children enrolled in Healthy Families lose coverage due to failure to pay the premium.** The Healthy Families Program charges premiums for children with family incomes above 100 percent and up to 250 percent of the FPL. Families pay monthly premiums of \$4 to \$9 per child, up to a maximum of \$27 per family.³³ Many children, however, lose Healthy Families coverage due to missed premium payments.³⁴ For example,

while there were over 673,000 children enrolled in Healthy Families in May 2004, between June 2003 and May 2004 the state terminated coverage for about 74,000 children for failure to pay their premium.³⁵

Loss of Medi-Cal Coverage Would Lead to an Increase in the Number of Uninsured Californians

Nationally, Medicaid programs play a major role in helping states reduce the number of uninsured and respond to losses of private health insurance due to rising premiums, unemployment during economic downturns, and other factors. The loss of Medi-Cal coverage by nearly 100,000 low-income Californians would mean they would have to seek alternative sources of care and many would likely become uninsured.³⁶

Uninsured individuals are less likely to receive needed health care, resulting in poorer health outcomes. For example, studies document the importance of health coverage to children's well-being and life outcomes.³⁷ Children with health coverage are more likely to have better health outcomes than those without. Better health status can improve educational outcomes, thereby resulting in higher wages and improved economic well-being later in life. Health coverage helps ensure that children have a regular source of care and that they receive cost-effective, preventive services, such as immunizations, that lead to better health outcomes. Uninsured children, on the other hand, are more likely to use emergency rooms as a regular source of care and are more likely to have unmet needs for prescription drugs, dental care, and medical care.

The Governor's Proposal Could Result in Higher Per Beneficiary Medi-Cal Costs

Imposing premiums could result in healthier individuals leaving Medi-Cal. Individuals who remain in Medi-Cal could be less healthy, resulting in higher costs per beneficiary. For example, researchers found that premiums in Florida's health insurance program for children led healthier beneficiaries to drop coverage. This resulted in higher average program costs, since those who remained in the program were less healthy.³⁸

Higher Costs Would Likely Be Shifted to Other Parts of the State's Health Care System

Even if premiums generate short-term state savings in the Medi-Cal Program, other parts of California's health care system, including community clinics and public hospitals, would likely incur higher costs as low-income persons who leave Medi-Cal seek alternative sources of care. Uninsured individuals, for example, tend to lack a regular source of health care and often seek care in hospital emergency rooms.³⁹ A national survey found that visits to physicians' offices by uninsured persons declined by about 37 percent between 1996-97 and 2000-01, while hospital emergency room visits by uninsured persons increased by about 10 percent during the same period. Further, in 2000-01, uninsured persons relied on emergency rooms for 25.2 percent of their ambulatory care visits, as compared to 7.6 percent for individuals with private insurance. In Oregon, the number of emergency room visits by uninsured persons at a Portland hospital increased by 17 percent during the three months following the implementation of Oregon's Section 1115 waiver, as compared to the prior year.⁴⁰

The Governor's Proposal Would Increase Program Complexity and Administrative Costs

In California, counties determine initial and ongoing eligibility for Medi-Cal. Imposing premiums on hundreds of thousands of Medi-Cal enrollees could increase program complexity and administrative costs related to:

- **Determining who is required to pay premiums.** Counties would have to make additional calculations to determine whether individuals are required to pay Medi-Cal premiums. Moreover, the Administration proposes to require counties to use a different methodology to calculate certain families' income levels to determine premium payments than is used to establish program eligibility.
- **Tracking premium payments.** Counties would have to establish systems to determine whether individuals had paid their premiums to remain eligible for the program.
- **Re-enrolling individuals who have lost coverage.** County administrative costs would increase to the extent that individuals re-enroll in Medi-Cal after losing coverage due to missing two consecutive premium payments. However, the Medi-Cal application process is complex and could discourage some individuals from re-applying.⁴¹

THE GOVERNOR SEEKS FEDERAL APPROVAL TO RESTRUCTURE SAFETY-NET HOSPITAL FINANCING

A federal waiver governing certain aspects of safety-net hospital financing in California will expire on June 30, 2005. Rather than seek to renew the current waiver, the Administration proposes, as discussed above, to restructure safety-net hospital financing through a Section 1115 waiver that would cover the major federal funding sources for safety-net hospitals. The Administration has been negotiating a new hospital financing agreement with the federal government since 2004.

The Administration suggests that federal funding for California's safety-net hospitals is at risk of significant reduction absent a new hospital financing agreement. The federal government has taken steps to restrict states' use of "intergovernmental transfers" (IGTs) to obtain federal funding (see below).⁴² Since California uses IGTs to obtain federal funding for safety-net hospitals, federal changes could reduce the amount of federal funds the state receives through this mechanism.

The federal government has raised several concerns with the state's safety-net hospital financing proposal. The outcome of the negotiations with the federal government will be critical to California's safety-net hospitals and to the state's health care system.

Major Components of the Governor's Hospital Financing Proposal

Components of the Administration's safety-net hospital financing proposal include:

- **Reducing IGTs as a mechanism used to obtain federal Disproportionate Share Hospital (DSH) and supplemental funds.** Public entities such as counties and the University of

Safety-Net Hospital Financing in California

Public and private safety-net hospitals in California rely on several federal funding streams. These hospitals receive federal Medicaid matching funds for services provided to Medi-Cal patients.⁴³ The state also operates several programs that provide additional federal funds to help safety-net hospitals cover their costs. Eligible safety-net hospitals receive nearly \$2 billion in federal funds through three key hospital funding programs:

- **Disproportionate Share Hospital (DSH) Program.** The DSH Program provides funding for hospitals that serve many Medicaid and uninsured patients. The state distributes DSH funds to hospitals based on a formula. The federal government limits DSH payments to states and has significantly reduced DSH payments to California hospitals in recent years.⁴⁴
- **Emergency Services and Supplemental Payments Program.** This program, also called the SB 1255 Program, provides supplemental funds to certain hospitals that contract with the state to serve Medi-Cal patients.
- **Graduate Medical Education Program.** This program provides supplemental funds to cover the teaching costs of certain hospitals that serve eligible Medicaid recipients. These hospitals include university teaching hospitals, non-university teaching hospitals, and children's hospitals.

California (UC) provide funds that the state uses to obtain federal DSH and supplemental funds. Federal law authorizes the use of IGTs. However, the federal government has adopted policies outside the regulatory or statutory process to restrict the use of IGTs.⁴⁵

- **Using “certified public expenditures” (CPEs) to provide the match for federal funds.** Under the Administration’s proposal, county and UC safety-net hospitals would “certify” expenditure of public funds used to provide services to Medi-Cal and uninsured patients. These CPEs would be used to access federal Medicaid matching funds.⁴⁶ The state’s proposal would allow hospitals to use CPEs for indigent patient health care costs as a match for federal funds.⁴⁷
- **Shifting costs for public hospitals from the state to counties.** CPEs for selected public safety-net hospitals would replace state General Fund support for these hospitals. Thus, affected public entities, including counties, would assume full responsibility for providing the funding to obtain federal funds for their hospitals. In turn, state funds no longer provided to the affected public safety-net hospitals would be shifted to private safety-net hospitals.
- **Establishing a “safety net care pool.”** The state proposes to deposit certain federal funds into a safety net care pool, which could include the state’s federal DSH funds. These federal “pool” funds would primarily be accessed through CPEs. The Administration proposes to allow eligible entities, including non-hospital health care providers, to use the pool funds to cover health care services provided to Medi-Cal beneficiaries and uninsured individuals in safety-net hospitals and through public programs.
- **Breaking the link between federal funding and fee-for-service patients.** Public hospitals currently receive certain federal payments based on the number of fee-for-service Medi-Cal patients for whom they provide care. However, another component of the Governor’s

Medi-Cal restructuring proposal would shift certain beneficiaries from fee-for-service Medi-Cal to managed care. This would likely reduce the number of fee-for-service patients served by safety-net hospitals as well as corresponding federal funds. Therefore, the Governor proposes to break the link between federal funding and fee-for-service patients through the structure of the proposed Section 1115 waiver.

Outcome of Federal Negotiations Could Have a Significant Impact on California's Health Care System

The federal government has raised a number of concerns with the state's hospital financing proposal. Failure to obtain federal approval of any single component of the state's proposal could undermine the entire proposal, since it involves a complex array of provisions. In addition, the federal government's efforts to reduce overall Medicaid spending suggest that obtaining increases in federal funding for safety-net hospitals may be difficult.⁴⁸ The outcome of the hospital financing negotiations could have a significant impact on hospitals' ability to serve the state's Medi-Cal and uninsured populations. For example, funding reductions would impair hospitals' ability to operate emergency rooms and trauma centers, potentially affecting all Californians who rely on safety-net hospitals.

The negotiations involve a number of technical and policy issues that may affect the structure, level, and distribution of federal funds for safety-net hospitals. For example, decisions on how to calculate expenditures under the proposed CPE approach for purposes of meeting federal auditing requirements will determine federally allowable expenditures. In turn, this will affect whether hospitals have access to federal funds at a level that is at least as high as the current level.

In assessing the hospital financing proposal, the state should consider:

- **The total level of federal funding for California under the new waiver.** Failure to obtain federal approval on key components of the state's proposal could significantly affect the level of funding under a new waiver:
 - Federal funds for public hospitals could decrease if many Medi-Cal beneficiaries are shifted from fee-for-service Medi-Cal to managed care, as the Governor proposes.
 - Prohibiting the use of spending on indigent health care as a match for federal funds would reduce the level of funding for California under the proposed CPE approach.
- **The distribution of funds for affected hospitals.** Even if the federal government approves a new waiver, the state will likely have to change the distribution of funds to hospitals. It is not clear how the proposed CPE approach would affect the distribution of funds among affected hospitals. In addition, the Administration has not provided details on how the state would distribute funds from the proposed safety net care pool, which could be accessed by non-hospital providers under the Administration's proposal.
- **Counties' ability to assume costs for public hospitals.** Counties have been squeezed by pressures on their budgets.⁴⁹ It is unclear whether counties would be able to provide sufficient funds under the proposed CPE approach to maximize available federal funding.

THE GOVERNOR PROPOSES TO CAP ADULT DENTAL BENEFITS

Another component of the Medi-Cal restructuring proposal would cap adult dental benefits at \$1,000 in a 12-month period. However, many low-income adults lack the discretionary income to pay for needed dental care above the \$1,000 limit. Consequently, this proposal could prevent some beneficiaries from obtaining appropriate and timely dental care. In addition, while the state may realize short-term savings due to lower dental benefit costs, capping dental benefits could increase other Medi-Cal health expenditures. For example, untreated dental needs could lead to other health problems that would require more costly Medi-Cal services.

Current Medi-Cal Dental Benefits

Under Medicaid law, states must provide comprehensive dental benefits to child beneficiaries. However, state coverage of adult dental benefits under Medicaid is optional. California provides comprehensive dental benefits to about three million adult Medi-Cal beneficiaries. Dental benefits include:

- Diagnostic and preventive dental hygiene;
- Emergency services;
- Tooth extractions;
- Root canal treatments; and
- Prosthetic appliances (i.e., dentures).

The Governor's Proposal Would Cap Adult Dental Benefits for 94,900 Adults

The \$1,000 cap would not apply to emergency services, and hospital costs associated with dental treatment, and federally mandated services provided by physicians. The Administration has not provided a list of specific dental services that would be excluded from the proposed limit. The Administration estimates that capping dental benefits would reduce benefits for about 94,900 adults, including 52,900 adults who are elderly, blind, or have disabilities, for state savings of \$26.3 million in 2008-09.⁵⁰

The Governor's Proposal Would Undermine the Dental Health of Low-Income Adults

The Administration argues that, "The \$1,000 annual adult dental benefit will make Medi-Cal more consistent with private coverage while at the same time covering the majority of the dental needs of beneficiaries...."⁵¹ However, studies find that:⁵²

- **Low-income adults have poorer dental health than higher-income adults.** Low-income adults have more untreated dental needs and suffer from greater tooth loss because of decay or gum disease than higher-income adults.
- **Adults with disabilities may require special accommodations to obtain dental care.** For example, some adults with disabilities may require intravenous sedation or general anesthesia, which increases the cost of dental exams and treatment.

In addition, higher-income adults who have private coverage may be better able to afford

out-of-pocket expenses for dental care. As noted above, people with low incomes bear out-of-pocket medical costs that consume a significant portion of their already low incomes.

The Governor's Proposal Could Increase Medi-Cal Costs Per Beneficiary

Capping adult dental benefits could result in higher Medi-Cal costs per beneficiary if untreated dental needs affect the general health of Medi-Cal beneficiaries. Oral tissues may signal the presence of other diseases in the body. Dental examinations can detect these diseases earlier and result in more timely treatment. Left untreated, oral diseases can spread to other tissues in the body, thereby affecting an individual's general health.⁵³ Untreated dental needs could lead to other negative health conditions that would require more costly Medi-Cal services.

THE GOVERNOR PROPOSES TO EXPAND THE USE OF MANAGED CARE

The Governor proposes to increase the number of Medi-Cal beneficiaries enrolled in managed care plans. The Administration, as noted above, would seek federal waiver authority under Section 1915(b) of the Social Security Act to implement this proposal. Approximately 816,000 additional families, children, elderly individuals, and people with disabilities would enroll in a Medi-Cal managed care plan, rather than in fee-for-service Medi-Cal, under the Governor's proposal. The state should carefully consider several implementation issues to ensure that Medi-Cal beneficiaries who are shifted to managed care plans maintain access to services if this proposal is adopted.

About Half of Medi-Cal Beneficiaries Are Enrolled in Managed Care

Currently, 3.2 million of the state's 6.6 million Medi-Cal beneficiaries, primarily families and children, are enrolled in managed care.⁵⁴ Under current law, most families and children must enroll in managed care in the 22 counties in which managed care is available. Seniors and people with disabilities are required to enroll in managed care in some, but not all, counties where managed care is available. Seniors and people with disabilities currently comprise only 10 percent of beneficiaries enrolled in managed care. Under the Governor's proposal, the number of individuals enrolled in managed care who are elderly or have disabilities would almost double.

California uses three managed care delivery models in Medi-Cal:

- **The Two-Plan Model.** The county contracts with one locally developed health plan, known as the "local initiative," and one competitively selected commercial health plan. In these counties, families and children must enroll in managed care. Elderly individuals or people with disabilities may enroll in fee-for-service Medi-Cal or a managed care plan. The Two-Plan model is available in 12 counties.⁵⁵
- **The County Organized Health Systems (COHS) Model.** The county appoints a governing board to operate an organization that acts as a health insurer, known as the COHS. In these counties, all Medi-Cal beneficiaries must enroll in managed care and there is no fee-for-service option. Five COHS plans operate in eight counties.⁵⁶
- **The Geographic Managed Care (GMC) Model.** The county contracts with multiple health plans. Unlike the Two-Plan model, plans are not competitively selected. Rather, any plan

that meets state requirements may negotiate a contract to enroll Medi-Cal beneficiaries. In these counties, families and children must enroll in managed care. Elderly individuals and people with disabilities may enroll in fee-for-service Medi-Cal or a managed care plan. Two counties use the GMC model.⁵⁷

The Governor's Proposal Would Increase the Number of Medi-Cal Beneficiaries in Managed Care

Under the Governor's proposal, approximately 816,000 additional Medi-Cal beneficiaries would enroll in managed care, including:⁵⁸

- **Approximately 262,000 children and families.** The Administration proposes to expand the COHS and GMC models to additional counties. In these counties, the state would enroll new Medi-Cal beneficiaries in managed care and gradually transition current beneficiaries from fee-for-service Medi-Cal to managed care.⁵⁹
- **Approximately 554,000 elderly individuals and people with disabilities.** Elderly individuals and people with disabilities would be required to enroll in managed care in the 14 counties where managed care is currently an option and in additional counties to which the Administration proposes to expand managed care. The state would enroll new Medi-Cal beneficiaries in managed care and gradually transition current beneficiaries from fee-for-service Medi-Cal to managed care in these counties.⁶⁰

The Administration estimates that the proposal would result in state savings of \$85.5 million (\$169.9 million total savings) in 2008-09. This estimate assumes that savings will equal 5 percent of fee-for-service costs.

The State Should Carefully Consider Implementation Details

The Administration suggests that, "Managed care, implemented in a careful, deliberate manner, can increase access to services, improve patient outcomes, increase accountability for health care dollars, and be more cost effective than an unmanaged fee-for-service program."⁶¹ The state should ensure that, if this proposal is adopted, the increased use of managed care does not diminish beneficiaries' access to Medi-Cal services. This includes access for elderly individuals and people with disabilities, who tend to have multiple and chronic conditions and use the most health care services.

In 2003, the California HealthCare Foundation released a number of studies assessing the status of people with disabilities in Medi-Cal managed care.⁶² The studies found that:

- **Adequate rates for health plans are critical.** People with disabilities use more costly services, such as prescription drugs, and need additional services, such as case management and transportation. The state should set rates that reflect the actual cost of providing health services to this population. Inadequate rates could discourage health plans from participating or reduce beneficiaries' access to health care.⁶³
- **There is significant variation in the experiences, scope, and practice of serving people with disabilities among health plans and managed care models.** The COHS plans, which have more experience in serving people with disabilities, can offer lessons for the delivery of services to this population.

- **There are limited data on service delivery to people with disabilities.** There is a lack of information regarding the needs and experiences of people with disabilities in managed care. The state would need to track data and outcomes for purposes of monitoring quality.
- **Health plans acknowledge challenges in serving this population.** Challenges include identifying members with disabilities, coordinating with other health programs that serve the same population, ensuring appropriate and adequate equipment for special needs, overcoming communication barriers, and ensuring an appropriate and adequate provider network.
- **Many health plans are committed to serving this population and there are identifiable promising practices.** There may be promising practices in areas such as case management and care coordination, consumer advisory representation, and member outreach and education that could help in designing service delivery systems.

THE GOVERNOR PROPOSES TO CHANGE THE MEDI-CAL APPLICATION PROCESS FOR CHILDREN

The Governor proposes to process certain Medi-Cal applications for children through a centralized contractor, rather than through county welfare offices. The Administration suggests the proposal would speed enrollment of children in Medi-Cal and result in other efficiencies.

Improving the enrollment process for Medi-Cal could increase the number of families who apply for their children. In 2003, about 207,000 uninsured children were eligible for, but not enrolled in, Medi-Cal. However, it is unclear how the proposal would improve the current enrollment process for children without further details on design and implementation. Moreover, the state’s experience with the current Single Point-of-Entry (SPE) contractor, MAXIMUS, suggests that failure to address key performance issues could adversely affect children’s access to services.⁶⁴

How Do Children Enroll in Medi-Cal?

Families may apply for Medi-Cal for their children through:⁶⁵

- **A joint Medi-Cal and Healthy Families mail-in application.** Families may apply for Medi-Cal or Healthy Families for their children by completing a joint Medi-Cal/Healthy Families mail-in application and sending it to the state’s SPE contractor, which screens for eligibility for both programs. If the applicant appears eligible for Healthy Families, the SPE contractor processes the application. If the applicant appears to be eligible for Medi-Cal, the SPE contractor forwards the application to the appropriate county for processing.

Children who apply through this process may receive Medi-Cal immediately if the child appears to be eligible for Medi-Cal based on the SPE screen. This “accelerated enrollment” of children allows the child to receive Medi-Cal while the county makes a final determination regarding eligibility.

- **A Medi-Cal application.** Families may also apply for Medi-Cal by mailing a Medi-Cal application to, or completing an application in person at, a county welfare office.

The Governor's Proposal Would Allow the SPE Contractor to Process Medi-Cal Applications for Children

Under the Governor's proposal, the SPE contractor, rather than county welfare offices, would process Medi-Cal applications received for children.⁶⁶ The contractor's new responsibilities would include completing income and immigration status verifications and forwarding a recommendation regarding an applicant's eligibility to the Department of Health Services for review and certification. Once the application is certified, the contractor would forward the application to the appropriate county for management of the case.⁶⁷

The Administration estimates the proposal would affect approximately 120,000 applications for children submitted annually through the SPE and result in state savings of \$7.1 million in 2008-09.

Would the Governor's Proposal Result in Efficiencies or Faster Enrollment of Children?

The Administration suggests that this proposal would improve the current enrollment process by speeding enrollment of children into Medi-Cal and creating efficiencies. However:

- **There is no evidence indicating that the SPE contractor could process the applications more efficiently.** The contractor would replace some of the activities currently performed by counties. However, the proposal could add new administrative requirements that would increase costs:
 - The state would have to certify the contractor's recommendation regarding a child's eligibility in order to meet federal requirements for processing applications, since federal law requires public employees to process Medi-Cal applications. This would create an additional layer of administrative review. Currently, counties assess eligibility without state review.
 - Counties use automated systems for processing applications. Significant additional costs could occur if the state and/or contractor must develop a new automated system to process applications.
 - There would be administrative costs for transferring case information from the contractor to the counties for ongoing case management. Currently, counties collect and retain case information, such as family income.
 - The state would have to monitor the contractor's performance and manage the contract.
- **Children already receive Medi-Cal immediately under the "accelerated enrollment" process.** Currently, children who appear to be eligible for Medi-Cal do not have to wait for the county to finalize the eligibility processing to receive coverage. Therefore, eligible children would begin to receive Medi-Cal immediately, whether the SPE contractor or the county processes the application.⁶⁸

Current SPE Contractor Had Problems Meeting State Performance Standards

The state currently measures SPE contractor performance in several areas, including:

- Quality of customer service provided through the Healthy Families and SPE toll-free numbers;
- Determining completeness of Healthy Families applications;
- Timely processing of program reviews and appeals; and
- Forwarding Medi-Cal applications to counties in a timely manner.

During early operations, MAXIMUS did not meet most of the state's performance standards. This resulted in complaints from advocates regarding access to services. For example, the contractor was required to process 99 percent of Healthy Families Program reviews and appeals within 15 business days of an applicant's request. In March 2004, the contractor had only met the requirement in 18 percent of cases. Subsequently, the contractor improved its performance and in September 2004 had met all state performance standards.

The state currently requires counties to meet performance standards for processing Medi-Cal applications. If adopted, the Governor's proposal would need to include adequate training for the private contractor's staff and monitoring of contractor performance standards.

CALIFORNIA CAN IMPROVE MEDI-CAL WITHOUT NEGATIVELY AFFECTING BENEFICIARIES

During the public workshops convened in 2004, Administration officials argued that restructuring Medi-Cal is necessary to improve the program and shore up federal financing. However, the Governor's proposals could undermine Medi-Cal beneficiaries' access to care, reduce enrollment of eligible individuals, shift costs to other parts of the state's health care system, and threaten the state's financial ability to provide Medi-Cal services by capping federal funds for certain services and beneficiaries.

In contrast, California could improve Medi-Cal by implementing cost-saving strategies, seeking additional federal Medicaid funding, and simplifying eligibility rules. These measures could be achieved by pursuing routine Medicaid state plan amendments, changing state law, seeking limited federal Medicaid waivers, and/or urging enactment of federal legislation.

Implement Cost-Saving Strategies

California could pursue several strategies that would produce cost-savings or increase federal funding for Medi-Cal. For example, the state could:

- **More effectively enforce Medi-Cal drug rebate and fraud and abuse laws.** Drug manufacturers must pay rebates to states and the federal government for drugs provided to Medicaid beneficiaries.⁶⁹ California could do a better job of collecting these rebates. California has failed to collect at least \$337 million and possibly as much as \$1.34 billion in rebates owed to the state by drug manufacturers, according to the federal HHS Office of Inspector General.⁷⁰

In addition, there is increasing evidence that manufacturers are violating drug rebate rules. For example, drug manufacturers have not been accurately reporting the "best price" at which they sell their drugs. Manufacturers also have been artificially inflating drug prices that are used to calculate Medicaid pharmacy reimbursement rates.⁷¹ California should

aggressively enforce the law and obtain financial settlements from drug manufacturers that could be reinvested in the Medi-Cal Program.⁷²

- **Continue to implement other pharmacy cost-containment measures.** Like other states, California has implemented significant Medi-Cal pharmacy reforms.⁷³ Nonetheless, there is evidence that state Medicaid programs are overpaying pharmacies for prescription drugs dispensed to Medicaid beneficiaries.⁷⁴ States base their pharmacy reimbursement rates on drug prices reported by manufacturers to commercial pricing services. However, such prices may be much higher than the prices pharmacies pay to wholesalers or manufacturers for drugs covered by Medicaid.⁷⁵

To rein in costs, some states require drug manufacturers to report accurate prices. In Texas, for example, drug manufacturers must submit accurate pricing information to the state's Medicaid program in order for their drugs to be covered by Medicaid.⁷⁶ California could use accurate pricing data to more effectively enforce drug rebate requirements and monitor fraud (discussed above), as well as to set a more cost-effective Medi-Cal pharmacy reimbursement rate.

Moreover, federal law allows states to set reimbursement limits for certain drugs that have at least two generic competitors. While California has adopted such limits for some drugs, it could expand that list to ensure that it does not overpay pharmacies for generic drugs dispensed to Medi-Cal beneficiaries.⁷⁷

- **Make greater use of disease management programs.** Disease management provides coordinated specialty services to patients with chronic illnesses or conditions to ensure cost-effective, high-quality care. It is not yet clear whether disease management will produce substantial cost savings. However, both the private sector and public programs, such as Medicare and Medicaid, have begun experimenting with this approach.⁷⁸ States may claim federal Medicaid matching funds for health care and administrative services provided through disease management programs.⁷⁹ In 2003, California allocated funds to develop such programs.⁸⁰ The state could institute Medi-Cal disease management programs through a routine state Medicaid plan amendment.⁸¹

Maximize Federal Funding

California could also promote policy changes at the federal level to increase the amount of federal funding the state receives for Medi-Cal. The state could:

- **Urge the federal government to increase drug manufacturer rebates.** California could encourage Congress to increase the rebate amounts that manufacturers must pay to states.⁸² Congress could also further expand the scope of the rebate. For example, manufacturers must pay additional rebates if prices for brand name drugs covered by Medicaid increase faster than the rate of inflation. The scope of the additional rebate could be extended to generic drugs.
- **Seek federal Medicaid funding for immigrants who have legally resided in the US for less than five years.** In 1996, Congress barred states from providing Medicaid coverage to immigrants who have legally resided in the country for less than five years. California uses state-only funds to cover this group through Medi-Cal. California could encourage the

federal government to reverse its policy and allow federal Medicaid matching funds to be used for legal immigrants who meet all Medicaid eligibility requirements, but who have not resided in the US for at least five years.⁸³

Simplify Eligibility Rules

California could reduce Medi-Cal spending by eliminating duplicative functions and reducing burdensome paperwork requirements. For example, the state could:

- **Simplify Medi-Cal income and assets rules.** States have broad flexibility to determine how to count income and assets in assessing Medicaid eligibility.⁸⁴ States may disregard various types of income as well as eliminate consideration of assets.⁸⁵ For example, California could eliminate the Medi-Cal assets test for parents, as it has done for children. California could also standardize income and assets rules across various means-tested programs, such as Medi-Cal and Food Stamps, in order to simplify program administration and eliminate duplicative functions. However, such changes must be carefully designed to ensure that they do not exclude currently eligible individuals.
- **Allow beneficiaries to self-report their income and assets.** States also have broad flexibility regarding how they verify income and assets.⁸⁶ California could allow Medi-Cal applicants and beneficiaries to certify that their income and assets meet state and federal guidelines, thereby relieving counties of a significant administrative burden.⁸⁷ Alternatively, counties could use data from other programs, such as Food Stamps, to verify Medi-Cal eligibility without requiring applicants and beneficiaries to submit additional paperwork.
- **Eliminate burdensome reporting requirements and provide “continuous eligibility.”** Federal regulations provide states with broad flexibility to adopt rules regarding when beneficiaries must report changes that may affect their eligibility.⁸⁸ For example, states may allow Medicaid beneficiaries to report income or asset changes only when such changes would make beneficiaries ineligible for Medi-Cal. However, California currently requires that parents in Medi-Cal report their income and assets twice per year, regardless of whether they have experienced a change in circumstances.⁸⁹ This creates a burden on beneficiaries, as well as on counties, which must process the paperwork. California could reduce unnecessary paperwork by allowing Medi-Cal beneficiaries to submit forms only when there is a change that affects their eligibility for Medi-Cal.

Furthermore, California could implement “continuous eligibility” for additional Medi-Cal beneficiaries by disregarding changes in income and assets between annual eligibility reviews, which would effectively eliminate reporting until the next eligibility review.⁹⁰ California already provides 12 months of continuous eligibility for children and youth under age 21. In 2002, California received federal approval to effectively extend continuous eligibility to low-income parents enrolled in Medi-Cal, but the state has not implemented this provision.⁹¹

Scott Graves of the California Budget Project (CBP) and Judith Solomon of the Center on Budget and Policy Priorities (CBPP) prepared this report. Support for this report was provided by a grant from The California Endowment. The CBP was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. Support for the CBP comes from foundation grants, publications, and individual contributions. The CBPP is a nonpartisan, nonprofit policy institute that conducts research and analysis at both the federal and state level on fiscal policy and on programs and policies affecting low- and moderate-income families.

ENDNOTES

¹ Department of Health Services, *Medi-Cal Redesign, January 2005* (January 10, 2005), p. 3. The Administration announced its intent to restructure the Medi-Cal Program in early 2004. Administration officials circulated documents describing potential restructuring options and convened a series of workshops to seek public comment on those options. Public workshops were held in March and April 2004 and covered Medi-Cal issues ranging from benefits and cost sharing to finance and cost savings. Bobbie Wunsch, *Medi-Cal Redesign Stakeholder Report* (Pacific Health Consulting Group: May 7, 2004).

² Kaiser Commission on Medicaid and the Uninsured, *2000 State and National Enrollment and Spending Data (MSIS)*, "Table 2: Medicaid Payments per Beneficiary by Group, FFY 2000" (March 2004), downloaded from <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=32747> on July 7, 2004.

³ Safety-net hospitals include public, children's, teaching, and private hospitals that provide access to care for low-income and uninsured persons.

⁴ California currently has 20 federal Medicaid waivers, most of which are for specified groups and services. For example, the Multipurpose Senior Services Program provides home- and community-based services to Medi-Cal recipients who are at least 65 years old and are medically needy. This waiver enables these individuals to live in their own home rather than a nursing care facility. Senate Budget and Fiscal Review Subcommittee #3 on Health, Human Services, Labor and Veterans Affairs, *Analysis of Health, Human Services, Labor, and Veterans Affairs Issues as Proposed in the Governor's 2004-05 Budget Bill* (February 5, 2004), pp. 3-16 to 3-17.

⁵ Department of Health Services, *Revised California Section 1115 Waiver Proposal* (March 6, 2005) and *Hospital Financing Redesign (HFR): California's New Section 1115 Waiver Proposal* (March 28, 2005).

⁶ States may seek comprehensive waivers that encompass most or all of a state's Medicaid program or relatively limited waivers that affect certain beneficiaries and/or apply to a limited set of services. States may, for example, seek less expansive waivers to provide home- and community-based services to beneficiaries with long-term care needs, provide family planning services, require beneficiaries to enroll in managed care, or limit the provider network serving Medicaid beneficiaries.

⁷ California already has a number of waivers under the authority of Section 1915(b) of the Social Security Act. These waivers allow the state to operate its managed care programs and manage its system of selective contracting with safety-net hospitals. Under the Selective Provider Contracting Program (SPCP) waiver, the state negotiates rates with contracting hospitals, which results in significant savings in Medi-Cal inpatient hospital costs. The current 1915(b) waiver governing the SPCP expires on June 30, 2005, as discussed below.

⁸ For example, federal courts have ruled that the HHS Secretary may not waive certain federal requirements related to the Medicaid drug rebate program or to beneficiary cost-sharing limits.

⁹ Centers for Medicare and Medicaid Services, *Steps in the 1115 Demonstration Proposal Process* (November 1, 2002), available at www.cms.hhs.gov/medicaid/1115/gensteps.asp.

¹⁰ Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors #02-007 (May 3, 2002), citing 59 Federal Register 49249 (September 27, 1994).

¹¹ Bobbie Wunsch, *Medi-Cal Redesign Stakeholder Report* (Pacific Health Consulting Group: May 7, 2004).

¹² The FMAP is a state-specific percentage that is adjusted annually by the federal government based on a state's per capita income relative to the national average.

¹³ Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives* (Kaiser Commission on Medicaid and the Uninsured: February 2002).

¹⁴ Budget neutrality is not required by federal statute or regulation, but rather is a long-standing Office of Management and Budget policy.

¹⁵ Social Security Act, Section 1903(m)(2)(A)(iii).

¹⁶ The state's proposal includes a provision that would allow the state and CMS to modify the budget neutrality cap in case of "unanticipated changes in case load or utilization of hospital services by Medicaid-eligibles under the waiver."

The meaning of “unanticipated changes” would be negotiated during the development of the waiver terms and conditions.

¹⁷ It is likely that the federal government would negotiate a per capita cap, rather than an aggregate cap, on Medicaid funding as a condition of approving a Section 1115 waiver allowing California to impose premiums on certain Medi-Cal beneficiaries. In February 2004, Washington State received federal approval to charge premiums for Medicaid coverage provided to certain children. The waiver, which has not been implemented, would impose a per capita cap on federal funds for the children subject to the premiums. Details of the waiver can be found at <http://www.cms.hhs.gov/medicaid/1115/wa1115wpp.asp>.

¹⁸ Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing Policies Can Create Significant Financial Risks for California* (Kaiser Commission on Medicaid and the Uninsured: July 2004).

¹⁹ Alternatively, the state could spend federal matching funds in excess of the cap and fully repay the federal government after the waiver expires. No state has ever elected this repayment option. Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing Policies Can Create Significant Financial Risks for California* (Kaiser Commission on Medicaid and the Uninsured: July 2004).

²⁰ The Administration assumes that savings will be achieved through disenrollment of individuals and families who do not pay the required premiums. This assumption is consistent with research on the impact of premiums on low-income individuals. See Leighton Ku and Teresa A. Coughlin, “Sliding Scale Premium Health Insurance Programs: Four States’ Experience,” *Inquiry*, Volume 36, Number 4 (Winter 2000), pp. 471-80.

²¹ Total Medicaid spending, including both federal and state funds, in California was \$2,532 per enrollee in federal fiscal year 2002, compared to a national average of \$4,141 per enrollee. Center on Budget and Policy Priorities analysis of data reported to CMS in the Medicaid Statistical Information System as of February 15, 2005 (excludes administrative costs, DSH payments, Medicare payments and certain payment adjustments).

²² California Health Care Foundation, *Public Programs: Access to Physicians in California’s Public Insurance Programs* (May 2004).

²³ US General Accounting Office, *Medicaid and SCHIP: States’ Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), pp. 6-7. States generally may not require premiums “from certain low-income individuals within certain groups, including children, pregnant women, individuals in families with dependent children, individuals with disabilities, and elderly persons, but exceptions exist.”

²⁴ US General Accounting Office, *Medicaid and SCHIP: States’ Premium and Cost Sharing Requirements for Beneficiaries* (March 2004), pp. 45-47. According to the General Accounting Office, “States may require premiums from certain working adults with disabilities who received Medicaid coverage under the Balanced Budget Act of 1997 or the Ticket to Work and Incentives Improvement Act of 1999.” The category of adults with disabilities includes working adults.

²⁵ The FPL for a family of three in 2005 is \$1,341 per month. The SSI/SSP grant level is \$812 per month for individuals and \$1,437 per month for couples as of April 2005.

²⁶ The California Work Opportunity and Responsibility to Kids (CalWORKs) Program is California’s welfare-to-work program.

²⁷ The Administration proposes to allow individuals to pay premiums through various options, including mail, phone, automated payroll deductions or bank account withdrawals, or in-person at physical locations.

²⁸ Senate Budget and Fiscal Review Subcommittee #3 on Health & Human Services, *Informational Hearing: Governor’s Proposed Medi-Cal Redesign* (February 17, 2005), p. 20. The Administration estimates that about 20 percent of those affected by the premiums would lose Medi-Cal coverage due to missed premium payments, but assumes that Medi-Cal enrollees who are eligible for both Medi-Cal and Medicare would not lose Medi-Cal coverage.

²⁹ Department of Health Services, *Medi-Cal Redesign, January 2005* (January 10, 2005), pp. 14-15. The Healthy Families Program provides low-cost health coverage for children with family incomes too high to qualify for Medi-Cal, up to 250 percent of the FPL.

³⁰ Julie Hudman and Molly O’Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured: March 2003), p. 5.

³¹ The data are from the 2000 Bureau of Labor Statistics’ Consumer Expenditure Survey. “Low-income” is defined as families who earned less than 200 percent of the FPL, or \$27,476 for a family of three in 2000. Claudia Williams et al., *Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage* (Kaiser Commission on Medicaid and the Uninsured: April 2004).

³² Peter J. Cunningham, *Prescription Drug Access: Not Just a Medicare Problem* (Center for Studying Health System Change, Issue Brief Number 51: April 2002), p. 2. Chronic conditions include diabetes, heart disease, and depression.

³³ The 2004-05 Budget requires families with incomes over 200 percent of the FPL, but less than or equal to 250 percent of the FPL, to contribute \$15 per child up to a maximum of \$45 per family for Healthy Families services beginning July 1, 2005.

³⁴ Currently, the state terminates Healthy Families coverage if the premium has not been paid by the end of the second month.

³⁵ Managed Risk Medical Insurance Board, *Healthy Families Disenrollment Statistics, June 22, 2004 (Possibly Avoidable)*,

downloaded from <http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt14.pdf> on June 29, 2004. It is unclear how many children who lose Healthy Families coverage due to failure to pay the premium meet eligibility requirements for the program.

³⁶ Oregon made sweeping changes to its Medicaid program under a Section 1115 waiver in 2003. Oregon raised premiums to between \$6 and \$20 per month and enforced stricter premium payment policies. These changes applied to certain adults whose incomes did not exceed the FPL and who were not receiving Temporary Assistance for Needy Families (TANF) cash assistance or General Assistance. One survey found that 72 percent of those who lost Medicaid coverage after the program changes remained uninsured. See Oregon Health Research and Evaluation Collaborative, *The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study* (March 2004).

³⁷ Kaiser Commission on Medicaid and the Uninsured, *Children's Health – Why Health Insurance Matters* (May 2002); Kaiser Commission on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured* (May 2002); American College of Physicians, *No Health Insurance? It's Enough to Make You Sick – Scientific Research Linking the Lack of Health Coverage to Poor Health* (2000); and US Department of Health and Human Services, *Access to Health Care Part 1: Children* (National Center for Health Statistics: Series 10, No. 196: July 1997).

³⁸ Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Center on Budget and Policy Priorities: May 7, 2003).

³⁹ Peter Cunningham and Jessica May, *Insured Americans Drive Surge in Emergency Department Visits* (Center for Studying Health System Change, Issue Brief Number 70: October 2003).

⁴⁰ Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program* (Kaiser Commission on Medicaid and the Uninsured: June 2004), p. 3. The study did not control for other factors that may have influenced emergency room use.

⁴¹ In addition, some individuals could lose eligibility for Medi-Cal if they lose coverage for failure to pay their premium. Families who have transitioned from the CalWORKs Program are eligible for continuing Medi-Cal coverage with incomes up to 155 percent of the FPL. If these families lose their Medi-Cal coverage, they would not be eligible to re-apply for Medi-Cal if their incomes exceed 100 percent of the FPL.

⁴² In addition, the President's proposed budget for federal fiscal year 2006 includes measures to further restrict states' use of IGTs.

⁴³ The federal government limits Medicaid payments to hospitals through "upper payment limits" (UPLs). UPLs were designed so that hospitals would not be paid more for Medicaid inpatient care or long-term services than the Medicare program would pay.

⁴⁴ For example, the federal Balanced Budget Act of 1997 reduced DSH payments to California by nearly 20 percent between federal fiscal years 1998 and 2002.

⁴⁵ For example, the federal government has used audit findings as a basis for disallowing IGTs as a mechanism to obtain federal supplemental payments.

⁴⁶ Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-92. IGTs would continue to be used to match a portion of California's annual DSH funds; however, IGTs would become a less prevalent mechanism to obtain federal funds for safety-net hospitals under the Administration's proposal.

⁴⁷ Indigent patients include those who are uninsured, underinsured, or unable to pay for their health care and those who are not eligible for state-administered health programs, such as Medi-Cal or the Healthy Families Program.

⁴⁸ The President's federal fiscal year (FFY) 2006 budget includes a number of measures to reduce federal Medicaid spending. Moreover, the FFY 2006 budget resolution passed by Congress in April 2005 cuts Medicaid funding by \$10 billion over five years.

⁴⁹ For example, the 2004-05 budget agreement shifted \$1.3 billion in property tax revenues from local governments, including \$350 million from counties, to reduce the state's contribution to K-14 education. Under the agreement, the property tax shift occurs in 2004-05 and 2005-06.

⁵⁰ The Administration estimates that its proposal to cap dental benefits for adults would result in state savings of \$24.5 million in 2005-06 and \$26.3 million per year starting in 2006-07.

⁵¹ Department of Health Services, *Medi-Cal Redesign, January 2005* (January 10, 2005), p. 14.

⁵² General Accounting Office, *Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations* (April 2000) and General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations* (September 2000).

⁵³ US Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General* (September 2000).

⁵⁴ Approximately 3.4 million Medi-Cal beneficiaries are enrolled in fee-for-service Medi-Cal.

⁵⁵ The 12 counties are Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Fresno does not have a local initiative and has two commercial plans. Individuals who are eligible for both Medi-Cal and Medicare may not enroll in managed care.

⁵⁶ The eight counties are Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo.

⁵⁷ The two counties are Sacramento and San Diego. Individuals who are eligible for both Medi-Cal and Medicare may not enroll in managed care.

⁵⁸ The Governor also proposes to implement Acute and Long Term Care Integration projects in Contra Costa, Orange, and San Diego counties. The projects would “implement a protocol to assess and divert individuals from costly long-term inpatient nursing facility care.”

⁵⁹ The Administration proposes to expand the COHS model to include Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, and Ventura counties, with the possible addition of Lake County; expand the GMC model to include El Dorado, Imperial, Madera, Merced, and Placer counties, with the possible addition of King County; and convert Fresno County’s model to a GMC model.

⁶⁰ In counties with a GMC plan, elderly individuals and people with disabilities who do not have Medicare coverage would enroll in managed care.

⁶¹ Department of Health Services, *Medi-Cal Redesign, January 2005* (January 10, 2005), p. 9.

⁶² California HealthCare Foundation, *Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives* (September 2003); California HealthCare Foundation, *Adults with Disabilities in Medi-Cal Managed Care: Conference Summary* (June 2003); California HealthCare Foundation, *Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States* (September 2003); and California HealthCare Foundation, *Adults with Disabilities in Medi-Cal: Utilization and Expenditure Trends, 1995-2001* (June 2003).

⁶³ Experience with the COHS model, which covers people with disabilities, suggests that adequate rates are an important issue. The Governor’s Proposed 2004-05 Budget assumed that San Mateo County’s COHS would cease operation and revert to a fee-for-service system due to financial problems. The Legislative Analyst’s Office reported that part of the problem may have been rates that were based on outdated information about the actual cost of health care services being provided by health plans to individuals. The 2004-05 Budget included a rate increase to the COHS counties to address the issues of fiscal solvency.

⁶⁴ The SPE is a central processing center for all joint Medi-Cal and Healthy Families mail-in applications. The SPE contractor screens for Medi-Cal and Healthy Families eligibility and processes Healthy Families applications.

⁶⁵ Children can also enroll in Medi-Cal or Healthy Families through other public programs. The Child Health and Disability Prevention (CHDP) Gateway, for example, pre-enrolls children in Medi-Cal for up to 60 days. Meanwhile, these children can apply to Medi-Cal or Healthy Families for ongoing coverage. The CHDP Gateway also automatically enrolls certain infants under age 1 in Medi-Cal. In addition, children in the National School Lunch Program can apply for Medi-Cal using information from the NSLP application, without having to submit a separate Medi-Cal application.

⁶⁶ If the proposal is adopted, the Administration would seek federal approval of a state plan amendment.

⁶⁷ Ongoing case management would include annual eligibility redeterminations.

⁶⁸ Federal law requires Medi-Cal applications to be processed within 45 days.

⁶⁹ Social Security Act, Section 1927.

⁷⁰ Office of Inspector General, *Audit of the Medicaid Drug Rebate Program in California* (US Department of Health and Human Services: December 23, 2003).

⁷¹ Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers* (Taxpayers Against Fraud Educational Fund: November 2003).

⁷² The federal Medicaid rebate law, federal Medicare and Medicaid fraud and abuse laws, the federal False Claims Act, and the California False Claims Act provide California with adequate legal authority to pursue litigation against drug manufacturers. Social Security Act, Section 1927(b)(3)(C); Social Security Act, Section 1128A; 31 United States Code, Sections 3729-3733; and California Government Code, Sections 12650-12655. See also Andy Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers* (Taxpayers Against Fraud Educational Fund: November 2003).

⁷³ For example, in the 2003-2004 Budget, the state established education programs to encourage physicians to prescribe more cost-effective drugs and implemented “step-therapy” requirements so that beneficiaries use less costly drugs before proceeding to more expensive drugs. Senate Budget and Fiscal Review Committee, *Final Action Report: A Summary of the 2003 Budget Act* (September 25, 2003).

⁷⁴ Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002).

⁷⁵ Many states reimburse pharmacies at the average wholesale price (AWP) minus 10 percent. However, the Office of Inspector General found that pharmacies paid on average AWP minus 17.2 percent for single source drugs and AWP minus 72.1 percent for generic drugs with at least three competing manufacturers. Office of Inspector General, *Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products* (US Department of Health and Human Services: September 16, 2002). California will reimburse pharmacies at the average wholesale price (AWP) minus 17 percent, a change included in the 2004-05 budget agreement.

⁷⁶ See Texas Health and Human Services Commission, *Request for Information for New Drug Product or for Additional Information of Products Currently Included in Texas Medicaid* (Revised May 1, 2002).

⁷⁷ Federal law requires “federal upper limits” (FULs) on drugs costs for generic drugs with at least two generic

competitors. Federal law permits states to set their own payment limits, known as Maximum Allowable Cost (MAC) limits. California applies such limits to 37 drugs under its Maximum Allowable Ingredient Cost (MAIC) program. Andy Schneider, *Medicaid: Purchasing Prescription Drugs* (Kaiser Commission on Medicaid and the Uninsured: January 2002); National Pharmaceutical Council, *Pharmaceutical Benefits under State Medicaid Programs: 2002* (2003); Senate Rules Committee, Office of Senate Floor Analyses, *Analysis of SB 1170* (April 22, 2004).

⁷⁸ Ashley Short, Glen Mays, and Jessica Mittler, *Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care* (Center for Studying Health System Change: October 2003).

⁷⁹ Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors (February 28, 2004).

⁸⁰ Senate Budget and Fiscal Review Committee, *Final Action Report: A Summary of the 2003 Budget Act* (September 25, 2003).

⁸¹ The Centers for Medicare and Medicaid Services cites existing state flexibility under Social Security Act, Sections 1905(a)(6), 1905(a)(13), and 1932(a). Social Security Act Section 1905(a)(19) would also likely provide authority for disease management programs under the existing case management benefit.

⁸² Manufacturers must pay a rebate equal to the higher of (1) 15.1 percent of the average manufacturer price (AMP) or (2) the “best price” at which manufacturers sell to wholesalers and other purchasers for subsequent retail sales. The minimum rebate percentage has remained at 15.1 percent since January 1, 1996.

⁸³ The proposed Immigrant Children’s Health Improvement Act (ICHIA) would allow states like California that provide state-funded coverage to legal immigrants to receive federal Medicaid matching funds for pregnant women and children who have legally resided in the country for less than five years. ICHIA was included in S. 845, the Senate-passed version of the Medicare drug legislation, but was dropped from the final Medicare drug bill passed by Congress in 2003.

⁸⁴ Social Security Act, Section 1902(r)(2). However, states may not adopt criteria that are more restrictive than the criteria under an applicable cash assistance program. For example, states may not adopt Medicaid eligibility criteria for the elderly and people with disabilities that are more restrictive than the criteria for the Supplemental Security Income program. Section 1931(b)(2)(C) of the Social Security Act gives states similarly broad flexibility in setting Medicaid eligibility criteria for families with children that include parents. In this case, eligibility criteria may not be more restrictive than the criteria in place under the Aid to Families with Dependent Children (AFDC) program prior to enactment of federal welfare reform in 1996.

⁸⁵ Eligibility criteria for Medicaid may include a family’s financial assets. The vast majority of states, including California, have eliminated the assets test for children under both Medicaid and the State Children’s Health Insurance Program (SCHIP) in order to reduce administrative complexity and streamline the enrollment process, as many low-income families have few or no resources. However, only 21 states have eliminated the assets test for parents under Medicaid.

⁸⁶ The sole federal requirement is that states must verify the immigration status of applicants. Social Security Act, Section 1137(d).

⁸⁷ In California, counties administer the Medi-Cal Program, along with most other health and human services programs.

⁸⁸ Under federal Medicaid regulations, states must have procedures in place to ensure that beneficiaries make timely and accurate reports about changes in circumstances and that states act promptly to reassess eligibility based on that information. 42 Code of Federal Regulations, Section 435.916(b).

⁸⁹ The 2000-01 Budget eliminated the requirement for adults to submit quarterly forms to retain Medi-Cal coverage and allowed beneficiaries to self-report changes in income or other circumstances within 10 days. However, the state increased the reporting requirement by adopting “semi-annual” reporting in 2003. Children are exempt from Medi-Cal reporting requirements.

⁹⁰ States can modify income and resource counting rules to effectively provide 12 months of continuous eligibility for parents under federal law. Social Security Act, Section 1931(b)(2)(C).

⁹¹ Medicaid State Plan Amendment Transmittal Number #01-019, downloaded from http://www.cms.hhs.gov/medicaid/stateplans/state_data/CA/spa/CA01_019.