

# Health Care Reform Stakeholder Group Meeting Notes

**1:00 – 3:30pm, February 1, 2013**

**Sheraton Grand Sacramento  
1230 J Street, Sacramento, CA**

## Member Organizations attending:

Gary Passmore, Congress of CA Seniors; Erin Gabel, CA Dept of Education; Sarah Hastings, CA State Association of Counties; Kristin Barlow, CA Mental Health Directors Association; Rusty Selix, California Council of Community Mental Health Agencies; Sarah Muller, California Association of Public Hospitals and Health Systems; Patrick Johnston, California Association of Health Plans; Anne McLeod, California Hospital Association; Catherine Douglas, Private Essential Access Community Hospitals; Dion Aroner, Child Care Providers United, AFSCME / UDW; Caroline Jenell, California Medical Association; Mike Herald, Western Center on Law and Poverty; Jon Youngdahl, SEIU State Council; Kevin Aslanian, Coalition of California of Welfare Rights Organizations; Frank Mecca, County Welfare Directors Association; Ellen Wu, California Pan-Ethnic Health Network; John Ramey, Local Health Plans of California; Jody Hicks, California Academy of Family Physicians; Christina Hamilton, UDW/AFSCME, Tom Renfree, Alcohol and Drug Program Administrators Association of CA

## Member Organizations Attending by Phone:

Sonia Vasquez and Lark Galloway-Gilliam, Community Health Councils; David M. Souleles, County Health Executives Association of California; Karen Keeslar, California Association of Public Authorities for IHSS; Elizabeth Landsberg, Western Center Law and Poverty; Janie Whiteford, California IHSS Consumer Alliance; Eric Carlson, National Senior Citizens Law Center; Anthony Wright, Health Access California; Kim Kruckel, Child Care Law Center; Kalleen Lyman, County Medical Services Program Governing Board; Jason Kletter, CA Opioid and Maintenance Providers, Al Senella, California Association of Alcohol & Drug Program Executives/Tarzana Treatment Center; Anne Donnelly, Project Inform; Kim Lewis, National Health Law Program, Michael Odeh, Children Now

## State Staff Attending:

Diana Dooley, Secretary, Health and Human Services Agency; Ana Montasantos, Director, Dept of Finance; Will Lightbourne, Director, Dept Social Services; Toby Douglas, Director, Dept of Health Care Services; Katie Johnson, CA Health and Human Services Agency; Len Finocchio, Deputy Director, Department of Health Care Services; Sara Swann, Department of Finance. Pete Cervinka, Dept of Social Services.

## Members Not Attending

AARP CA; Alliance to Transform CalFresh; California Association of Physician Groups; California Association of Health Facilities; California Children's Hospital Association; California Primary Care Association; County; Disability Rights California; Latino Coalition for a Healthy California; Neighborhood Legal Services-Los Angeles; The Children's Partnership

## Welcome

***Diana S. Dooley, Secretary, California Health and Human Services Agency***

Thanks you all for being here today present and participating on the phone. California has been a leader in implementing the Affordable Care Act. We have come a long way and we are all committed to the next leg of the journey. This meeting is to begin a conversation about how to implement the expansion of Medicaid – one significant part of the coverage aspect in the Affordable Care Act (ACA). The Governor's budget provides a frame for conversation about the expansion. The California 2010 waiver included the "bridge to reform through the Low Income Health Program, which was begun with language in mind from the ACA that the expansion would be mandatory. The court has said it is not mandatory. The mandatory aspect of expansion is the part of ACA that will occur by virtue of the changed rules.

The optional expansion relates to the newly eligible. There are still many issues that are uncertain, for instance the claiming rules to distinguish the newly eligible from existing eligible population. This is important because of the different rates of federal participation between the mandatory and optional expansion groups. We can't be any more certain about budget estimates until we receive more guidance from the federal government. This is a fundamental change in roles, responsibilities and risk between the state and counties in the service for this population. We need to sort this through and make clearest estimates we can as to how we will serve them; how beneficiaries will navigate this system and get the coverage that will lead to better health.

This is the first of several opportunities for broad engagement. This is a scoping meeting and listening session to understand the questions you have; what the structure, operations and considerations should be for the expanded Medicaid program. Toby Douglas and Will Lightbourne will conduct most of the meetings and catalog those issues. We are happy to have a joint effort with Ana Montasantos and her team from the Dept of Finance so we can move forward together to realize implementation of ACA. The Governor has emphasized that we do not want to move backward. It was a hard lift to get to a balanced budget and pass Proposition 30. It is critical to design what we do over the next decade in a way that it is sustainable for the future.

***Ana J. Matosantos, Director, Department of Finance***

Thanks for joining us to develop this policy change for California. This is broader than traditional health care discussions. In either scenario for implementation, there is an expanded role on state side for health care and a corresponding reduction on county side for indigent population. We want to work through what that means and what happens to respective roles and responsibilities and financing for the state and county in the two options. This is a complex web of programs and we want to be thoughtful about how we implement this in a sustainable way going forward. In my mind, there are people, system and county implications from this.

**Member Questions**

*Gary Passmore, Congress of CA Seniors*, This is a comment not a question. Important to note that two months ago, many of us were worried about whether the administration would bring forward a proposal about expanding Medi-Cal. I want to acknowledge the Governor and staff for moving to this conversation instead of whether to implement rather than how to structure it. I hope we can get it done in a way that works for everybody.

*Ellen Wu, California Pen-Ethnic Health Network*: I understand this is the budget proposal and there are many policy elements that go along with it. Where will we see the policy elements – do we have to wait until the financing is resolved?

*Dooley:* There isn't a distinction between finance and policy. They are completely integrated. That is why we are all here for this conversation.

*John Ramey, Local Health Plans of CA:* Currently, we are suffering an unintended crisis in Healthy Families Program over payment of premium. The pool is short and premiums from December are not paid. Normally, non-payment of premium triggers procedures to terminate that coverage. No one wants to discuss terminating kids, especially during transition to Medi-Cal, so my question is what can we do about what I call a breach of faith?

*Matosantos:* We have done what we can with reserve to pay as many claims as we can. We need legislative supplemental appropriation to pay. This is a priority and we are working on legislation to get the appropriations done and bills paid as quickly as possible.

*Kim Lewis, National Health Law Program:* Is anything available in writing about the proposal and the options you are considering?

*Douglas:* We will present the options orally to describe the proposal. This is a discussion we want to have rather than putting out documents. There is a discussion in Governor's budget that lays out the framework. As we develop more information, it will be posted on website.

*Anthony Wright, Health Access:* I want to underscore appreciation for the context here: HOW to move forward, not WHETHER to move. If this is about state/county roles in a Medicaid expansion, we need to include a conversation about the commitment to the remaining uninsured. We can't have a conversation about allocating resources and responsibilities without discussing what resources will be available for the 2-4 million we who will remain uninsured.

*Dooley:* This question illustrates how complex these issues are. This conversation is about how the population of newly eligibility will get the care they deserve and need. Those who will remain uninsured are not directly included in this conversation. There are many other aspects of the system this will relate to - there is enormous unmet need and we recognize that. It relates to this conversation but it is not the subject of this conversation.

*Jon Youngdahl, SEIU:* SEIU members are excited to work on implementation of ACA and Medi-Cal expansion. SEIU are the workers that provide care in public and private sector. We need to continue to work on the affordability of the care and the quality and access they will receive.

### **Overview of the State's Medicaid Expansion Proposal**

#### ***Toby Douglas, Director, Department of Health Care Services***

Toby Douglas will review the two options and take questions on each. Given the complexity of state-county relationship and financing, we see there are two viable approaches for implementing the expansion under both options, we would continue as single state entity for Medicaid and eligibility determination and enrollment will continue in the way it is planned under ACA implementation.

Option 1: Under this option, the state will use the existing Medi-Cal Managed Care system to serve the expansion population of childless adults and others. They would be enrolled into managed care under the current structure and provided services with the same delivery system.

#### ***Will Lightbourne, Director, Department of Social Services***

The expansion is important on the human services side as well. What roles will various state funded human services play? The Governor's budget indicated human services such as child care is one example. What are other programs to consider? Cal-WORKS, Cal-Fresh may be subjects here.

Within adult programs, although the IHSS growth was transferred, there may be SSI/SSP responsibilities to be considered. These are all in the mix for conversation. We want to be sure to have conversation about the policy potential to strengthen programs through respective responsibility changes as well as understand any pitfalls. There will be possibilities and concerns in each option.

Option 2: The 1115 waiver LIHP expanded coverage to childless adults in 51 counties and additional counties are coming on board. Counties have developed their own systems of care with hospitals, clinics, providers and health plans to deliver and pay for care. Option 2 builds on the LIHP. This is a voluntary program for the 58 counties. They will develop systems and deliver care for the expansion population. They would provide benefits similar to Medi-Cal and Covered CA. There is no long term care under both options. Eligibility determination happens in county social services and online application. While this option is not as much realignment of funds, either option does reduce obligation of county to serve uninsured and an increase of insured who are eligible today. So even under this option, we expect a conversation about realignment of funds currently used for uninsured adults for other services.

There are many risks and pressures in proposals overall. Realignment funds will go down given the increase in coverage. There are major implications at state level regardless of the option. There will be no asset tests; there will be electronic verification, and other changes. Streamlining and other changes increase coverage and do cause pressures at the state. We don't know who will be claimed at 100% FFP and who will be counted as 50-50 match. We could have significant enrollment of those currently eligible that we need to pay for at 50% due to ACA. There are also pressures from increased payments to providers that cause fiscal impact. There are changes in delivery system and interfacing with Covered CA that will increase pressure on the state. This is why we need more conversation and that is why we have these two options.

### ***Questions from Member Participants***

*Erin Gabel, Dept of Education:* Is child care realignment discussion in both options or only in the state option?

*Douglas:* It is in both options but the extent is different. In option 1, the state is taking all obligation for the expansion as well as existing programs under Medi-Cal. Even under option 2, there is a need to have discussion. Note: It subsequently was clarified that the realignment of child care is an option under the state option, not the county option.

*Erin Gabel, Dept of Education:* Are you looking for other options from group?

*Lightbourne:* In both the full group dialog and as we develop subgroups, we can look at other options

*Sarah Hastings, CA State Association of Counties:* The risks outlined for state exist for counties as well.

*Kristin Barlow, CA Mental Health Directors Association :* It sounds like the parameters today are to focus on optional expansion, not on streamlining eligibility?

*Douglas:* Yes, that is correct. The mandatory expansion will be covered on a call next week

*Rusty Selix, CA Council of Community Mental Health Agencies :* The budget noted extra cost for those currently eligible who will now enroll. For Mental Health, this is a county cost – not state cost. If money is to be shifted based on newly enrolled, there is a factor for mental health that should be factored into the equation.

*Douglas:* We currently have program through counties for Mental Health-Substance Abuse. That is part of the conversation as we go to an expansion. What are the interactions with the expansion for the existing populations will be an important discussion.

*Sarah Muller , CA Association of Public Hospitals and Systems:* We are fully committed to long term sustainability. We share concerns on risks and opportunities from expansion. Full expansion will still include many uninsured. We want to create a structure that is sustainable and maximizes enrollment.

*John Ramey, Local Health Plans of CA* Has there been any consideration under county option regarding protection of Knox Keene Act and regulation by Dept Managed Health Care. Any thought to whether and how this regulatory environment would exist on options?

*Douglas:* Currently the LIHP's don't follow Knox Keene, however there are requirements under federal law – many similar to Knox Keene, such as network adequacy that they are expected to follow. We do not envision the counties follow Knox Keene under option 2 but they would follow Medicaid policy.

*Jody Hicks, CA Academy of Family Physicians:* We are glad to see the expansion and the acknowledgement of the pressures on providers. How will we build in incentives to be sure providers will take the new insured population as well as a commitment to solving the need for a pipeline?

*Douglas:* Yes, we have to solve the network adequacy issues under either option. We are working to implement the increase in rates to primary care providers and get the money out. This will help with provider networks.

*Patrick Johnston, CA Association of Health Plans:* There are at least two big variables: cost and management. The State retains responsibility for health care services and quality for expansion population, correct?

*Douglas:* The state remains the single Medicaid entity. We are ultimately responsible even though the county is delivering the care but following the rules we set out, similar to the way Mental Health functions now.

*Patrick Johnston, CA Association of Health Plans:* Currently, with Medi-Cal, the plans are the intermediary with the state. The DHCS and DMHC regulate performance in plans. As you look to expand eligibility under Medicaid, what is the increased challenge and work load without an intermediary? How do you evaluate the challenges and costs if you pursue a 58 county option.

*Douglas:* The state would provide oversight. County would have responsibility for network adequacy. This is part of the roles discussion - one important variable.

*Anne McLeod, CA Hospital Association:* Hospitals acknowledge the discussion is complex and we have concerns over either option. As we enroll many new eligibles, we need to insure they can receive services and network adequacy is already a problem.

*Catherine Douglas, Private Essential Access Community Hospitals:* PEACH members are important in the access network for Medi-Cal consumers. As the state did the LIHP, it created a transition plan that said enrollees could remain with their provider. This is important for continuity of care. Also you gave them information on the benefit package, choice of new plan, choice of providers. If newly eligible would be locked into county system, we have concerns.

*Dion Aroner, AFSCME/UDW:* Looking back, there was a proposal last year to realign child care. We shared our concerns at that time. There are two principles for any discussion: provision of child care is done in community – not by government is an important principle, and second, anything we do

needs to IMPROVE structure or access. Whatever we do on financing side must improve those elements.

*Lightbourne:* Those are good principles for any of the human services elements.

*Carolyn Ginno, CA Medical Association:* There are access to care concerns in Medi-Cal now. In particular, there are concerns on county option around network adequacy.

*Douglas:* Under county option, this needs to be discussed more in future meetings. There would be requirements for network adequacy but what they would be is part of our discussion.

*Mike Herald, Western Center on Law and Poverty:* We agree that we need a set of principles that go beyond a fiscal swap and improve system of care under realignment. My question is timing. Will decisions need to happen by early 2014? When will realignment occur - in the future? How much time will we have to sift through data and options? How much is tied to budget going through in June?

*Lightbourne:* The fiscal and policy issues are not separate as Secretary Dooley said. Implementation could vary according to specific service or system. Policy decision needs to be done as a package now.

*Jon Youngdahl, SEIU:* We agree with county that a strong safety net is critical. We want to work with you on LTC.

*Kevin Aslanian, CA Coalition of Welfare Rights Organizations:* We are concerned with the two options. Are there issue memos with pros/cons listed and data that we can share with community?

*Douglas:* As part of budget there is an overview of the proposals. Additional detail is for us to discuss here

*Frank Mecca, County Welfare Directors Association:* Welfare Directors, responsible for eligibility, want to thank administration. We are looking forward to put systems in place for first class service regardless of the option for ALL the programs low income families rely on.

*Christina Hamilton:* UDW/ACSME represents people affected by the proposals. We look forward to working with everyone.

*Ellen Wu, California Pen-Ethnic Health Network:* We have many concerns and questions. Following up on cost: it seems taking up discussion of cost for expansion without discussing remaining uninsured would be detrimental to state it seems it is presumed there is enough money now. This is an opportunity for the state to recognize efficiencies and it doesn't seem efficient to have 58 versions. We are not sure how the expansion will actually play out. So, it seems we need to have lag time before money is swept from counties so we know more about the remaining uninsured.

*Gary Passmore, Congress of CA Seniors:* We need to be mindful of the need to have a viable safety net structure in place because there will be millions not eligible or not covered.

*Douglas:* The proposals are based on the Administration's strong commitment to a strong safety net system. That is part of why we have two options. Under either option, we want to maintain a strong safety net. This is a fundamental principle – that we do not destabilize the safety net system.

*Gary Passmore, Congress of CA Seniors:* I am concerned that we enter the conversation with statement that Long Term Services and Support is not included in the system. How much flexibility is there in the discussion? What if legislation included LTSS for expansion population? Would the federal government let us do it?

*Douglas:* The Essential Health Benefits guidance is out and LTC is not included. We share the value of LTSS but there is another eligibility process that must be moved through to be eligible. It is not clear that legislation could add it in.

### **Members on Phone**

*Al Senella, CA Association of Alcohol & Drug Program Executives:* Substance Abuse benefit under program is currently carved out to counties. The benefit is inadequate to meet needs and far short of parity. The expansion population includes folks who receive substance use services through other systems – not the county – through block grants etc. Perhaps up to 70% of these consumers may qualify for Medi-Cal. The cost being considered here are too narrow. Currently, counties are not willing to discuss expanding the benefit to meet parity because of worry over cost of service and the fact that it is underfunded. Why are we not looking at true cost?

*Douglas:* This is an important question. This question may fit in a future, next steps discussion under benefits.

*Lark Galloway-Gilliam, Community Health Councils:* Community Health Councils works to expand coverage and simplify the system. There is a tension here between financial considerations and how to design effective system that expands access. What do we mean by “county”? What do we mean by “voluntary”?

*Douglas:* For what is “county”, we look to the LIHPs. It would be up to county to determine whether to use county health department, private, clinics. It varies by county. County would decide whether to deliver or identify who to deliver. Voluntary: we expect all counties to participate or with a model like CMSP. It will not be a state – county mixture.

*David Souleles, County Health Executives Association of CA:* The pressure of timing to roll out on Jan 2014 is nerve wracking whichever option is chosen. We want to be sure that there is acknowledgement that local jurisdictions will retain significant responsibility in either option and we need to leave counties able to meet their statutory responsibility.

*Ann Donnelly, Project Inform:* I have two concerns about the county option: 1) the variability of systems – not all providers are included in county systems. We need to leverage the infrastructure under Ryan White. 2) Network adequacy does not cover HIV because of the small numbers. We will need to ensure that county option includes a requirement to include providers out of network if there is not adequacy. For Ryan White, to offer wrap around it is not clear how they can interact with 58 systems. For those who fall into frail option, many HIV will qualify and it is difficult to see how that is cost saving for state. For some with chronic conditions, they might have three systems to deal with and it is problematic to see how they would navigate.

*Anthony Wright, Health Access:* Strongly support the LIHP, but I echo concerns of different standards and networks. I would not have supported LIHP as expansion program – it is only a bridge. It has taken two years to get 52 county implemented and it would be very difficult to imagine how every LIHP might scale up for this expansion. This is not truly a practical option given timing of approvals. I understand the need for decision in place for state/county relationship but it seems there is give in the timing. The full cost does not kick in for 3 years

*Douglas:* The 1115 waiver approval took work with federal partners. Approvals can be fast or slow and there are many moving pieces. We would have to explore how to get the counties up and running to make it statewide. The Administration wants to do this right and have it sustainable. We can't separate the many issues in regard to timing. There are many eligible consumers coming on the

program today based on the streamlining and other changes. This creates pressures now and means we can't separate the issues based on timing.

*Elizabeth Landsberg, Western Center on Law and Poverty:* The WCLP has many concerns regarding the county option. We hope the ACA will be about unifying, streamlining, making the program work for consumers. We understand the need to discuss funding including needs of residual uninsured. We want to resolve this and return to conversation about funding, including protecting the safety net.

*Kim Kruckel, Child Care Law Center:* Child care programs have been rooted in Dept Education for 70 years. Are there any programs in other state agencies being considered as part of this realignment?  
*Lightbourne:* All the other examples I mentioned are in HHS.

*Jason Kletter, CA Opiate and Maintenance Providers:* Substance Abuse is mostly nonexistent under LIHP. It will be important for state to have strong oversight of EHB in ACA. I noted that waivers would be required for the county option – what are these? Will Substance Abuse services continue to be carved out?

*Douglas:* The 1115 program is a good place to start to look at the types of waivers. We will not waive income or waiting lists. We are working to integrate care across systems. We expect under either option we would have continued conversations about aligning incentives and dealing with the whole person.

*Kim Lewis, National Health Law Program:* There are a number of legal and other issues likely to arise in the county option: benefits, accountability variation such as Knox Keene, network adequacy, timing delays and readiness. It would help to know when you would make a decision.

*Douglas:* There is conversation between the Legislature, Administration, the Counties and all of you. We have talked to federal colleagues about options.

*Tom Renfree, County Alcohol and Drug Program Administrators of CA:* Parity is a huge issue. I am concerned about implementation of parity under this.

### **Member and Public Input on Issues for Future Stakeholder Group Meetings**

#### ***Facilitated by Bobbie Wunsch, Pacific Health Consulting Group***

Please list issues for future consideration as part of the process on the index cards available for both members and the public. Additional issues might include Financing, Operations, Federal approval, the Delivery System and others. For those on the phone, send an email listing issues to [chhsinfo@chhs.ca.gov](mailto:chhsinfo@chhs.ca.gov). All the issues will be recorded in summary and will be used to structure future meetings.

#### **Discuss Process for Stakeholder Input**

***Toby Douglas, Director, Department of Health Care Services***

***Will Lightbourne, Director, Department of Social Services***

*Douglas:* Over the last several years, we have had an 1115 Bridge to Health Care Reform waiver advisory group. They provide discussion, input and oversight of waiver components. That will continue and is a separate process focused on waiver component. This discussion is about expansion alternatives. This first meeting was to help scope out and structure future meetings to flesh out the two options. Will and I will be at each meeting. We also have key staff to facilitate the content

and answer questions. Katie Johnson, HHS, Len Finocchio, DHCS, Sara Swan, Dept of Finance and Pete Cervinka, Dept of Social Services are all on the team working to support this process. We will put up a web site for this topic. It is likely next meeting will be the week of 2/18 or 2/25. We thank The California Endowment for funding this effort. We are so fortunate to have support of funders.

### **Public Comment**

*Kristin Jacobson, Alliance of CA Autism Organizations:* Has there been a policy decision for whether Medi-Cal expansion and current Medi-Cal population benefits will be same. We support similar benefits across existing populations, exchange populations and expansion. Can we participate in advisory committee or other ways to ensure Autism needs are addressed?

*Douglas:* The benefit package would be similar to Medi-Cal today without LTC and similar to Covered CA. We will have presentations at a future meeting about these benefits.

*Bruce Pomer, Health Officers Association of CA :* Health officers are concerned about the residual uninsured as it relates to realignment funding. There have already been massive cuts in public health at the local level from the state and the prospect of federal funding is dim. Anything to realign indigent care needs to take into account core health and chronic disease work.

*Chris Jensen, Resources for Independent Living:* The Independent Living Center of Sacramento and Yolo believe expanding health care is important and we believe single payer is the solution. We work in multiple counties and think that the state option will be consistent. Losing LTC services is a big deal and a concern. It was a step backwards when we eliminated optional benefits.

*Grace Trujillo, Parent:* My child had a fractured skull at birth due to saving the cost of C-section. Is there money being put into the system to prevent injuries at birth that end up costing more money later? Protocols and the standards are being reduced over time. The cost has an impact on whole society.

*Douglas:* Thank you for sharing your story. We are moving to more accountability and reporting on quality as well as payment systems to reward quality.

### **Public Comment on the Phone**

*Tina Kim, Community Clinic Association of Los Angeles County:* Whatever option is pursued, it must be developed thoughtfully. LA is strained beyond its limit. Together with CPCA, we support the state option. More than 1.2M in LA County will remain uninsured. We ask the state to look at realignment at the back end.

*Mark Romoser, Silicon Valley Independent Living Center:* Why was LTC exclusion singled out in the expansion?

*Douglas:* LTC is available today under Medi-Cal and will continue in 2014. The process to receive services requires eligibility based on disability and assets and other requirements. For the expansion population, the LTC benefit is not included. Consumers can become eligible through the existing system.

*Nina Weiler Harwell, AARP:* We are concerned about omission of LTC for populations 50 and older and urge that LTC be included.

*Karen Fessel, Autism Health Insurance Project:* I want to underscore the comments on autism. Many don't qualify for regional center services. No one participating as a member is representing autism.

*Steve Horn, CA Medical Transportation Association:* Will the expansion change who is eligible for medical transportation? Will you look at different monitoring of access to care that is easier to report difficulties with access? The current system is not effective.

*Douglas:* There will be more detail in benefits discussion.

## **Health Reform Stakeholder Meeting**

### **Topics and Questions Submitted: Members and Public Attendees**

#### **Policy and Systems**

##### **Member Input**

- What specific network adequacy and access monitoring procedures will be utilized prior to expansion being effective in Jan 2014?
- Toby described option 1 (state program) as an expansion of MCO members. How will we organize the expansion in the 26 counties without managed care? How might managed fee for service work for the expansion?
- Is there any willingness to require Knox Keene licensure for LIHP's in the expansion, since they will be acting as full coverage plans?
- Toby mentioned a comparable system of oversight similar to Knox Keene for county-designed delivery systems that were not managed care – this is troubling.
- Does it really make sense for consumers and providers to operate two distinct Medi-Cal systems going forward?
- Is modification or repeal of county responsibility for the medically indigent (section 17000) under consideration?

##### **Public Input**

- How will expansion be implemented in counties that cannot or will not voluntarily implement the expansion?
- Will LIHP's continue under the state option or will those programs be discontinued?
- Rules on network adequacy that would be expected under the county option. Also questions have been raised regarding payment of claims under the county option and how that would work and the cost impact to counties.

#### **Human Service/Other Realignment**

##### **Member Input**

- Integration of the ACA eligibility efficiencies into Cal-Fresh and Cal-WORKs, RCA, RMA, CAPI

- The childcare and/or other program realignment policy and financing issues are far too complicated and specific to address adequately in this larger forum. What will process be for a deeper discussion on this point with pertinent stakeholders?
- When/how will details of childcare realignment proposal be shared? Should we assume the proposal is identical to last year's proposal? Or is the point of this process to craft a proposal?

## **Cost/Financing**

### **Member Input**

- Statewide option:
  - only consideration is cost to state for taking on newly eligibles
  - not the same cost, efficiency of scale to administer program
  - know how much it will actually cost the state before funds are taken from the county
  - also assumes counties are currently adequately funded to provide the services they should be
- Is the county-based approach a way of demanding that counties give up revenue dedicated to the care of the Medically Indigent?
- Is the state comparing the costs of expanding LIHP's vs. expanding the existing Medi-Cal network? Will this be a factor considered as the process moves forward?
- What is the cost to the state for implementing the county/LIHP option, and expanding the counties infrastructure due to this new workload?
- The state has estimated the cost to the state GF of existing eligibles being enrolled in Medi-Cal to be \$350M. Has the state begun to estimate the cost to counties (who provide and pay for specialty mental health to Medi-Cal beneficiaries) of the existing eligibles becoming enrolled? If so, please provide details. If not, please describe plan.
- Would like further discussion and information regarding your assumptions about the idea that counties would save so much \$ under option 2 that they could both finance the benefits they would need to provide plus enter into an altered Realignment structure to generate state GF savings
- Realignment Issues:
  - What do we mean by realignment?
  - Establish a set of principles
  - Evaluate potential options based on principles
  - Only realign a program if it will result in better program outcomes
  - How do we ensure funding is adequate to meet future growth
  - How do we protect funds from diversion by counties or legislature

### **Public Input**

- Has there been any consideration to eliminating the county mental health plans and consolidating coverage with health coverage? The MH/SA funding could be funneled to the health plans. This should reduce county and state administrative responsibilities and costs.

- If the Administration is not considering the individuals that are not covered, including immigrants - will county costs for covering these individuals be factored in to the supposed savings?
- Realignment: scope of programs being considered, detailed financial information on each program and the Dept of Finance's estimate for county savings under the state option.

## **Eligibility**

### **Member Input**

- Under option 1, it would be good to understand more about Administration's thinking for the transition of those served today in county MIA programs (LIHP and beyond – not just LIHP) into an expansion program under MAGI rules, primarily from an access to care/continuity perspective
- How will you deal with numbers of folks that move in and out of Medi-Cal eligibility and the 138% of FPL Cap and perhaps into the 138-200 subsidy group?
- What is the process for transitioning new expansion enrollees into regular Medi-Cal should they become eligible (get pregnant, etc).

## **Benefits**

### **Member Input**

- We need a discussion of benefits package for expansion
- We would like to know how the state plans to implement and enforce the parity requirements of federal law for health plans and Medi-Cal to provide coverage for mental health and substance use disorder treatment at parity with other medical benefits
- What is status of 1115 waiver plan for meeting behavioral health needs (originally required by Oct 2012 but delayed to March or April 2013)
- Having everyone who goes to primary care screened for mental health and alcohol and drug needs through a 9 question self-completed form with co-located Mental Health professional to do evaluation and diagnosis and initial treatment is now proven to be cost effective paying for itself in physical health hospital reductions. It is part of Duals Plan (CCI) but not yet part of rest of Medi-Cal managed care – how do we make this universal? (It is my understanding that Minnesota and Colorado already do this)
- How are other states with Medicaid expansion plans dealing with LTSS benefits for newly eligible?
- What impact will the changes have on regional center consumers who currently receive health care as part of the Lanterman Developmental Services Act?
- Have you considered using the MCO tax to pay for restoration of adult dental services and providing that benefit to expansion population at little or no cost?

## **Public Input**

- What are the cost implications of different options for benefit packages?
- Restoration of optional benefits
- The federal Olmstead Act requires state's Medicaid plans to provide Medicaid alternatives to Long Term Care (LTC). Given Olmstead, how likely is it that CMMS will anticipate or even require Medicaid expansion plans to include home and community based services (HCBS) as an alternative to LTC?
- When the state option benefit is described as "a comparable Medi-Cal benefit" – how might that "comparable" benefit be different from the current existing Medi-Cal benefits?
- Transportation assistance to health care provider locations

## **Process and General Considerations**

### **Member Input**

- Discussion of how the work of this stakeholder group will be used to decide which option to proceed with.
- How are you going to engage the Legislature in this process? What happens if they don't like your approach and have other ideas?
- Discussion of the readiness activities the state would need to undertake for option 1, and assessment of how the state would improve current access issues in Medi-Cal under that option
- Assessment conducted of whether or not counties could do Option 2?

### **Public Input**

- When does the state need to decide between the two options (state/county) in order to implement them by Jan 1, 2014?
- Someone representing the Autism Community should have a seat at the table.
  - Is there a mechanism for a group representing the autism community to participate on this advisory committee?
  - There are a lot of issues with Medi-Cal expansion that affect autism differently, especially with the DSM5 changes. Unique needs of autism community need to be addressed and understood.
  - Has there been a policy decision on whether the benefit package for Medi-Cal expansion would be equivalent to Medi-Cal existing population?
  - Autism community agrees with the HIV community and would support similar benefits across existing/expansion Medi-Cal and Exchange populations to ease transition and continuity.

- Parity is a large issue for autism community. Implementing EHB's including mental health and substance abuse – behavioral health treatment and federal parity and habilitative and rehabilitative care.
- DSM 5 is going to result in large portion of autism community falling through cracks on EPSDT and mental health benefits. EPSDT excludes autism disorder. Now autism is primarily served through DDS/regional centers. Asperger's and PDD-NOS are served through county mental health. After DSM 5, all will be "autistic" no more Asperger's and PDD-NOS, but Aspergers and PDD-NOS will still not be eligible through regional centers and not eligible for county mental health. This needs to be addressed.
- Autism community would support statewide Medi-Cal expansion instead of county administration to have consistent benefits, Knox Keene protections, ease of use administratively – as long as that means benefits under Covered CA are in Medi-Cal.
- Standard of care for autism – behavioral health treatment/applied behavioral analysis (BHT/ABA) are not available through Medi-Cal but are going to be available through exchange EHB and private insurers.

## **Other Comments**

### **Member Input**

- Concerned that a county-centered expansion could lead to fragmentation long term with split between red counties and blue counties easing enrollment/access and benefits systems they offer
- Do you think it is appropriate to extort health plans good will for children in Healthy Families by not paying health plans? - extort the health plans to support the MCO tax?
- Is the HF program "cobra" provisions of AB2x needed or desirable if a "bridge" program is instituted?

### **Public Input**

- Standard of care is reduced to save money/prevent injuries from delivery of children: when standard of care or protocols are reduced or eliminated, managed care saves money in the short run but its costs are much more when there are injuries. Research needs to be done why there is a large amount of Mental Health Issues. Need to do research on long and short term saving. When hospitals want to save money they reduce or eliminate one step in their Medical Standard of Care Protocols. This leaves room for someone to get injured as a result of the reduction or elimination of procedures. The injuries acquired leave the person with life time care and medical expenses. The hospitals have short term savings but the tax payers end up paying long term care which is expensive. How to prevent birth trauma which causes mental health issues. Current saving \$26,000 saving/\$3.8M cost LTC.
- Can ACA funding be used to create "centers of excellence" for persons with autism or other developmental disabilities? The need for this population is growing rapidly but services have not kept up.

## COMMENTS SUBMITTED VIA WEBSITE

**Question:** If the 2nd option is chosen—realignment of services to the county level. What support/infrastructure building would be given to small counties that have not implemented a LIHP at this time?

**Question:** How will mental health and substance abuse benefits and service delivery be designed and implemented under both options? In particular, many of the newly eligible people will have some mental health problems but will not be severely mentally ill, and therefore not clients of county mental health systems. Will there be opportunities to provide more integrated medical (primary care) and behavioral health services for newly eligible people? How is this likely to differ depending on which option (state or county) is selected?

**Question:** I am a pediatrician who is very passionate, specifically about the underserved youth who are both uninsured or insured by Medi-Cal currently. I work as a medical consultant for California Children's services for Placer County. I also work as a volunteer medical provider at our county clinic as well as volunteer faculty for the UC Davis Medical Center. I am thrilled about the proposal to expand coverage for the uninsured but have significant concerns about access as in my experience it is quite difficult to get provider access for this population as it stands right now. I see this point in time as an opportunity to implement some changes in how we deliver care to this high risk population and focus on the Medical Home model in hopes of improving reimbursement and therefore to improve access.

1. In either of the proposals being considered has there been any discussion on how benefits will be structured and any change in emphasis on the reimbursement rate towards payments for enhanced medical home model of practice?
2. How will the county model program deal with the fact that this population can be notoriously mobile between residencies and counties and how will the management of their coverage when this change in residency occur?

**Question:** Will legal residents who have been in the country for less than 5 years (waiver of the 5-year bar to enroll in Medicaid after obtaining legal status) be able to enroll in Medi-Cal and the Exchange? I understand that this was an optional for the states and am not clear whether California has taken a position on it. I assume this ruling would be the same for the state expansion and the county expansion option

**Question:** Thanks for holding this event—we're very grateful to get more information about the Governor's proposal re: expansion. Under the state expansion option: if a number of social programs are shifted from to the state to the counties, would beneficiaries programs shifted to the counties maintain any pre-existing categorical

eligibility, based on the state criteria for state services? For instance, if CalWORKs became a county responsibility, would children in the program still be eligible for a state program like CalFresh?

**Comment:** I am writing as the executive director of the Autism Health Insurance Project and also a parent of a child on the autism spectrum. We are an advocacy and educational non-profit organization dedicated to helping families with children with autism get medically necessary services through their health care system.

Children with autism have a variety of health care needs, including the need for regular, comprehensive psychological and neuro-developmental assessments; regular, ongoing speech and occupational therapy, and daily intensive behavioral health therapy (also known as ABA). Most of these services are not currently available through Medi-Cal or EPSDT, and qualified providers that accept Medi-Cal are few and far between. Some of our population have been able to get limited services through the DDS sponsored regional center system, but many have needs and do not meet Lanterman criteria. Some regional centers routinely and inappropriately refer clients after age 3 to the school districts, which are ill equipped to handle many of these needs, most of which are health care services.

With the passage of SB 946, the people of CA have spoken. Private health insurance is now required to step in and provide direct services to this population. Research shows that these interventions, if provided early and with enough intensity, can have a large enough impact to make the difference between living a fully independent life and one with a huge amount of dependence.

California must step up to the plate and provide these services to low-income families as well. This population's needs must be included in the discussion, and set aside in the budget.

**Comment:** Thank you for convening the HCR Stakeholder Group on 2/1, and thank you for including me as a Member. I found the first meeting, which I participated in by telephone, very helpful to understanding the issues at hand and the proposed stakeholder process to work through them. My comment is to suggest a future topical meeting and/or sub-group meeting focused on the social services side – i.e., Child Care, CalWORKs, CalFresh and others listed by Director Lightbourne – that are also part of this state/county responsibility conversation. This topic may need to be sequenced after some of the foundational Medi-Cal discussions, and it may need to be broken out into sub-topics (e.g. child care may need its own session). But I look forward to having a forum where these issues can be addressed front and center, and would be happy to work with key staff on setting that up, if helpful. I look forward to hearing next steps and seeing more detail on potential proposals, as they emerge.

**Comment:** We look forward to a more streamlined and efficient “enrollment process” in the coming expansion of Medi-cal. We also support the continuing improvement of the quality of care and services for beneficiaries in need. Thank you for working with our organization.

**Question:** Newly eligible are going to move around, maybe a lot. County option (option 2) seems to imply that every move could require re-enrollment and change of delivery system. Am I understanding this? Kindly address electronic communication among counties now: current status, future vision, how this element of county-based administration could possibly work and why it would have to in order to accommodate normal population movement. Thx. Hellacious tradeoffs going on here. Thanks for the public process thus far.

**Question:** I'm a member of the stakeholder group for the expansion. There was a mention today in the meeting about seeking waivers of some federal managed care standards. What waivers might those be, and why might they be necessary/desirable?

**Comment:** It is critically important to review the variety of services that can be "swapped" with the counties resulting from the Medicaid expansion and the pros and cons of each. It is also important to have any other work groups report or have an update provided at each meeting such as the county/state work group. It will help to inform the entire process and discussion.

**Question:** On today's call it was mentioned that LTSS would not be provided by the plans, but would instead be provided through existing waivers and state run Medicaid programs. The information I have received so far indicates the plans would provide LTSS. Can you please clarify this point?

**Comment:** Thank you for the invitation to voice my concerns via e-mail as there was insufficient time to take Q&A from the audience other than the Committee Members.

As the Mother of a 37-year old son who was diagnosed with paranoid schizophrenia at the age of 22, I wish to voice my concerns and proposals to protect the most vulnerable in our Society from further budget cuts and to restore those previously made.

My concerns are that the two proposals so far discussed do not give special consideration for people with long term disabilities, the physically and mentally disabled. Please keep in mind that the first symptoms of schizophrenia appear between the ages of 18 to 25 (the brain is not fully developed until the age of 25), too young to have had a long-term career with health benefits.

In addition to implementing medication co-pays, the State of California dropped dental and optical Medi-Cal services coverage about 3 to 4 years ago. Those who are disabled and on Medi-Cal and do not have family members who can assist them financially, cannot afford these services. This has been a disaster for many of our consumers at SJC Behavioral Health Services. Oral health is very important for general health. Additionally, many consumers lost their teeth and cannot eat proper foods, are self-conscious about their appearance, cannot read anything they have to sign and seek more isolation – all of which will add to increased mental and physical health problems and health care costs. Please also keep in mind that Mental Health Research has been at an all-time low for years and all current anti-psychotics have serious physical side effects, including dyskinesia (old medications) or weight gain/diabetes (2<sup>nd</sup> generation). This also leads often to "self-medication" or substance abuse, for which services are almost non-existent.

Persons who will qualify for this proposed coverage due to low income have opportunities to achieve higher income levels over time in this great country of ours unlike those who have been disabled with a serious mental or long term physical illness at a young age.

Based on the above, I propose that you will create not only a "current" and "newly-covered" group but also an "existing disability group" to appropriately create the necessary safety net for those with long-term disabilities. Creating co-pays and cutting services, such as dental and optical, only increases the severity and cost to treat these illnesses.

My next concern is that the State will create a financial burden on the Counties. I am a Resident of San Joaquin County which is primarily agricultural, has a high rate of unemployment, a high rate of foreclosures, a high rate of homeless people (many with mental illness and substance abuse problems) and a high rate of undocumented workers.

My proposal is that the State assess and provide our County with adequate funding for mental health and substance abuse Services on parity with physical services.

**Question:** I submitted a couple of post cards during the meeting February 1, 2013. I just provided some of my thought and jotted down some incomplete questions I had at the time.

The time allotted in the public comment was not enough time to explain what happened to my son birth trauma which has caused him life time "mental illness"? I know my son is not the only one who has suffered by this.

I have also attached a copy of outline what I been through my son and questions.

These are just a couple of the questions I have.

1. **Recent studies have been done where they have determine that people who had a blow to the head, like football players, and vets who come back from war over time devolved mental illness. Does a complicated birth trauma cause mental illness? Does the use of forceps and vacuum to assist children during delivery cause mental illness? Have independent research studies been conducted?**

I feel it does. I have talked to parents where their son or daughter had a complicated birth, but their child birth score where great after birth. However, their mental illness does not come out until they are older.

I have spoken to some parents this has happened too.

**What is being done to prevent birth trauma by using forceps and vacuumed to assist a child during delivery that causes mental illness? Like my son.**

The past couple of years it has been very sad for us to know and find out this. Where are our patients' rights? Are medical staffs writing procedures, events and medications as they are done? Who is looking out for patients when we enter into a medical facility to get help?

We are both Accountants and we know too well about cost analysis. When accountants and hospital budget staffs get together to find ways to save money, it is a concern for us. Because they estimate that if they eliminate a procedure, they will save XX amount of money in a year. But no studies have been done to realize the LONG TERM impact. This needs to be looked in more closely.

When hospitals want to save money, they reduce or eliminate one step in their medical standard of care or hospital protocols. As a result, this makes standard of care smaller when this is done. This leaves room for someone to get injured as a result of the reduction or elimination of procedures. The injuries acquire leave the person with multiple disabilities and life time care and many medical life time needs. The medical field needs to go back and evaluate how much money they are actually saving by reducing or eliminating the standard of care and their protocols. The hospitals have short-term saving, but taxpayers end up paying long term care for disabled person with many medical needs. As everyone knows it is very expensive. No wonder the cost for MED-I-CAL, Med-I-Care and Health Insurance (Blue Cross, Blue Shields, Health Net and etc.) companies have increase so much these past decade.

My current understanding is that forceps and vacuum are only used unless it is medically necessary like in my son's care. However, all these standards of care and hospital protocols have been reduced over the years which hospital are forced to use forceps and vacuums much more in emergency. What does necessary mean? If standard of care or hospital protocols are reduced the chances forceps and vacuum are used are much higher.

2. **Hospital should not be the one determining their protocols and standards of care? This is a "conflict of interest" for the hospitals.**

Our son injuries as well as other could have been prevented. The smaller the standards of care or hospital protocols are there is more room for injuries. This is a **"conflict of interest"** for the hospitals. The hospital should not be the one's determining the standards of care or their own protocols. The one who should be doing it are MED-I-CAL, MED-I-CARE and Health

Insurance companies. They need to analysis the full Long TERM impact every time a standard of care or hospital protocols are reduced or eliminated because Insurance companies and taxpayer will be paying for it in the long run if injuries accrued. For example, Manage Care Hospitals are looking for ways of saving money and cut cost so they can offer low premiums. However, as a result, these hospitals cut corners to save money and cut cost by eliminating procedure or test this saves the hospital money. We have also noticed that when a law suit happens and a person is injured the protocols are revised so the hospital will not get sued again. By doing this, it allows other people to get injuries, but hospital and doctors are not liable because the hospital followed their protocols which have been reduced over the years. If prior patients have accrued injuries it is more than likely future patients will get injured as well. If the injured patients leaves that hospital and goes to another hospital to get treatment for their medical needs. That means the new Health Insurance companies, Medicare, or Medi-Cal ends up paying the medical bills for those patient injuries. If the patients decide to stay in that same hospital because they never finger out that their injuries could had been prevented. The hospital still makes money because they are treating the patients they injured as the result of reducing or eliminate protocols. For those reasons, Medi-Cal, Medicare and Health Insurance companies should determine standards of care or hospital protocols. The smaller they are the more room for error.

Bottom line (TAXPAYER) which is Medi-Cal and Medicare will be paying for those patients and our son's medical bills for life of injuries of which could had been prevented and Kaiser saved \$26,000. I believe this is happening more than taxpayer knows, Health Insurance companies and Department of Public Health needs to investigate this further. Since they are the one's paying for all their medical treatments and life time care. With programs like IHSS, Social Security, Mental Health, WIC, Welfare, Alta Regional, CCS, and all these different Federal and State programs.

As we mentioned above, we have no legal representation and we have no chance of winning our son's case without an attorney. As we mentioned before, Grace Wishes she had the strength to fight but she doesn't. Grace is currently still sick and she has these low grade fevers which vary through the day for almost 8 months. Grace is getting better, but she doesn't have the strength.

All we wanted was justice and the truth to come out for our son. If we were able to prove his case or not, we figured the taxpayers and the system fortunately will end up paying for our disabled son care once we died. He was left disabled and not able to take care of himself. If the services are still available, than.

If our son case would have been settled, we would not been able to talk about it. Just as so many other parents in the past who have settled and their medical records get removed and studies cannot be conducted. Maybe there is a reason behind all this. Now, Grace is well educated and able to help other children, so they will not have the same fate as our son. Grace is sure there is someone out there who is willing to look into the standard of care and hospital protocols.

**3. Has research been done to determine the impact when hospital protocols and standards of care are reduced? Long term impact?**

None, that I am aware of when the children are teens and adults.

**4. The Medi-Cal program should be located in one area just like Medicare.**

It is so difficult that the 58 counties are handling it. There is more room for errors, misuse, higher cost, and smaller offices do not have the staff to make quick changes and training necessary.

5. **Each hospital has their own hospital protocols. What is the guideline each hospital use to reduce or eliminate their own hospital protocols down each year?**
6. **In the panel of Health Care Reform Stakeholder Group I did not hear someone represent patients' rights?**

There needs to be patients' right advocacy in the panel. All babies, children, teens, adults or elders need to have the right of which medical provider they chose. I would not like to choose my medical provider. After what I have been through, I would not like to be in the network of Kaiser a manage care health provider. I am sure there are other people too who had bad experience with a particular manage care health provider and do not wish to go with them.

**Comment:** Thank you for inviting us to participate in the Health Care Stakeholder Group call held on Friday, February 1, 2013. Due to the large volume of participants, we wanted to send our comments via email. As you are aware Latino Coalition for a Healthy California (LCHC) is the only statewide organization that focuses its work on Latino health. With undocumented immigrants being left out of the health care reform process this leaves a huge void with our families, as such we need to insure we secure maximum State and Federal funding to strengthen our safety net clinics. In addition we have concerns regarding how this process will address the increasing vacancy of primary care physicians and lack of access to health care services. We continue to have great concerns on the lack of a culturally and linguistically competent/diverse workforce.

Ensuring the medical staff as a whole is providing competent linguistic services has been a challenge prior to health reform, how will this be monitored so that Latinos are able to make informed decisions about their health care?

Q: 1. How come the public is being informed that the transition is going smoothly, when in fact there have been issues? How are you honestly handling the transition issues? Are they being dealt with and not ignored, just to keep pushing the Phases along? Such as:

- 3 counties have already experienced problems with the transition: San Mateo, San Diego and Orange County
- Technical issues with the program - as guidelines and test parameters still have not been produced by the Government
- Consumers not being able to access care
- Children are being dropped completely from coverage
- Families that have siblings - some siblings were transferred to Medi-Cal while other siblings remained in Healthy Families
- Medi-Cal receiving renewal packets for Healthy Families

Lawsuit filed in December stating the recipients' rights were violated and they lost access to their doctors in the transition:

<http://www.latimes.com/news/local/la-me-medical-lawsuit-20121223,0,4294383.story>

2. What is being done for those who are being dropped from their plans due to the transition? How are you handling the consumers that are falling thru the cracks?

3. Regarding the Optional Expansion for Medi-Cal, what is being done on the county side to check their funding to see if the county-approach is even a possibility that should be considered? Esp.

those counties who are bankrupt, those who will be filing for bankruptcy within the months ahead, and for those counties that have no money to spare?

3a. What happens when people move ... happens all the time, esp. now with our horrible economy ... from one county to the next. How will you handle their coverage if the State takes the county-approach expansion?

4. Specialists - for those with disabilities .. what is being to protect them? To ensure that they will continue to have access to their specialists, MD's, prescriptions, etc.?

5. Are you seriously monitoring the transition? What I mean is this ... issues that are coming up because of the transition, are they really being looked at and given a fair shake ... as they foreshadow what will come about in the future transition phases ... or are you just pushing it through and hoping upon hope that all the issues that are happening will just .. go away?

**Comment:** First and foremost – we appreciate the invitation to provide input both through written comments and participation in the Healthcare Reform Stakeholder Group meetings. Community Health Councils' is writing to express some of the concerns and reservations we have regarding the State's outlined proposals for the optional expansion of the Medi-Cal program. It is our expectation that the expansion program will at a minimum:

1. Provide equitable access to healthcare across counties;
2. Ensure a set of standardized benefits and services comparable to the current Medi-Cal program;
3. Provide for the seamless transfer and eligibility of enrollees across county boundaries;
4. Standardize and simplify eligibility determination and enrollment across counties;
5. Expand consumer choice of healthcare providers;
6. Provide minimal or no disruption in continuity of coverage and medical care for current Low Income Health Program enrollees;
7. Leverage state funding and maximize all available federal funding;
8. Improve the distribution of healthcare resources to increase access in under-resourced communities;
9. Reduce administrative cost and not shift costs to the county; and
10. Fully incorporate the healthcare safety net to ensure continuity of care and preserve the financial viability of the system for the continued uninsured.

Although the Governor's proposed 2013-2014 state budget put forth two proposals for the optional Medicaid expansion, the county-operated option seems far more problematic given the current timeline for implementation and the potential impact on the stability and sustainability of the program. We are concerned that the county option perpetuates a fragmented system which clearly divides current and future Medi-Cal beneficiaries, and would argue that splitting the expansion program from the existing Medi-Cal program conflicts with the ACA requirement for simplification. Additionally, the recent consolidation of the Healthy Families Program into Medi-Cal was accomplished in order to minimize fragmentation of our existing health coverage system. It would seem as though the county option further fragments the system as parents may have their children enrolled in one program and they themselves in another. We continue to be concerned about the real or perceived perception of a "two tier" system of healthcare coverage with the exclusion of the Medi-Cal program in the new Covered California Health Benefit Exchange. We caution the state against unintended consequences of a decentralized county run program in this day of health reform. The budget notes that the county based expansion would build off of the existing Low Income Health Programs (LIHP) and that

“counties would act as the fiscal and operational entity responsible for the expansion”. However, the number of individuals enrolled in the LIHP pales in comparison to the projected number of newly eligible Medi-Cal beneficiaries.

The Legislative Office acknowledges that some counties may need a significant amount of time to prepare for such a project<sup>1</sup>. While many of the counties have developed a health delivery system and administrative infrastructure – we question if this capacity is sufficient to take on the many administrative roles that would be expected with increased demand. The counties must be prohibited from placing caps on enrollment based upon network capacity or financial constraints

A recent report by the CalSIM projects an influx of \$3.5 billion in federal Medi-Cal spending, which will cycle through the healthcare system and result in \$190 million in State General Fund revenue thus partially offsetting the \$453 million GF increase in Medi-Cal spending. A County-based approach could significantly alter the flow of federal dollars and much of the anticipated increase in GF dollars could be diverted to administration of 58 separate Medi-Cal expansions and unequal access to healthcare coverage across the state.

We have experienced the inability to fully implement the “two-plan” model in every county and seen historically significant variance between counties in the implementation of eligibility determination. The “all or nothing/one or the other” position the state is taking is problematic given the significant variance in capacity of the 58 counties. Should the state decide to implement the county run option - counties should be able to opt-out and the state must be prepared to provide the necessary infrastructure and administrative support in this instance.

The long term sustainability of the expansion effort and the health of over 1.4 million newly eligible Medi-Cal beneficiaries<sup>3</sup> are at stake in these proposals, and the decision to create a county based Medi-Cal Program should not be made without a comprehensive assessment of county readiness, the impact on access to care and the development of a series of criteria for participation. The assessment and eligibility criteria for a county run program option should include, but not be limited to the following:

- An assessment of the financial health of the county and development of specific financial reserve or bond requirements similar to what is required under state law for a HMO;
- An assessment of the patient to physician capacity, geographic coverage, specialty care capacity and language access of the provider network followed by the development of specific threshold standards;
- The development of a required set of standardized basic services;

The proposed county operated system also raises the following additional questions:

- The state has a well-developed oversight process for the Medi-Cal Program that includes grievance and appeals protocols as well as plan management. It is not clear how much of this the state will continue to offer under the new county option, or if the state will now need to create an entirely new process for reviewing what is implemented in 58 separate programs.

-Local social services offices would continue to conduct enrollment and eligibility within the county option. This is an administrative cost that is currently paid for by the state. ***Would counties now assume this payment for newly eligible or would the state continue to compensate counties for this function?***

-Currently Medi-Cal services for Legal Permanent Residents under the 5 year federal ban are paid out of the State General Fund. ***Will the state continue to provide additional funding to counties to serve this portion of the newly eligible population or will the cost be absorbed by the county as part of the financial liability and responsibility under the new county run system?***

We trust that we have provided an objective perspective from the vantage point of consumers who will be the end users of the new expansion program. Thank you again for the opportunity to provide our input and analysis. We look forward to continuing our participation on the workgroup and dialogue with the agency.

**Note: (refer to email dated 2/5/2013 from Annie Park for letter attachment)**

**Question:** I listened in today but it wasn't what I was expecting. We are heavily involved in advocacy for mental health services in the implementation of the ACA, but today's call was about draft regulations for parts of implementation of ACA but also for legislation and court orders. I am not well versed enough on Medi-Cal rules for the document to be useful to me without hours and hours of reading and analyzing. ***Is there a summary of the proposed changes and when are comments due but they didn't allow for questions?***



