



The Bridge to Reform: How Can California Be Ready for Reform & Expansion on Day One, Through the Medicaid Section 1115 Waiver

The enactment of federal health reform creates new framework and goals for the Medi-Cal program, especially in light of current discussions to renegotiate the California Medicaid hospital waiver for the next five years.

The Section 1115 waiver should focus on expanding coverage as a bridge to implementing national health reform in California in 2014 and beyond.

Medi-Cal is a considerable benefit for the state of California, covering 7 million Californians and bringing in billions in federal matching funds for our health system and our economy. We can use the waiver to take advantage of the opportunity of health reform to cover as many Californians as possible by engaging in effective expansion and enrollment efforts, and bringing in massive federal money that would help our state's providers and our economic recovery.

Those who argue that Medi-Cal is unaffordable overlook the very considerable economic benefits of the program, including job creation as well as federal dollars to California. California failed to take full advantage of the benefits of the creation of S-CHIP, foregoing millions of dollars in federal assistance. Failing to get ready for health reform would be an even more costly mistake for our economy, since the federal government will fund 100% of the cost of expansion populations in 2014-2017 and 90% after 2020.

In our discussions with the Obama Administration officials, we have learned that the Obama Administration is committed to early implementation of national health reform. We believe that efforts to undermine health reform, cut eligibility, or make other cuts go backwards from the direction provided by the new law. We believe that waiver negotiations will be more successful if it embraces early implementation and enrollment of new Medicaid patients, and is seen as providing early, demonstrable success of health reform.

Medi-Cal Waiver: A Bridge to Health Reform?

Health Access proposes a number of steps designed to smooth the cost curve of implementation and maximize federal revenue, particularly leading up to 2014, through early implementation of federal health reform through both targeted expansion and pre-enrollment activities.

The provisions in the recently-enacted health reform legislation will be implemented during the term of the 1115 waiver, which would run from 2010 to 2015. Many of the key elements of health reform, including the Medicaid expansion, would be implemented in 2014.

The new law requires states to expand their Medicaid programs on January 1, 2014 to non-elderly adults and children up to 133% of the federal poverty level (\$29,400 for a family of four). This includes people with disabilities who may not otherwise be sufficiently disabled to qualify for Medi-Cal and importantly childless adults, who generally could not be covered under Medicaid under prior law without a waiver.

The federal government is picking up the overwhelming bulk of the expansion costs, providing over \$70 billion over ten years to subsidize coverage for Californians. Over \$33 billion is new money to California

through Medicaid. The federal matching rate for “newly eligibles” averages 97% over the first ten years, and will be:

- 2014-2016: 100%
- 2017: 95%
- 2018: 94%
- 2019: 93%
- 2020 and beyond: 90%

The regular match (normally 50%-50% for California) will apply for current eligible Californians who newly enroll. States have the option to cover new populations at regular Medicaid match starting on January 1, 2011: while this may not be feasible in California given our current budget crisis, we believe it is essential to plan for responsible implementation in the 1115 waiver.

The “reconciliation” package of improvements to the health reform law not only includes increased state aid, but also requires states to increase primary care physician rates to 100% of Medicare in 2013 and 2014 with the federal government picking up 100% of the increased costs.

For the newly-eligible population, states are required to provide “benchmark” benefits to the newly eligible population, rather than the regular Medicaid package. The state can determine these benchmark benefits, and whether they are as good as a regular Medicaid package or much weaker, akin to typical private insurance plans.

Eligibility would use new income counting rules starting in 2014, based on modified adjusted gross income (which is similar to tax code to allow better alignment). It would take existing disregards into account by allowing 5 percentage point bump-up. The bill also extends presumptive eligibility option for children and pregnant women to newly eligible populations (and existing parents), and must have coordinated procedures with exchange. The asset test is also eliminated, except for long-term care.

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

As its top priority, the new waiver should enable California to be ready to take advantage of the enhanced federal match (100% for newly eligibles) on Day One of health reform, January 1, 2014.

On top of the existing 7 million Californians with Medi-Cal coverage, there are potentially over 1.7 million newly eligible Medicaid patients (according to the UC-Berkeley Labor Center analysis). That number has probably increased along with the rise in the uninsured, as reported by UCLA which estimated recently that the number of uninsured has jumped from 6.4 million in 2007 to 8.2 million in 2009. While we all hope that the economy has recovered by 2014, whether the number of uninsured will drop concomitantly is not clear.

The waiver should include a plan by which at least one million of those newly eligible Californians are enrolled in the first few months. Take-up of Healthy Families was slowed in the late 1990s due to unnecessary barriers to enrollment. California should not repeat those mistakes – we will pay a high price in lost federal revenues to our economy if we do. California will get a higher federal match in the beginning years 2014-2016 (100% federal financing in the first three years) than in the later years (90% federal financing in 2020 and beyond). We’ve learned a lot about how to effectively and efficiently enroll Californians in public programs—from identifying the person or family, helping them fill out the necessary paperwork, not making it too complicated, being culturally and linguistically competent, and assisting with retention and utilization.

The new reform provides California with a new baseline for negotiations on the waiver. Previously, we were dealing with our current program, where we already have the least expensive per-patient Medicaid program in the nation, so it would have been hard to make large claims about savings beyond our already frugal ways. California should argue that our state should get credit for past efficiency, but we can even more credibly claim that we will be frugal with the new population, and that we merit savings back.

Savings from improved efficiency should be invested in expanding coverage. Health Access proposes both targeted expansions and various mechanisms for pre-enrollment.

Recognizing the current budget crisis, Health Access proposes that broader expansions be included in the waiver, but contingent on a trigger. These broader expansions could be triggered in advance of 2014 as revenues become available, due to savings, improvements in the economy, ballot measures, or other sources.

A powerful argument for any pre-enrollment activity is to identify people who are eligible, and get them signed up so they are covered on Day One. An additional argument for providing any care is to prevent a spike in use due to pent-up demand. Typically, a previously uninsured population will use more care in its first years of coverage because of care deferred or health conditions made worse by lack of care. Early enrollment, both of targeted populations and broader expansions, can help to smooth the cost curve for the newly eligible population as well as those eligible but not continuously enrolled.

The Section 1115 waiver creates an opportunity for California to be ready to maximize federal revenue in those years. Early implementation of federal health reform should be designed to smooth the cost curve of expanded coverage by mitigating the impact of pent-up demand by previously uninsured populations. Health Access proposes a series of steps to address pent-up demand of previously uninsured groups in 2010-2013 in order to help smooth the cost curve in 2014-2016.

Health Access proposes the following changes as a bridge to national health reform:

① *Expand Medi-Cal Coverage to Targeted Populations*

Health Access proposes that in 2010-2013 California expand Medicaid coverage to targeted populations as revenue is available, either from savings realized through the waiver, from an improving economy, from ballot measures or from other sources.

Specific populations that could be targeted include:

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

② *Establish Auto-Enrollment for Infants in 2010*

Health Access proposes that any infant born to a parent that is uninsured or on Medi-Cal should be deemed eligible and automatically enrolled in Medi-Cal at birth. Any infant that is born to a parent covered by the Access for Infants and Mothers (AIM) program should be automatically enrolled in Healthy Families at birth. Existing law already provides auto-enrollment of uninsured infants into Medicaid but barriers to enrollment have undermined the effectiveness of this policy.

Given that any infant born in this country meets citizenship requirements as a result of the United States Constitution, automatic enrollment will assure health coverage during the critical first months of life. This approach is administratively efficient because it obviates the need for verification of citizenship under the Deficit Reduction Act of 2005 (DRA).

It would also eliminate the county-by-county variation in enrollment of infants. The waiver should provide for auto-enrollment of infants upon approval of the waiver. While technically some infants are currently eligible for Medi-Cal, unnecessary barriers impede enrollment of infants in Medi-Cal or Healthy Families: the burden should be on the government, not the parent, to make enrollment happen. That's what auto-enrollment is.

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

Health Access proposes that the Coverage Initiatives currently in place in ten counties be revised and extended to serve as a gateway to enrollment of childless adults into Medicaid when it is expanded to cover childless adults in 2014, or earlier if state revenues recover. Today, 100,000 Californians are enrolled in the Coverage Initiatives: the Coverage Initiatives are a good means of smoothing the cost curve by addressing pent-up demand in advance of expanding Medi-Cal to childless adults. Indeed, those who have signed up for the county Coverage Initiatives are disproportionately those with significant health care needs.

Enrollment in the Coverage Initiatives needs to be further increased both to smooth the cost curve of pent-up demand and to create a gateway to fast enrollment in Medi-Cal coverage for childless adults in 2014.

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

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

Health Access suggests that since the counties will be providing the non-federal match through Certified Public Expenditures, the county hospital and health system should be the anchor of the provider network under the successor to the Coverage Initiatives. This approach has already been demonstrated by Healthy San Francisco. By creating medical homes anchored in the county hospital system along with community clinics and other private providers as appropriate, coverage initiatives can become the medical home for childless adults once they are eligible for Medi-Cal in 2014.

To the extent that the individuals covered by the Coverage Initiatives have mental health and substance abuse issues, expansion of the Coverage Initiatives can help counties to better manage costs arising from not only mental health and substance abuse treatment but also other social services as well as jail costs.

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

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

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

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

⑤ ***“Frequent Flyers” Program***

A series of demonstration projects have indicated that a small number of individuals use the emergency room with much greater frequency than other uninsured individuals. The cost of these “frequent flyers” affects not only Medi-Cal but also other human services, including mental health and substance abuse services. Early implementation of a frequent flyers program would mitigate pent-up demand for care while relieving the strain on emergency rooms in advance of coverage expansions. The Western Center on Law and Poverty estimates that enrolling 10,000 frequent users into a program could save Medi-Cal over \$13.5 million annually with a two-year startup.

⑥ ***Simplify Eligibility Determinations: Initial Income Test, Self-Certification of Income, Presumptive Eligibility***

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

Health Access California also supports self-certification of income. Preliminary data for pilots on self-certification done in Orange and Santa Clara Counties indicated that the pilots worked well, and a Lewin Group study estimates that Californians could save \$6 million in administrative funds. We suggest both simplification procedures should be implemented in 2011 as part of the waiver and in preparation for implementation of health reform.

In addition, the state could adopt presumptive eligibility procedures for children and pregnant women in Medi-Cal, which under health reform legislation, could be extended to new populations. By adopting the simplified procedures as part of the waiver, the state will have the systems in place to extend those procedures to new populations when enrollment begins.

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

The federal health reform legislation eliminates the asset test for those Medicaid beneficiaries who are not long-term care eligible. Health Access California supports the proposal of Western Center on Law and Poverty and others to eliminate the asset test effective in 2011.

⑨ ***Eliminate the Churning of Coverage by Creating Default to Re-Enrollment in 2012***

To quote Western Center, *et al.*,

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

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

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

In a health reform construct that relies upon an individual mandate to assure continuous coverage, churning increases both administrative costs and health services costs while undermining individual compliance with the mandate. To minimize churning in Med-Cal, Health Access proposes that in 2012-13, Medi-Cal convert to a system of defaulting to re-enrollment rather defaulting to disenrollment as in the current system.

⑨ ***Beyond No Wrong Door: Automatic Enrollment Whenever Life Changes***

The concept of “no wrong door” is designed to assure that whenever a family or individual tries to sign up for public coverage, they find that every door is the right door and leads them to the coverage they need. This is an important policy concept that should not be lost in the transition to health reform.

But we must build beyond this construct. No “wrong door” suffers from the same policy flaws as the assumption that individuals will sign up for 401k’s and allocate their dollars appropriately given their risk tolerance and life circumstance: while some people did, many did not. We need to move to a policy construct in which at every change in life circumstance, enrolling in affordable coverage is relatively automatic: lose your job, keep coverage through the exchange or Medicaid; have a baby, the baby is covered on your coverage at work or through public programs; change jobs, keep coverage through the transition; lose your spouse, keep coverage through the exchange or Medicaid.

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

Health Access California has been participating in the current waiver Stakeholder Advisory Committee and technical workgroups, and was also an active participant in the debate over the previous waiver negotiated in 2005.
