State of California

ARNOLD SCHWARZENEGGER
Governor

Medi-Cal Redesign
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Health and Human Services Agency
S. KIMBERLY BELSHÉ, SECRETARY

Department of Health Services
SANDRA SHEWRY, DIRECTOR

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
MEDI-CAL REDESIGN

BACKGROUND

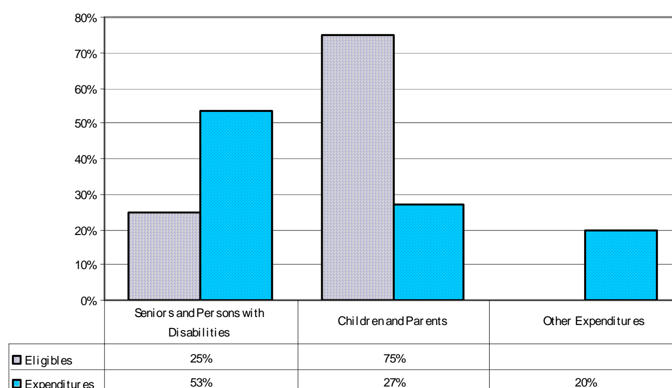
California's Medi-Cal Program provides medical assistance for qualified individuals with low income under Title XIX of the Federal Social Security Act. The California Department of Health Services (DHS) administers the program with the federal government providing a matching Medicaid reimbursement rate of 50 percent. Currently, Medi-Cal provides health care services to 6.6 million Californians – just under one in five Californians receive their health coverage through the Medi-Cal program.

Medi-Cal has been providing health care services to Californians since 1965. It is the health care funding source for low-income children, their parents, pregnant women, and seniors and persons with disabilities. In addition to providing those benefits that are required by federal law, California is one of eight States that provide a wide range of optional benefits.

Medi-Cal serves a dual role in providing health care for individuals while also providing funding for California's health care system. Medi-Cal is a primary funding source for the State's mental health programs, programs for the developmentally disabled, in-home supportive services, county health services and school-based health care services. Medi-Cal is also a critical funding source for the State's "safety net" providers - hospitals and clinics that serve a disproportionate number of Medi-Cal beneficiaries and indigent patients. Medi-Cal pays the medical expenses for almost half of all births, for two-thirds of nursing home days and is the largest source of public funding for mental health services in California.

Children and their parents comprise 75 percent of the Medi-Cal beneficiaries and account for 27 percent of the program's costs. Seniors and persons with disabilities account for 25 percent of the beneficiaries and 53 percent of the expenditures. The remaining 20 percent of expenditures include supplemental payments made to hospitals that serve the indigent; the Family PACT Program's family planning services; the Breast and Cervical Cancer Treatment Program services, the Child Health Disability Program Gateway pre-enrollment services; and targeted case management services

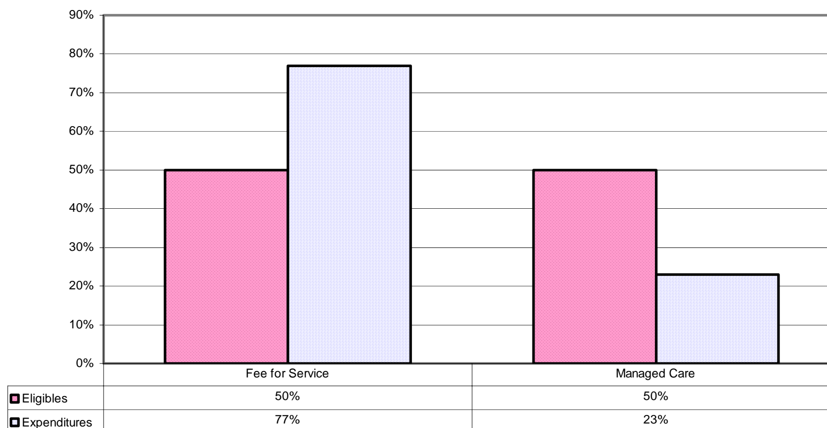
Medi-Cal Eligibles and Expenditures



	Seniors and Persons with Disabilities	Children and Parents	Other Expenditures
Eligibles	25%	75%	
Expenditures	53%	27%	20%

Two delivery systems serve Medi-Cal beneficiaries. The fee-for-service system operates in all 58 counties, serves 50 percent of beneficiaries (primarily seniors and persons with disabilities, pregnant women, and parents and children who need emergency or catastrophic care), and accounts for 77 percent of expenditures for Medi-Cal beneficiaries. The managed care system operates in 22 counties, serves 50 percent of beneficiaries (mostly children and their parents), and accounts for 23 percent of expenditures for Medi-Cal beneficiaries.

Medi-Cal Fee-for-Service and Managed Care



	Fee for Service	Managed Care
Eligibles	50%	50%
Expenditures	77%	23%

MEDI-CAL PROGRAM COSTS AND CHALLENGES

California operates one of the most cost-effective Medicaid programs in the country and covers a greater percentage of its population than most other State Medicaid programs. Notwithstanding the cost effectiveness of the State's Medi-Cal program on a per capita basis, program costs represent significant and growing General Fund expenditures. Medi-Cal is the 2nd largest expenditure in the State budget behind K-12 education. Program expenditures exceed $34 billion per year ($12.9 billion in State funds in the Governor's proposed budget for 2005-06).

Since 1998-99, General Fund expenditures in Medi-Cal have grown by 60 percent or approximately $4.5 billion. Much of this increase stems from program expansions and reforms that added 1.2 million of the total 1.6 million new beneficiaries - a 32 percent increase in total population covered. These expansions provide comprehensive health care coverage to previously uninsured working families and children and seniors and persons with disabilities. While these recent policy and program changes have afforded greater access to health care to previously under- or uninsured individuals, they have contributed significantly to increased program costs.

Enrollment of seniors and persons with disabilities, both those eligible for the Supplemental Security Income/State Supplemental Program (SSI/SSP) and those applying for or eligible for the "Medi-Cal Only" program, continues to grow as the population ages. Over the past three years, there has been a 13 percent increase in the number of eligible seniors and persons with disabilities enrolled in Medi-Cal. This represents an increase of approximately 193,000 individuals with costly medical needs.

Seniors and persons with disabilities typically have two or more chronic health conditions requiring overlapping treatment modalities. The treatment regimes for these individuals typically involve the use of multiple medications and hospitalizations in both acute and long term care settings. Pharmaceutical costs and acute care costs represent the two largest components of Medi-Cal expenditures for seniors and persons with disabilities.

With the exception of the five County Organized Health Care Systems, seniors and persons with disabilities enrolled in Medi-Cal receive care through the fee-for-service program. Under this care model, there is no active management or coordination of health care services and access to providers (specialists in particular) is limited, thus the most vulnerable individuals are left to manage their own complex health care needs. This unmanaged care can result in inappropriate utilization of services, inadequate care and needlessly high program costs. In counties where seniors and persons with disabilities have a choice to enroll in managed care, approximately 10 percent of them have enrolled.

Prior efforts to limit the expenditure growth trends in Medi-Cal have resulted in the low average per person costs of the program. Efforts to maximize federal reimbursement have also helped to slow the growth of Medi-Cal State costs. However, while the State has much to be proud of with regard to the history and operation of the Medi-Cal program, the continued and increasing fiscal demands place the long-term financial viability of Medi-Cal at great risk while also jeopardizing the State's ability to fund other programs. If left unchecked, the growth of Medi-Cal will exceed the growth of State revenue, causing reductions in other areas of the State budget. The magnitude of the Medi-Cal program in terms of people served and dollars expended compels close examination of the program structure, financing methodologies and operational activities.

REDESIGN OBJECTIVES AND PRINCIPLES

Governor Schwarzenegger is proposing to redesign Medi-Cal in order to advance the twin imperatives of maintaining health care coverage to eligible Californians, while containing costs and maximizing operational efficiencies. These efforts will provide for the long-term financial viability of Medi-Cal and lessen its impact on the overall State budget.

Restructuring of Medi-Cal will help to support the program's ability to continue to serve existing eligible groups; increase access to care; and improve health care outcomes. In working toward these objectives, the Medi-Cal Redesign effort is guided by the following principles:

- ✓ Maintain essential services to children and those most in need;
- ✓ Improve access to care;
- ✓ Promote the use of preventive services and early intervention;
- ✓ Encourage the appropriate use of services;
- ✓ Maximize community integration for persons requiring long term care services;
- ✓ Require affordable financial participation;
- ✓ Align benefit levels with private and public sector health coverage programs;
- ✓ Stabilize and protect funding for California's health care safety net; and
- ✓ Maximize federal funds.

MEDI-CAL REDESIGN POLICY INITIATIVES

The following briefly summarizes the key policy initiatives that comprise the Redesign effort. Each initiative is more fully described under the Medi-Cal Redesign Components section:

Increase Access to Care and Improve Health Outcomes through Managed Care Expansion:
This proposal will expand the geographic areas in which managed care is available and will expand the populations groups within Medi-Cal who are enrolled in managed care. Today, managed care is available to Medi-cal beneficiaries in 22 counties. When Medi-Cal Redesign is fully implemented, managed care plans will be available to Medi-Cal beneficiaries in 35 of California's counties. Families and children in 13 additional counties will enroll in managed care plans; certain seniors and persons with disabilities will enroll in managed care plans in all counties in which managed care is available (seniors and persons with disabilities are currently required to enroll in the existing 8 counties where the County Organized Health System model is operational). Acute and long-term care integration (medical and social services) projects will be implemented in three counties and will utilize a Long Term Care Diversion and Assessment Protocol to assess and divert individuals from costly long-term nursing facility care.

Stabilize the Financing of California's Safety Net Hospitals:
This proposal will pursue a new five-year Medi-Cal hospital financing "waiver" with the federal government to replace the current waiver that expires June 30, 2005. Major components of this waiver include continuing contracts with selected hospitals, replacing intergovernmental transfer funding with federally-acceptable sources of funding; preserving hospital financing for the uninsured irrespective of whether Medi-Cal beneficiaries are served through fee-for-service or managed care; and replacing the current funding methods with new systems that create opportunities to draw down additional federal Medicaid dollars.

Modify the Medi-Cal Benefit Package:
This proposal will align the Medi-Cal dental benefit package provided to adults with the benefits commonly provided in employer-based and public sector health coverage programs by placing a limit on adult dental services. This limit will be $1,000 in a 12-month period. This modification in dental benefits will cover the majority of beneficiaries' dental needs, including the cost of dentures. The limitation excludes the costs of federally mandated dental services, hospital costs associated with dental treatment, and emergency services.

Beneficiary Cost Sharing:
This proposal will institute monthly premiums for individuals with incomes above 100 percent of the federal poverty level and for seniors and persons with disabilities, with incomes above the Supplemental Security Income/State Supplemental Payment (SSI/SSP) level. Premium amounts will be $4 per month for each child under 21; $10 per month for adults with a monthly premium cap of $27 per month per family. Select populations participating in the Medi-Cal program, including those in the Medi-Cal share-of-cost programs, will be exempt from this proposal.

Improved Eligibility Processing for Children:
This proposal will streamline the Medi-Cal eligibility determination process for children whose applications are submitted through the Healthy Families Program vendor, known as the Single

Point of Entry. Medi-Cal applications for children that are received by the vendor will be processed by the vendor, instead of being forwarded to a county for processing. The single point of entry will be a centralized one-stop center to make eligibility determinations for Medi-Cal applications for children. The vendor will make a preliminary determination and, as required by federal law, a government employee will certify the child's eligibility for Medi-Cal.

MEDI-CAL PROGRAM IMPROVEMENTS

The following programmatic initiatives are presented as additional enhancements under Medi-Cal Redesign. These initiatives will further the objectives of cost containment and operational efficiencies for Medi-Cal.

County Performance Standards Monitoring:

This proposal will secure vendor services to monitor county compliance with federal and State performance standards pertaining to eligibility determinations and annual redeterminations. Currently, counties annually self-report to the State whether they have met all required performance standards. There is no State verification of these efforts. To assure that the program is being uniformly administered consistent with State law, this proposal implements a process of compliance monitoring. If lack of compliance is determined, fiscal sanctions against the county will be pursued.

Provider Enrollment:

This proposal will improve the process by which providers enroll in Medi-Cal. This proposal will be introduced in the spring of 2005 and will reduce the processing time of applications received.

MEDI-CAL REDESIGN COMPONENTS

The Administration's Medi-Cal Redesign proposal is as follows:

Increase Access to Care and Improve Health Outcomes Through Managed Care Expansion

California utilizes three managed care delivery models to provide health care to 3.2 million Medi-Cal beneficiaries. These models, the Two-Plan, the County Organized Health Systems, and Geographic Managed Care, are described below:

Two-Plan
The Two-Plan model of Medi-Cal managed care is available in twelve counties. In 1996 Alameda County became the first Two-Plan managed care county. The other Two-Plan counties include Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. In each Two-Plan county, the Department contracts with one locally developed health care service plan known as the Local Initiative and one Commercial Plan selected through a competitive procurement process. Fresno County did not develop a Local Initiative and therefore has two Commercial Plans. In general, enrollment is mandatory for families and children. The non-mandatory eligible groups (mostly seniors and persons with disabilities) access services through Medi-Cal's fee-for-service delivery system or can choose to enroll in a health plan. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment.

County Organized Health Systems
County Organized Health Systems are health-insuring organizations that are organized and operated by a governing board appointed by the county's Board of Supervisors. The first plan was implemented in Santa Barbara County in 1983. All Medi-Cal beneficiaries residing within the county are required to enroll regardless of their eligibility category, including individuals who are Medicare/Medi-Cal dual eligibles. There is no Medi-Cal fee-for-service delivery system in these counties. Five County Organized Health Systems plans operate in eight counties: Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo.

Geographic Managed Care
Under the Geographic Managed Care approach, the Department contracts with multiple health plans in the county. In contrast to the competitive procurement for the commercial plans in the Two-Plan model, contracts for Geographic Managed Care are secured via a non-competitive application process in which any plan meeting specified State requirements/standards is permitted to negotiate a contract with the State. In counties with the geographic managed care approach, Medi-Cal beneficiaries choose from among the multiple commercial managed care plans. This model has operated in San Diego County since 1996 and in Sacramento County since 1994. In these two counties, enrollment is mandatory for families and children. The non-mandatory eligible groups access services through the Medi-Cal fee-for-service system. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment.

Proposal:
This proposal will expand the geographic areas in which managed care is available and will expand the populations groups within Medi-Cal who are enrolled in managed care. The geographic expansion of managed care will be achieved by expanding the use of the County Organized Health System and the Geographic Managed Care models. Seniors and persons with disabilities are the population groups included in this expansion.

Today, 3.2 million Medi-Cal beneficiaries in 22 counties receive services through the Medi-Cal managed care program. Under this proposal, by Fiscal Year (FY) 2008-09, approximately 816,000 additional beneficiaries would receive health services through managed care arrangements, as follows:

- ✓ Families and children will enroll in managed care in as many as 13 additional counties (approximately 262,000 people):
- ✓ Certain seniors and persons with disabilities will enroll in managed care in 27 additional counties - this includes 14 counties where today managed care enrollment is optional for these groups and the 13 counties in which managed care is being expanded (approximately 554,000 people); and
- ✓ Acute and long-term care integration (medical and social services) projects will be implemented in three counties. The projects will implement a protocol to assess and divert individuals from costly long-term inpatient nursing facility care.

When the managed care expansion proposal is fully implemented, California will serve approximately 60 percent of Medi-Cal beneficiaries via organized health care delivery systems. Those beneficiaries who will remain outside of the managed care system include residents of California's most rural counties, as well as individuals who will not be required to enroll into managed care, such as those who are eligible for a limited scope of benefits, beneficiaries who only receive services in the months in which they pay a "share of cost", or those dually enrolled in Medicare and Medi-Cal.

In addition to the individuals who will not be enrolled in managed care, approximately 17 percent of all applicants who qualify for Medi-Cal managed care are in "transition". These individuals in "transition" are either in the process of being determined eligible for Medi-Cal or are awaiting enrollment into managed care. During this time period, their health care services are accessed through the fee-for-service system.

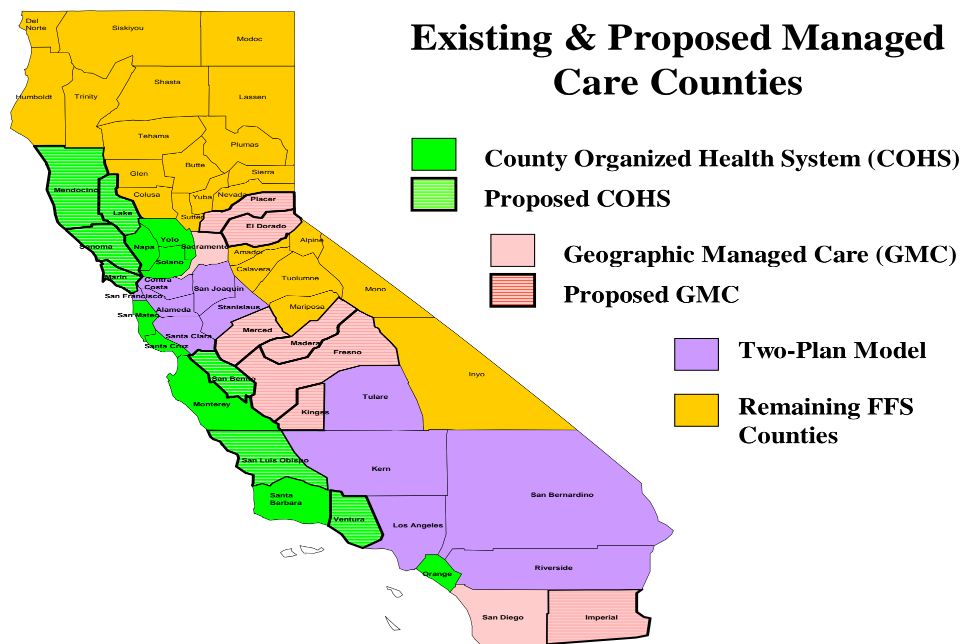
Acute and Long Term Care Integration
The expansion of managed care will also include the implementation of Acute and Long Term Care Integration projects in Contra Costa, Orange, and San Diego counties. Individuals in these counties who are Medi-Cal only and/or Medicare and Medi-Cal eligible (also known as "dual eligibles") will be enrolled in either a managed care plan or the acute and long term care integration plan. The acute and long term care integration health plans will offer a comprehensive scope of services that manages the full continuum of care including interdisciplinary care management, primary care, acute care, drugs, emergency care, dental services, home and community-based services and long term care. These projects will offer individuals greater choice in the decisions made regarding the needed services and support to meet their identified health care needs.

The three counties selected for the integration programs were chosen because they each represent one of the models of managed care in existence today and because the substantial interest these counties have demonstrated in the development of a Long Term Care Integration (LTCI) project.

The Acute and Long Term Care Integration projects will develop and implement a Long Term Care Diversion and Assessment Protocol (“Protocol“) for seniors and persons with disabilities. The goal of the Protocol is to ensure that seniors and persons with disabilities receive care that supports maximum community integration. The Protocol will be developed by a contractor who will have responsibility for the planning, development and implementation of this tool. The development process will involve the engagement of stakeholders, including consumers, advocates and representatives from home and community-based programs, and will require testing and validation prior to finalization. This development and implementation process will occur over a two year time period, once the contractor has been selected. The use of a diversion and assessment protocol is a priority under the State’s Olmstead Plan. The development and implementation of the Acute and Long Term Care Integration projects and the Protocol are consistent with the Olmstead decision in terms of offering choice to individuals and promoting maximum community integration.

The Protocol will provide the Acute and Long Term Care Integration projects with a uniform assessment protocol and data set that can be used to allow individuals to select home and community-based services instead of nursing facility care whenever possible. The Protocol will be completed by the care management team when a participant begins to have chronic care needs that may affect their ability to live independently. Once validated, the Protocol can serve as the model to be used by all managed care plans prior to long-term placement of individuals into institutions. If implemented effectively, use of the Protocol has the potential to improve client satisfaction with care and reduce long-term care costs under Medi-Cal.

The managed care expansion is depicted as follows:



Rationale:

Research and experience have shown that the delivery system in which health care is provided has an impact on the accessibility and quality of services. Managed care, implemented in a careful, deliberate manner, can increase access to services, improve patient outcomes, increase accountability for health care dollars, and be more cost effective than an unmanaged fee-for-service program.

Approximately 50 percent of the 6.6 million Medi-Cal beneficiaries, including over 81 percent of seniors and persons with disabilities, receive their health care through the fee-for-service delivery system. Medi-Cal's managed care delivery system has advantages for both beneficiaries and the State:

- ✓ Managed care plans are required to assure that adequate numbers and appropriate types of providers are available to serve Medi-Cal beneficiaries;
- ✓ Beneficiaries are better able to locate and access providers under managed care to meet their immediate health care needs;
- ✓ Improved provider access and care management result in improved health outcomes;
- ✓ Improved provider access and care management result in improved patient satisfaction; and
- ✓ The availability of improved provider access and care management in managed care can result in more appropriate utilization of health care resources resulting in lower costs to taxpayers.

Because the majority of seniors and persons with disabilities are not enrolled in managed care plans, they are not benefiting from the features of a managed delivery system. In the counties in which Medi-Cal beneficiaries who are seniors and persons with disabilities are enrolled in County Organized Health Systems, there is general consensus among stakeholders that the managed care system is far superior to that of fee-for-service and that the return of any model resembling fee-for-service would not be well received.

Under the Two-Plan Model, several Local Initiative health plans have invested in developing internal systems for specialty referral for seniors and persons with disabilities and have actively worked with senior and disabled advocacy groups to develop protocols specific to the needs of this population. The commercial plans that provide managed care services to Medi-Cal beneficiaries have gained expertise in caring for seniors and persons with disabilities under their commercial lines of business. Overall, the experiences gained and lessons learned under these various care models establish a foundation from which to build expanded managed care systems for seniors and persons with disabilities.

Impacted Populations:

The expansion of Medi-Cal managed care will impact approximately 816,000 of the 3.4 million people who are currently in fee-for-service Medi-Cal. The current populations enrolled in managed care are predominantly families and children who are required to enroll in managed care in those counties where managed care is available. Seniors and persons with disabilities are a voluntary population who may elect to enroll in a managed care organization.

Families and Children
The expansion of managed care enrollment for families and children (approximately 262,000 people) will be achieved by expanding the use of the Geographic Managed Care (GMC) and the County Organized Health System (COHS) models as follows:

Sacramento GMC:	Expand to include El Dorado and Placer Counties
San Diego GMC:	Expand to include Imperial County
New Valley GMC:	Convert Fresno to GMC and include Madera, Merced, and potentially Kings Counties
COHS model:	Expand to include the counties of Marin, Mendocino, San Benito San Luis Obispo, Sonoma, Ventura, and possibly Lake.

Expanded mandatory enrollment of families and children will occur by including new geographic service areas in Medi-Cal's managed care program as described above. As the Medi-Cal program develops the capacity to serve beneficiaries in these counties via a managed care delivery system individuals who are currently Medi-Cal beneficiaries will be enrolled in a managed care organization at the time of their next eligibility re-determination. All new Medi-Cal beneficiaries in the county will be enrolled in a managed care organization.

The seven counties listed above as potential County Organized Health System counties have been identified because of their proximity to an existing County Organized Health System, and a preliminary assessment of the Medi-Cal eligible population base in the county and the potential for developing an adequate provider network.

Seniors and Persons with Disabilities
The mandatory enrollment of seniors and persons with disabilities (approximately 554,000 people) into managed care will occur in any county in which managed care is available to Medi-Cal beneficiaries The transition of seniors and persons with disabilities to managed care enrollment in all existing Two-Plan and Geographic Managed Care model counties will be achieved in each county on a phased-in basis. As the health plans in these counties demonstrate the capacity to serve seniors and persons with disabilities individuals who are currently Medi-Cal eligible will be enrolled in a managed care organization at the time of their next eligibility re-determination. All new Medi-Cal beneficiaries in the county will be enrolled in a managed care organization.

Consistent with current policy, in counties with County Organized Health System all seniors and persons with disabilities including those with Medicare will be enrolled in managed care. In counties with Geographic Managed Care plans, all seniors and persons with disabilities that do not have Medicare coverage will be enrolled in managed care.

Managed Care Expansion: Issues

Health Plan Readiness
Expansion of managed care will be based on the State's decade-long successful experience and partnerships in establishing managed care delivery systems for Medi-Cal beneficiaries. Key factors in evaluating the readiness of any managed care arrangement include:

- ✓ Analysis of available service utilization and cost data;
- ✓ Network adequacy;

- ✓ Care coordination and carve-outs;
- ✓ Quality monitoring and improvement;
- ✓ Linkages with non-Medi-Cal services;
- ✓ Accessibility and availability of new treatment modalities;
- ✓ Community, provider and consumer input into the planning process; and
- ✓ Health plan and provider compliance with Americans with Disabilities Act of 1990.

Health Plan Readiness to Serve Seniors and Persons with Disabilities
The enrollment of seniors and persons with disabilities will require that participating health plans demonstrate readiness to provide services to this population. The Department, in collaboration with the federal government, will conduct readiness reviews of all Medi-Cal managed care plans prior to health plans becoming operational. Health plans will become operational when all standards and guidelines established by the Department have been satisfactorily demonstrated.

This readiness has been established in the County Organized Health System model where the enrollment of this population is mandatory. The County Organized Health System health plans have demonstrated the ability to care for these individuals and have achieved customer satisfaction and health outcome scores that on average are higher than non-County Organized Health Systems. This is evidenced by their performance on standardized health plan performance measures under the Health Employer Data Information Set (HEDIS) and standardized consumer satisfaction surveys under the Consumer Assessment of Health Plan Survey (CAHPS).

Several Local Initiative and commercial health plans have invested heavily in developing internal systems for specialty referral for seniors and persons with disabilities and have been working with senior and disabled advocacy groups at the local level to develop protocols specific to the needs of seniors and persons with disabilities.

Reimbursement Rates
A critical consideration associated with the managed care expansion proposal is the need to address adequate reimbursements to the health plans. The Administration is committed to working with plans on a rate structure that addresses plan capacity to adequately manage both the geographic and population expansions, but also recognizes the fiscal constraints of the State. A State savings of 5 percent of the fee-for-service costs is assumed with the managed care expansion proposal.

Fiscal Savings:
In Fiscal Year (FY) 2008-09, estimated savings are $177,000,000 ($89,000,000 General Fund [GF]).

The successful development and implementation of a geographic and population-based managed care expansion requires a careful, deliberate approach. The time needed to assure that appropriate delivery systems are in place before managed care is expanded means that initial costs will be incurred before out-year savings are realized. In addition, a significant portion of the up-front costs associated with this proposal are related to costs that are incurred during the transition period from fee-for-service to managed care. When there individuals transition from fee-for-service to managed care, payment of costs for services already rendered under fee-for-service but not yet paid are due at the same time as the monthly

capitation arrangements to managed care plans. Capitation payments are made for the month of enrollment without any payment lags, whereas there is a lag between the time services are rendered under fee-for-service and the point that the provider bills for the service and is paid.

Implementation Timeline:
The managed care expansion will be achieved through a phased-in process over a twelve- to eighteen-month period, commencing approximately January 1, 2007. There are multiple activities that will be undertaken prior to this effective date to ensure the success of the proposal. These necessary activities, once legislative authority is obtained, include the development and adoption of regulation packages, federal approvals, procurement of new contractors, contract amendments, development and implementation of stakeholder processes, systems development/updates for the fiscal intermediary and the enrollment broker, public notifications and hearings, and readiness assessments of the affected plans. A detailed implementation timeline can be found in ***Attachment A***.

Stabilize the Financing of California's Safety Net Hospitals

Proposal:
Federal authorization governing California's current hospital financing structure, the Selective Provider Contracting Program waiver, will expire on June 30, 2005. By this date, the waiver must be renewed, extended, or replaced. In FY 2004-05, California will receive approximately $3.8 billion from the federal government for reimbursement to hospitals under the fee-for-service program. In response to changes in federal Medicaid policy and because the structure of the State's existing waiver does not adequately address the financial challenges of California's hospital safety net, the Medi-Cal Redesign effort proposes to change the way in which Medi-Cal funds those hospitals which serve Medicaid and indigent patients.

The Administration has spent many months working with the affected hospitals and the federal government to develop an outline for a waiver that will provide stable federal funding for hospitals over a five-year period. The framework put forward by the Administration seeks to achieve the following:

- ✓ Continuation of the State program to contract with selected hospitals that provide care to Medi-Cal patients.
- ✓ Replacement of intergovernmental transfers with a source of funds that is acceptable to the federal government and allows for approval of the waiver.
- ✓ Authorization to allow the State to shift service delivery from Medi-Cal fee-for-service to managed care without reducing hospital funding for the uninsured.
- ✓ Provision of financing methods that allow federal funding for hospital care to increase as hospital costs increase.
- ✓ Use of the budget neutrality availability in the waiver to fund a portion of State and local costs for indigent care services.

The need to achieve federal agreement with regard to the financing of Medi-Cal hospital services exists irrespective of the other components of Medi-Cal Redesign.

Rationale:
The Selective Provider Contracting Program waiver is one of the primary financing mechanisms used to reimburse safety-net hospital providers for inpatient services. The waiver, as it currently exists, creates three critical problems that must be addressed to ensure the continued Medi-Cal funding of safety net hospitals:

- ✓ Under the waiver, the intergovernmental transfers (IGTs)[1] currently used are considered unacceptable by the federal government and it is unlikely that the waiver will be renewed with these funding mechanisms in place.
- ✓ The current financing system provides a perverse incentive to keep Medi-Cal beneficiaries in the hospital under the fee-for-service program so that hospitals can obtain funding for their indigent care programs. This conflicts with sound public policy and creates a barrier to the expansion of managed care - the principle component of the redesign proposal.
- ✓ Federal funding under the current waiver is limited and would likely significantly be reduced if the status quo were maintained.

California's hospitals are facing serious financial challenges. This problem is most severe in those hospitals that see large numbers of Medi-Cal beneficiaries and the uninsured. These hospitals depend on Medi-Cal to fund the care for both Medi-Cal patients as well as the indigent.

Impacted Providers:
Medi-Cal hospital financing via the Selective Provider Contracting Program waiver affects approximately 240 hospitals in the State that contract with Medi-Cal. Approximately 3.5 million Medi-Cal beneficiaries who receive their health coverage through the Medi-Cal fee-for-service program receive in-patient care financed by the Selective Provider Contracting Program waiver.

Fiscal Savings:
Absent a new hospital financing mechanism that decreases the reliance on the use of unacceptable intergovernmental transfers, $900 million of federal funding is at risk.

Modifying the Medi-Cal Benefit Package

Proposal:
This proposal will align the Medi-Cal dental benefit package with private sector employer-based and public sector health coverage programs by establishing a limit of $1,000 for dental services to adults (excluding federally mandated services provided by physicians, emergency services, and hospital costs associated with dental treatment), over a twelve month period.

Rationale:
The proposed changes align the adult Medi-Cal dental benefit with the covered dental services provided through many employer-based health plans, the Healthy Families Program, and the State's own employee health plan. Medi-Cal has a more expansive benefit package than is

[1] An IGT is a transfer of funds from a government entity to the State. These transferred funds constitute the States share of the total payments made by the State to the provider. Once the payment is made, federal reimbursement is claimed at the appropriate reimbursement percent (generally 50 percent). The net effect is that no State GF monies have been expended in making the payment; instead the required federal match is made by the entity making the IGT.

received by most Californians through their employer's health benefit plans. Virtually every dental coverage program has an annual cap or limit on benefits. The $1,000 annual adult dental benefit will make Medi-Cal more consistent with private coverage while at the same time covering the majority of the dental needs of beneficiaries, including the cost of dentures.

Impacted Populations:
This benefit change will impact all adult beneficiaries who have dental costs that exceed $1,000 in a 12-month period. This proposal will alter the dental services of approximately 3 million adult beneficiaries and will directly impact approximately 124,000 individuals a year. An annual benefit maximum for children is not proposed.

Fiscal Savings:
In FY 2005-06, savings anticipated from the dental reductions are approximately $50,000,000 ($25,000,000 GF).

Implementation Timeline:
Once legislative authority is provided for this proposal, system changes will be initiated, contract amendments will be developed and implemented, federal approvals will be sought, and necessary provider notifications and/or regulations will be developed and implemented. These activities will commence in July 2005 and will cover a six to nine month time frame. It is anticipated that the system redesign changes will be operational by August 2005.

Beneficiary Cost Sharing

Proposal:
This proposal will establish monthly premiums for individuals with incomes above the federal poverty level ($1,306 a month for a family of three) and above the monthly Supplemental Security Income/State Supplemental Payment level for seniors and persons with disabilities ($805 a month for a single person and $1422 a month for a couple, effective amounts for January 1, 2005).

Premium amounts will be $4 per month for each child under 21, and $10 per month for adults. Premiums will be capped at $27 per month per family. A two-month consecutive period of non-payment will result in disenrollment from Medi-Cal. The required premium payments represent approximately 1-2 percent of the total annual income for affected individuals. ***Attachment B***

Rationale:
Historically, beneficiary cost-sharing (co-pays, deductibles, premiums) has not been utilized by Medi-Cal, or as in the case of co-pays, has not been effective. Private sector employer-based health plans and some State and local government health programs have long required consumers to share in the cost of their health care. Premiums are regularly scheduled payments a beneficiary makes in order to remain eligible for benefits and are paid whether or not a beneficiary receives services in that month. As Medi-Cal has grown in both size and cost, increased scrutiny of the program has focused on the lack of beneficiary financial participation. This lack of financial participation is inequitable for similarly situated low-income individuals who must participate financially in employer-based health plans or in the other State and local government health plans. Premium requirements exist throughout private health insurance and

public programs that serve low-income populations, such as Healthy Families and some of the county-based Healthy Kids programs.

Currently, the Healthy Families Program charges premiums for families with incomes above 100 percent of the poverty level and many of the newly-created Healthy Kids county children's coverage programs charge premiums for families at income levels below the federal poverty guidelines. The proposed monthly premiums mirror the premium requirements that exist in the Healthy Families Program.

The implementation of monthly premiums in Medi-Cal will be modeled after the Healthy Families Program practices as follows:

- The first premium will be due at the time eligibility is determined and will be applied to the applicable month forward. The months between application and final determination of eligibility will not have a premium, including any retroactive months of eligibility.
- Beneficiaries will be disenrolled if they do not pay premiums for two consecutive months. If re-enrollment is pursued, beneficiaries will be required to pay back premiums owed from the previous six months in which they were enrolled.
- A variety of methods will be employed to enable premium payments, including mail (checks), phone (credit cards), automated payroll deductions or bank account withdrawals, or certain physical locations to make cash payments.
- Discounts of approximately 25 percent will be received for using automated payments or paying three months (the fourth month would be free) of premiums at once will be available and sponsors will be allowed to pay premiums on behalf of the beneficiary.

Requiring premiums for Medi-Cal beneficiaries with incomes above the poverty level is a positive step in eliminating the perceived stigma associated with participating in a "free program" in which the beneficiary has no responsibility to share in the cost. This change will also increase the equity with employer-based health plans and instill in the beneficiary a sense of ownership and personal responsibility for the health care they obtain.

As a result of the eligibility expansions that have occurred over the past several years, there are many individuals now receiving no-cost Medi-Cal who would have previously been ineligible or would have had a large share-of-cost to pay in order to receive Medi-Cal coverage. Under Medi-Cal Redesign, these individuals will maintain their eligibility and Medi-Cal will continue to pay for the vast majority of their health care needs, thus lessening the burden on the safety net system for the uninsured.

Impacted Populations:

Medi-Cal covers two-parent working families who apply with incomes up to 100 percent of the federal poverty level ($1,306 per month for a family of three); these families can increase their income up to approximately 155 percent of the federal poverty level ($2,024 per month for a family of three) while remaining on the program. Children ages one to six with family incomes up to 133 percent of the federal poverty level enroll in Medi-Cal, whereas children six and above with the same family income level currently enroll in Healthy Families and pay a premium. Medi-Cal also provides no-cost Medi-Cal to seniors and people with disabilities up to approximately 130 percent of the federal poverty level ($1,006 per month) and 134 percent of federal poverty level for a couple ($1,399 per month).

Premiums will be required of individuals who meet the designated income levels as previously described. The implementation of premiums will impact approximately 550,000 eligible beneficiaries – 460,000 children and non-disabled adults; and 90,000 seniors and persons with disabilities.

Premium payments are exempt for certain beneficiaries including: American Indians; Alaskan Natives; individuals with a share-of-cost; 1931 (b) enrollees enrolled in Cal Works; and infants under one year of age.

It is anticipated that premiums will be determined at the time of eligibility determination or at the time of the annual redetermination period during FY 2005-06. Beneficiaries will begin paying premiums in January 2007.

Fiscal Savings:
In FY 2006-07, preliminary savings of $11,106,000 ($5,553,000 GF) are anticipated. The initial costs in FY 2005-06, associated with this proposal are related to securing a contractor to collect the premiums and the county administrative chores associated with identifying which persons will be responsible for paying premiums. Once systems are operational, savings will occur in the out-years of this proposal. The savings estimates are a function of the amount of premiums collected and anticipated cost reductions related to persons who do not make premium payments and are subsequently disenrolled.

Implementation Timeline:
Once legislative authority is provided for this proposal, a waiver application for federal approval will be developed. It is anticipated that the waiver application will be submitted to the federal government by December 2005. The federal approval process may take six to nine months from this date. Concurrently, work will commence on the development of a request for proposals to solicit a contractor to implement premium collection activities. The contracting process typically takes 15 – 21 months once the request for proposal is released. During 2005-06, at the time of application or redetermination, counties will identify individuals who will be required to pay premiums. It is anticipated that premium payments will begin January 2007.

Improved Eligibility Processing for Children

Proposal:
This proposal will allow Medi-Cal applications for children received by the Healthy Families Program eligibility processing vendor, known as the Single Point of Entry, to be processed by the vendor instead of being forwarded to a county for processing. The change will speed enrollment of children. This proposal provides the opportunity to test the idea proposed by the California Performance Review of a centralized eligibility processing unit and offers promise of improved efficiencies in eligibility determinations.

Rationale:
Currently, the Healthy Families Program eligibility-processing vendor conducts a screening process for no-cost Medi-Cal and reports presumptive eligibility to the Medi-Cal Eligibility System. Once the county has received the application, county staff completes the application

review process. Much of this effort is duplicative. There are approximately 120,000 applications for children received per year via this method.

This proposal will allow the vendor to conduct screenings for no-cost Medi-Cal, grant accelerated eligibility and report to the Medi-Cal Eligibility Data System. Expanded responsibilities of the vendor include the completion of income and immigration status verifications. Immigration status verifications are required by federal law, due to the federal matching component. The vendor will prepare an initial eligibility determination recommendation for the Department to review and certify. The Department will confirm final Medi-Cal eligibility in compliance with current federal regulations. Once the certification process is completed, the vendor will forward the application to the county social services office of the child's county of residence for ongoing management of the child's case, including annual redeterminations.

This proposal will eliminate duplication, making the eligibility determination process much faster. Vendor accountability will be assured through financial penalties for not completing eligibility determinations within designated timelines. Applicants will be able to use a convenient toll-free telephone to obtain application assistance and status information.

Impacted Populations:
Applications for children deemed eligible for no-cost Medi-Cal received by the Single Point of Entry vendor will be impacted. There are approximately 120,000 applications for children received per year by the vendor.

Fiscal Savings:
The savings from this proposal in FY 2005-06 are estimated to be $1,242,000 ($1,196,000 GF) and ongoing of $15,900,000 ($9,269,000 GF).

Implementation Timeline:
Once legislative authority is provided for this proposal, State Plan Amendments for federal approval and scope of work deliverables for the current contractor will be developed. It is anticipated that the State Plan Amendment will be submitted to the federal government by August 2005 and federal approval is anticipated by December 2005. It is anticipated that the necessary contract amendments for the vendor will be implemented by December 2005 and subsequent instruction will be provided to the counties January 2006. The contractor eligibility determinations will commence March 2006.

PROGRAMMATIC OPERATING EFFICIENCIES

The following programmatic initiatives are presented as additional enhancements under Medi-Cal Redesign. These activities will further the objectives of cost containment and operational efficiencies for Medi-Cal.

County Performance Standards Monitoring:

Proposal:
This proposal will secure vendor services to monitor county performance standards, ensuring that initial eligibility determinations and annual redeterminations are completed within federal and State statutory guidelines.

Rationale:
Currently, the State fully funds the county cost of administering the Medi-Cal program, with 50 percent State General Fund and 50 percent federal dollars. Counties are required by federal and State law to complete initial eligibility determinations within 45 days of application and to complete annual redeterminations to determine continued eligibility.

Currently, counties submit reports to the Department annually to self-report whether they have met all of the performance standards. There is no State verification of these efforts. The Department is seeking to secure a contractor to monitor and validate compliance with eligibility determination and annual redetermination performance standard requirements; consult with county staff and State Medi-Cal policy staff to develop and quickly implement corrective action initiatives to bring counties into compliance with the performance standards; and recommend sanctions to reduce county administrative funds if the performance standards are not met.

Performing timely eligibility determinations will facilitate access to Medi-Cal eligible individuals while ensuring that the State is not covering the cost of health care for people who are no longer eligible for Medi-Cal.

Monitoring county performance will serve as an incentive for counties to complete eligibility determinations and annual redeterminations timely. It also holds counties accountable for eligibility determinations, since the State is at risk of sanction by the federal government if it covers ineligible individuals while failing to meet federal requirements for a timely re-determination. The State has an obligation to the taxpayers and the federal government to ensure counties fulfill their duty in this respect.

Impacted Populations:
All applicants and recipients of Medi-Cal will be impacted by this proposal.

Fiscal Savings:
No additional savings have been assumed from performance standards monitoring because the Medi-Cal Estimate already reflects a flattening in the caseload due to increased county compliance with requirements related to eligibility redetermination, and significant savings from the Mid-Year Status Reporting ($265 million TF, $132.5 million GF in 2005-06). The county performance standards monitoring activities will ensure that these savings are achieved.

Implementation Timeline:
Once legislative authority is provided for this proposal, a request for application and procurement process will be undertaken. It is anticipated that this process will take between 9 to 18 months and contractor activities will commence once the process is completed. Contractor activities can begin as early as March 2006 or as late as January 2007.

Provider Enrollment:

Proposal:
This proposal will be introduced in the spring of 2005 and will reduce the processing time of applications received.

The proposal will:

- ✓ Establish a call center to address provider enrollment questions;
- ✓ Improve the provider enrollment automation process;
- ✓ Develop a more comprehensive provider enrollment tracking system, databases, and file matches with licensing boards; and
- ✓ Provide adequate staffing to meet the existing workload.

Rationale:
A common concern for those delivering health care to Medi-Cal beneficiaries is that the process for enrolling and qualifying as a Medi-Cal provider takes too long. In January 2004, the provider enrollment backlog reached 15,362, with an average processing time of 144 days. During the current budget year, additional personnel were redirected to address the backlog and it dropped to 9,000. However, the backlog again increased when staff had to return to their primary job responsibilities.

Prompt enrollment of providers can help increase access to care for Medi-Cal beneficiaries and avoid financial hardship for providers who render services to beneficiaries while awaiting approval of their enrollment application,

IMPLEMENTATION SUMMARY

The redesign of Medi-Cal will require an investment of time and resources from state and county staff, health plans, the provider community and a broad array of stakeholders. Experience to date underscores the importance of a deliberate and gradual implementation so that systems and providers are ready and beneficiaries fully informed to understand the changes that will occur. For these reasons, implementation of the proposed reforms will take place over several years. When fully implemented, Medi-Cal Redesign will maintain and improve Medi-Cal coverage for eligible individuals and will reduce annual Medi-Cal expenditures by $287,180,000 ($144,902,000 GF). Savings over the first 5 years are expected to be $332,000,000 ($171,000,000 GF). A summary of the fiscal impact of Medi-Cal Redesign is in ***Attachment C.***

OTHER STATE EXPERIENCES

Nationwide, the fiscal challenges facing State governments and the increasing costs of Medicaid programs have prompted States to make changes to their Medicaid programs. States have relied on a wide array of cost-containment measures. According to the Kaiser Commission on Medicaid and the Uninsured, in fiscal year 2004, 50 States froze or reduced rate increases for providers, 48 States implemented new pharmacy cost controls, 21 States imposed eligibility restrictions, 20 States imposed new or higher beneficiary co-payments, and 19 States restricted or reduced benefits.

Managed Care

Nationally, many States now require seniors and person with disabilities to enroll in managed care. Medicaid managed care programs that serve seniors and persons with disabilities exhibit significant variations in design and operations.

According to the Kaiser Commission on Medicaid and the Uninsured, by 2000, fourteen States had enrolled over 75 percent of their Medicaid population in managed care. California was one of 29 States and the District of Columbia that had enrolled between 25 and 75 percent of the Medicaid eligible population into managed care.

Financing of the Safety Net Hospitals

California is the only State in the nation, which funds its hospitals in part through a federal 1915 (b) waiver. As such, it is the only State that must have its hospital funding processes reviewed and approved every two years by the federal government under a discretionary federal waiver. Other States rely upon permanent provisions of their State plan or five-year federal 1115 waivers.

According to the Centers for Medicare and Medicaid Services, there are 30 States that use intergovernmental transfers in a manner that they find unacceptable. California is among this group. As States propose changes to their Medicaid programs or seek renewal of their federal waivers, States are being required to eliminate their unacceptable intergovernmental transfers by the start of their next State fiscal year. No State without a federal statutory basis has prevailed in maintaining their intergovernmental transfers.

California has a State-specific provision in federal law related to its Disproportionate Share Hospital program that will allow California to keep some of its intergovernmental transfers under the new financing method.

Modifications to the Medi-Cal Benefit Package

Dental services to adults are an optional benefit that may be covered at the discretion of the State. Only eight States now provide full scope dental benefits to adults in their Medicaid program. Most States establish limits on the scope of benefits that are provided under their Medicaid program. These limits include fixed numbers of prescriptions and hospital days. The Medi-Cal program limits a variety of benefits such as six prescriptions per month. These

limitations can be overridden through the prior authorization system. Under prior authorization, with appropriate documentation of medical necessity from the requesting provider, the beneficiary can obtain the additional needed service(s).

Beneficiary Cost Sharing

Several States have attempted to control program expenditures by implementing beneficiary cost sharing. These States include Oregon, Arizona, Washington and Utah. The experience of Oregon is discussed below:

Oregon
In response to significant declines in State revenue, Oregon restructured its Medicaid program, known as the Oregon Health Plan. In February 2003, Oregon was granted a federal 1115 waiver to make benefit reduction revisions to its Medicaid program. These benefit reductions included elimination of mental health or substance abuse services, durable medical equipment (such as wheelchairs) and dental and vision services. The Oregon Legislature also eliminated prescription drug coverage, but later restored this benefit.

Oregon also used this waiver authority to establish $6 to $20 dollar monthly premiums for adults *who had incomes below the federal poverty level*. These premiums were imposed on over 100,000 adults, all with incomes below the federal poverty level. In addition, the State also implemented a requirement that if a person missed one premium payment, the person was disenrolled (the prior policy had been to disenroll at six-month eligibility reviews) and that non-payment could not be waived for "good cause". These premiums imposed on people with incomes below the poverty level coupled with the new stricter premium payment rules and benefit reductions resulted in approximately one half of those required to pay premiums dropping out of the program. The Kaiser Commission on Medicaid and the Uninsured found that over one half of the total disenrollment that occurred as a result of the premiums was associated with people with no income being dropped from the program for failure to pay their premiums. The Commission found that enrollment in the program dropped by 59 percent for people with no income and enrollment dropped by 44 percent for people with incomes between 85 and 100 percent of the poverty level.

Medi-Cal Redesign differs significantly from the Oregon proposal, as it does not require premiums for people with incomes below the poverty level. Rather, it establishes premiums for individuals with incomes above the poverty level consistent with the approach other government programs have successfully established.

Improved Eligibility Processing for Children

Florida and Texas are moving forward with efforts to centralize their eligibility determinations and enrollment processes.

Florida has submitted a Demonstration Waiver to the federal government, which is pending approval. Currently, Florida has a pilot office at which a vendor is making the final eligibility determination for cash aid and the companion Medicaid application. However, State staff will continue to make eligibility determinations for any Medicaid or Food Stamp applications without a companion cash application. The Florida 1115 Waiver seeks to demonstrate improved efficiencies to the Medicaid, Temporary Assistance for Needy Families (TANF) and

Food Stamp programs by using vendors to determine eligibility for all three programs, regardless of the relationship to a TANF case. Because of the risks associated with depending on the continued performance of one vendor for statewide automation, Florida has not yet determined if they will contract with one or several vendors to operate in the State.

In Texas, a Request for Proposal in 2004 yielded four proposals from vendors. Analysis of the cost-effectiveness of each proposal is underway to determine whether or not to proceed with privatization. If so, Texas would allow applicants to apply via the Internet, telephone, mail, or in-person. A vendor would operate a centralized clearinghouse to receive and scan the application and all supporting documentation. The vendor would review the application, evaluate it for completeness, and pursue further information or verifications. Once the vendor's review is completed, the vendor would submit the application to the automated eligibility system for final determination. Afterwards, State staff would review the application and eligibility determination on-line and certify final eligibility.

ATTACHMENT A

MANAGED CARE IMPLEMENTATION TIMELINE

		AREA					
		ALTCI [1]	Two-Plan/ ALTCI	GMC/Two-Plan ALTCI	Two-Plan	GMC	COHS/Other
		Orange	Los Angeles Riverside San Bernardino Contra Costa	Sacramento El Dorado Placer San Francisco Santa Clara Alameda San Diego Imperial	Tulare Stanislaus San Joaquin Kern	Merced Fresno Madera King	Ventura San Luis Obispo San Benito Marin Lake Mendocino Sonoma Santa Barbara
		Timeline			Critical Task		
Legislation Passed	Authority for Implementation	7/1/05	7/1/05	7/1/05	7/1/05	7/1/05	7/1/05
	Regulation Development	7/1/05	7/1/05	7/1/05	7/1/05	7/1/05	7/1/05
	Regulations Adopted	8/31/06	12/31/06	12/31/06	12/31/06	12/31/06	12/31/06
Post Legislation	Submission to Federal Government	10/1/05	10/1/05	10/1/05	10/1/05	10/1/05	10/1/05
	Approval from Federal Government	8/31/06	8/31/06	8/31/06	8/31/06	8/31/06	8/31/06
	Procurement/Application	N/A	7/1/06 [2]	N/A	N/A	10/1/06	N/A
	15 month Notice to Stakeholders	7/1/05	11/1/05	1/1/06	5/1/06	9/1/06	3/1/07
	9 month System Update: - Information Technology Systems Division - HealthCareOptions	12/1/05	4/1/06	6/1/06	9/1/06	1/1/07	7/1/07
	4 month Public Notice	5/1/06	9/1/06	11/1/06	2/1/07	6/1/07	12/1/07
	2 month Readiness Assessment	7/1/06	11/1/06	1/1/07	4/1/07	8/1/07	2/1/08
	Start Enrollment	9/1/06	1/1/07	3/1/07	6/1/07	10/1/07	4/1/08

[1] ALTCI = Acute Long Term Care Integration
[2] Requires competitive bid process for Contract Costa ALTCI with a 6 month pre-implementation period.

ATTACHMENT B

MEDI-CAL REDESIGN MAXIMUM YEARLY COST-SHARING AMOUNTS				
FAMILIES, CHILDREN, AND PREGNANT WOMEN				**Max % of Income for Program Particpation**
Family Size 1/	Premium 2/	Maximum Yearly Payment for Premiums	Minimum Yearly Income 100% FPL + $1.00	**> 100% FPL**
1 Child + 1 Adult 3/	$4 Child x 12 mos = $48 $10 Adult x 12 mos = $120	$168	$12,504	1.3%
2 Children + 1 Adult	$8 Children x 12 mos = $96 $10 Adult x 12 mos = $120	$216	$15,684	1.4%
1 Child + 2 Adults	$4 Child x 12 mos = $48 $10 Adult x 12 mos = $240	$288	$15,684	2%
SENIORS AND PERSONS WITH DISABILITIES				**Max % of Income for Program Particpation**
	Premium 2/	Maximum Yearly Payment for Premiums	SSI/SSP Payment Standard + $1.00	
Individual (Adult)	$10 Adult x 12 mos = $120	$120	$9,672 4/	1.2%
Couple	$20 Adults x 12 mos = $240	$240	$17,076	1.4%

1/ Family may be comprised of pregnant women, non-disabled children less than 21, CalWORKS, or share of cost eligibles.
2/ Premium maximum per month is $27; discounts available for paying 3 months in advance or using electronic fund transfers.
3/ A child is a person under age 21; an adult is a person at or over age 21.
4/ Individual Adult Seniors and Persons with Disabilities can have income of $12,072/yr and cost sharing would be one percent of this income level.

ATTACHMENT C

Medi-Cal Redesign
Fiscal Impact for First Five Years -- Total (Local Assistance and Support)
($ in Thousands)

	2004-05			2005-06			2006-07 8/		2007-08 8/		2008-09 8/		Net Impact - 5 Years	
	Total	GF	PYs	Total	GF	PYs	Total	GF	Total	GF	Total	GF	Total	GF
Managed Care Expansion 1/	$ 159	$ (11)	4.0	$ 7,869	$ 3,412	47.5	$ 81,240	$ 40,098	$ 110,350	$ 54,653	$ (169,929)	$ (85,487)	$ 29,689	$ 12,664
Restructure Hospital Financing 2/	$ -	$ -	0.0	$ 1,490	$ 686	12.0	$ 1,490	$ 686	$ 1,490	$ 686	$ 1,490	$ 686	$ 5,960	$ 2,744
Dental Benefit Modification 3/	$ -	$ -	0.0	$ (48,038)	$ (24,543)	1.5	$ (50,602)	$ (25,325)	$ (50,602)	$ (25,325)	$ (50,602)	$ (25,325)	$ (199,844)	$ (100,518)
Financial Participation 4/	$ -	$ -	0.0	$ 14,676	$ 6,847	3.5	$ (8,824)	$ (4,903)	$ (43,117)	$ (22,050)	$ (43,117)	$ (22,050)	$ (80,382)	$ (42,155)
Improved Eligibility Processing for Children 5/	$ -	$ -	0.0	$ 5,667	$ 976	19.5	$ (9,007)	$ (7,097)	$ (9,007)	$ (7,097)	$ (9,007)	$ (7,097)	$ (21,354)	$ (20,315)
County Performance Monitoring Standards 6/	$ -	$ -	0.0	$ 1,595	$ 612 7/	2.5	$ 3,395	$ 1,512	$ 3,395	$ 1,512	$ 3,395	$ 1,512	$ 11,780	$ 5,148
Total	**$ -**	**$ -**	**4.0**	**$ (16,741)**	**$ (12,010)**	**86.5**	**$ 17,692**	**$ 4,971**	**$ 12,509**	**$ 2,379**	**$ (267,770)**	**$ (137,761)**	**$ (254,151)**	**$ (142,432)**

1/ Expands managed care to families and children in up to 13 additional counties; seniors and persons with disabilities in 27 counties; and long-term care integration in 3 counties.

2/ New five-year hospital financing federal waiver to use local funds and unmatched state funds for indigent care services; preserve hospital financing for the uninsured whether Medi-Cal patients are served through fee-for-service or managed care; and create opportunities for increased federal reimbursement.

3/ Aligns benefits for adults with private sector employer-based or public plans, by limiting dental services to $1,000 per year.

4/ Implements monthly premiums for persons with incomes above the poverty level or the SSI/SSP level. $4 for children, $10 for adults, with cap of $27 per family. Assumes 5% reduction in non-institutional health services costs for beneficiaries who pay premiums.

5/ Would have allowed initial Medi-Cal eligibility applications for children received through the Single Point of Entry (SPE) to be processed by the SPE instead of being forwarded to the county for processing. State staff would complete final certifications of the eligibility determinations.

6/ Monitoring by a contractor to verify county performance standards relative to initial eligibility determinations and annual redeterminations in accordance with federal and state statutory requirements.

7/ Local assistance cost of $600,000 ($300,000 GF) to be added in May 2005 Estimate.

8/ State staff costs for 2006-07 forward reflect 2005-06 costs as placeholders, and do not reflect staffing changes that may be necessary in those years.