

blue shield
of california
foundation

working committee summary report

a roadmap to coverage

implementing a childless adult
medi-cal waiver in california

Harbage Consulting
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[about the working committee](#)

The Working Committee on Waiver Development and Medi-Cal Expansion is a nonpartisan group set up to probe how California can more effectively draw down federal dollars as part of expanding healthcare coverage to more Californians while improving care delivery. With more than 30 members representing all aspects of the health sector, the Committee met regularly between February and November 2007. Committee Members were not asked to endorse any specific policy or point of view. Documents and reports generated for the Working Committee are posted at www.caworkingcommittee.org.

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[about this report](#)

This report is informed by the proceedings of the Working Committee and the feedback of the members. However, the recommendations are solely those of Harbage Consulting. The report is not endorsed by the Working Committee.

[about harbage consulting and the authors](#)

Harbage Consulting is an independent, Sacramento-based health policy consultancy. All the clients are nonprofit entities. Peter Harbage, president, has 15 years of experience in health care, with a special focus on Medicaid. With an impressive background in health care and public affairs, Hilary Haycock served as an independent consultant to the firm and drafted a significant portion of the text. Lisa Chan, a director at Harbage Consulting, also contributed to this report.

preface

“Playing Catch-Up,” a February 2007 report for Blue Shield of California Foundation, found that “California has the authority to obtain more federal Medicaid dollars, and that doing so would likely increase access to medical care and strengthen the state’s overall economy.”

In other words, our state is missing an opportunity to extend health care to thousands more of the underserved through a new waiver agreement. That provides compelling rationale for the exploratory waiver development work that has now been underway for a year.

The Working Committee on Waiver Development and Medi-Cal Expansion, which convened in February 2007, has been fortunate to engage the full breadth and diversity of health policy stakeholders, strategists, and thinkers. The participants, listed on the facing page, deserve our thanks and appreciation for coming to the table to learn lessons from other states, explore options for a future federal waiver, and engage in dialogue about complex issues and sensitive trade-offs. Their thoughts, questions, and concerns provide richness and depth to the issues explored in this report.

The exploratory process would not have been possible without the insightful leadership of consultant Peter Harbage and his team. Synthesizing the key points of the discussion, this report – as its title suggests – provides a challenging roadmap for future work on a California waiver.

As this process moves forward, the Foundation is committed to remaining engaged at whatever level is helpful. To reach the goal we all share – health coverage for all Californians – will require many steps, large and small. We hope this proves to be one such step down that road.

Crystal Hayling
Chair, Working Committee
President and CEO, Blue Shield of California Foundation

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executive summary

There is broad agreement that California's healthcare system needs reform, especially to better serve the state's most vulnerable residents. To address this, California engaged in a great debate this past year over how the system could be improved. As the backbone of our healthcare system, the nature and role of Medi-Cal, California's Medicaid program, was a critical question in the year's discussion.

The Working Committee on Waiver Development and Medi-Cal Expansion (Working Committee) originally was convened to help educate California's healthcare stakeholders about federal Medicaid Section 1115 waivers and how a new waiver for California could offer health coverage to uninsured, low-income, childless adults. With more than 30 members representing all different health care sectors, the monthly gathering of this diverse group was a rare opportunity for stakeholders to learn from each other.

Although comprehensive health reform stalled in 2008, a childless adult Section 1115 waiver could still be a critical mechanism for California both to create a more stable safety net and obtain its fair share of federal dollars. However, achieving the benefits offered by a childless adult waiver will not be easy. Obtaining Section 1115 waivers can be a complex and protracted process. There are trade-offs that must be made. For example, the federal government attaches complex conditions to waivers, especially around the sources and uses of funds. System changes can also be required, and it is common for waivers to expand the use of managed care. The major challenge of any waiver is calculating budget neutrality, meaning that Medi-Cal programs under the waiver cannot cost the federal government any more than they would have without a waiver.

Change will be hard. For the type of change discussed in this paper to be successful, every stakeholder in the system – from government agencies to providers and advocates – will need to look beyond the immediate concerns of their constituencies and carefully consider how the tough choices and trade-offs will benefit the whole system. A successful waiver

does not necessarily mean that the waiver will benefit every stakeholder directly, or that the stakeholders will achieve all of their specific goals. However, a successful waiver will mean tangible improvement in the entire system as a whole.

This paper seeks to outline those tough choices. It is well-informed by the discussion that has taken place at the Working Committee over the past year. This paper offers a roadmap to policymakers on the nature of the decisions needed and the options for making those decisions. All of the critical issues to be addressed in a waiver are discussed, including:

expanding coverage

The paper analyzes the nuts and bolts of a childless adult waiver by considering the kind of insurance issues that would need to be addressed, such as the eligibility rules, the benefit package, and cost-sharing issues, as well as the nature of the delivery system. Health care is not free. Expanding full Medi-Cal benefits to childless adults will require careful consideration of what is realistically affordable. California will need to balance providing meaningful benefits packages and affordable cost sharing with the overall cost of the program.

strengthening the safety net

Expanding Medi-Cal coverage raises critical questions about the role of public hospitals and clinics and how they could be affected under a new waiver. Given the precarious nature of safety net funding and the interconnectedness of the safety net, change must be made thoughtfully and carefully as to limit unintended negative consequences. Issues that need to be considered include ensuring the sustainability of safety net providers, preserving provider choice, and developing a program design that does not detrimentally impact both public and private safety net providers. Additionally, payments for all Medi-Cal providers are currently some of the lowest in the nation, leading to important questions about the need for payment increases.

meeting budget neutrality

California will need to find savings in our existing Medi-Cal programs in order to fund coverage expansions through a childless adult waiver. One way other states achieve these savings is by expanding managed care to create more efficient programs. But some thought leaders in California have been reluctant to make managed care mandatory

for the Aged, Blind and Disabled population. The Working Committee spent significant time considering how to address managed care in a way that would work for all Californians. Stakeholders, including the federal government, will need to think creatively about how to achieve the compromises needed to make budget neutrality work.

All of the questions posed by a childless adult waiver make for a daunting task. Yet, as explained in this paper, it is possible to navigate these difficult choices. Options exist, if stakeholders are able to develop a shared vision for the future and trust each other to work towards that vision. California can, and should, work towards developing and implementing a childless adult waiver to benefit California's uninsured and Medi-Cal's beneficiaries.

section 1: introduction

In January 2007, California Governor Arnold Schwarzenegger and leaders in the state legislature launched an unprecedented statewide health reform debate. A critical part of this debate has been over the role that Medi-Cal, California's version of the Medicaid program, can play in a reformed system. This focus is not surprising. As the backbone of the country's healthcare system, Medicaid plays a critical role in providing care nationally and in California.

The California health reform debate prompted the creation of the Working Committee on Waiver Development and Medi-Cal Expansion. The Working Committee initially focused on a specific facet of the Medi-Cal discussion: the possibility of expanding Medi-Cal coverage to childless adults. The primary goal was to consider the political and policy challenges involved with what could be the most significant change in Medi-Cal since the program started 40 years ago.

It quickly became clear that covering childless adults is a complex proposition that would require a more comprehensive view of reform beyond simply understanding who could be added to Medi-Cal. This is true for many reasons, but two stand out. First, California's safety net is highly interconnected. It is difficult to change any part of the system in isolation because the funding is intertwined. Any change in the system will create ripple effects that must be taken into account. Second, the coverage of childless adults in Medi-Cal requires special permission from the federal government. The conditions under which permission could be obtained from the federal government almost necessitate a broader Medi-Cal reform effort.

Meeting on seven different occasions from February to November 2007, the Working Committee engaged in extensive shared learning to discuss policy approaches. In addition to many presentations from experts from around the state and country, Working Committee members actively participated in facilitated discussions to share ideas related to covering childless adults

under Medi-Cal. The result was a series of ideas about what California's healthcare system needs and what it could look like, as well as some of the concerns and issues stakeholders have around changes to the system. With more than 30 members representing all different areas of the healthcare sector, the monthly gathering of this diverse group was a rare opportunity for stakeholders to learn from each other.

This paper is a roadmap to help California's policymakers and stakeholders explore the trade-offs and compromises necessary to build a successful childless adult coverage waiver. This report pulls together and summarizes the critical work done by the larger consulting team retained by the Working Committee. Each of the retained consultant organizations (Health Management Associates, Sellers Feinberg, and Bailit Health Purchasing) has a separate report.

Following the Introduction, Sections 2 and 3 discuss the need for a waiver and principles for reform. Section 4 talks about the nuts and bolts of designing a waiver, such as how to design the benefit package. Section 5 then discusses the waiver's relationship to the safety net. To help promote understanding of the budget neutrality calculation, Section 6 discusses the steps that can be taken to make sure that these financial issues can be addressed. The focus of Section 7, healthcare quality, is important in and of itself, though the thoughts offered here are intended to show how California could help make federal approval of the waiver more likely.

When policymakers are prepared to consider a childless adult waiver, this paper and the significantly more detailed work provided by a wide range of expert consultants retained by the Working Committee will prove to be a valuable resource. More valuable still is the thinking that Working Committee members have done over the past year about how to move towards a childless adult waiver. The recommendations made in the paper on how to make those compromises are the suggestions of Harbage Consulting alone and are not to be attributed to the Working Committee or its members.

section 2: the crucial role of a waiver

Medicaid is the backbone of America's healthcare system. A partnership between the federal government and the states, Medicaid will spend more than \$330 billion dollars this year, or one sixth of all U.S. health spending, to provide health insurance and services to more than 60 million low-income and at-risk Americans. This includes more than six million individuals enrolled in Medi-Cal, California's Medicaid program.

Over the past 30 years, states have been granted Medicaid waivers that allow for program innovation, cost containment, and targeted financial investments. A waiver is necessary to give California the flexibility in Medi-Cal to maximize federal dollars to improve care for our neediest residents by expanding coverage and stabilizing the safety net. Raising California's federal Medicaid reimbursement rate per resident to that of other large states like Pennsylvania or New York could generate anywhere from \$5 to \$24 billion in new federal dollars.

what is medi-cal's role in california's healthcare system?

Medi-Cal represents 20.5 percent of all healthcare spending in California¹ and is the largest Medicaid program in the nation. Medi-Cal plays three significant roles in healthcare delivery:

Major Source of Coverage: With more than 6.6 million enrollees, Medi-Cal is the largest single source of health insurance in the state, providing coverage for:²

- Nearly 20 percent of Californians under 65 years of age;
- One-third of children; and
- Most people living with AIDS.

1 Kaiser Family Foundation, statehealthfacts.org

2 California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007

Major Source of Federal Funds: The projection for fiscal year 2007–08 by the California Legislative Analyst's Office shows that California will spend approximately 14 percent of General Fund dollars, or \$14.3 billion, on Medi-Cal. That spending will draw in \$22.7 billion in matching federal healthcare dollars, bringing total estimated Medi-Cal spending to approximately \$37 billion.³

Major Source of Provider Revenues: Medi-Cal's more than \$40 billion budget pays for many healthcare services in California, including:⁴

- Forty-six percent of births;
- Two-thirds of nursing home residents; and
- Nearly two-thirds of all net patient revenue for public hospitals, with many private safety net hospitals⁵ receiving a significant portion of their revenue from Medi-Cal as well.

what challenges do medi-cal and the safety net face?

"Systems are going to need to change as we move the way we provide services. We need to start saying, what transformation needs to happen? What do we all really think the system needs to change, and what sort of steps do we need to build into a waiver to allow that to happen?"

Lucien Wulsin, Jr., Project Director of the Insure the Uninsured Project

The Working Committee discussed the challenges facing Medi-Cal and California's healthcare system more broadly. The fundamental cause of all these challenges is the chronic underfunding of California's safety net.

While it is generally agreed that the safety net is underfunded, it can be difficult to precisely assess the adequacy of funding in the safety net.

In 2003, the UCLA Health Policy Center found that if the state's uninsured were fully insured, total spending from all sources would double for the previously uninsured population, from \$7.4 billion annually to \$14.8 billion. Even accounting for variation in administrative expenses between the

³ California Legislative Analyst, "Major Features of the California 2007 Budget," August 31, 2007

⁴ California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007

⁵ California has an extensive network of private safety net hospitals. Their state association, Private Essential Access Community Hospitals (PEACH), reports that their members devote at least 25% of their revenues to caring for the uninsured and low-income patients.

insured and uninsured, these dollars, at least in part, represent the many medical services the uninsured are not receiving because the safety net does not have the resources necessary to provide them.

The five specific challenges discussed by the Working Committee are directly linked to the goals for a waiver:

- Low federal funding;
- Perverse financial incentives that mean safety net providers generate most of their operating revenue by caring for the uninsured and that were memorialized under the 2005 hospital waiver;
- High levels of uninsured, low-income adults ineligible for current Medi-Cal programs;
- Inadequate access to care for beneficiaries; and
- A fragmented and precarious safety net.

low federal funding

Despite its central role in California's healthcare system, Medi-Cal is significantly underfunded by both the state and federal government, as referenced in the earlier report, "Playing Catch-Up," published by Blue Shield of California Foundation. California has 12 percent of the nation's population but supports 15 percent of our country's Medicaid population using only 11 percent of total Medicaid resources.⁶

As shown in the chart on page 13, "Federal Medicaid Spending per Beneficiary," federal spending for California is low according to any number of indicators, particularly in comparison to other large states such as New York. For example:

- California ranks 49th out of the 50 states and the District of Columbia in federal spending per beneficiary;
- California ranks 23rd in per resident federal Medicaid spending, receiving just half what New York does in per resident spending; and
- California's federal Medicaid dollars are only 11.5 percent of the state's total healthcare spending, whereas Medicaid funding makes up 18.6 percent of New York's total healthcare spending.⁷

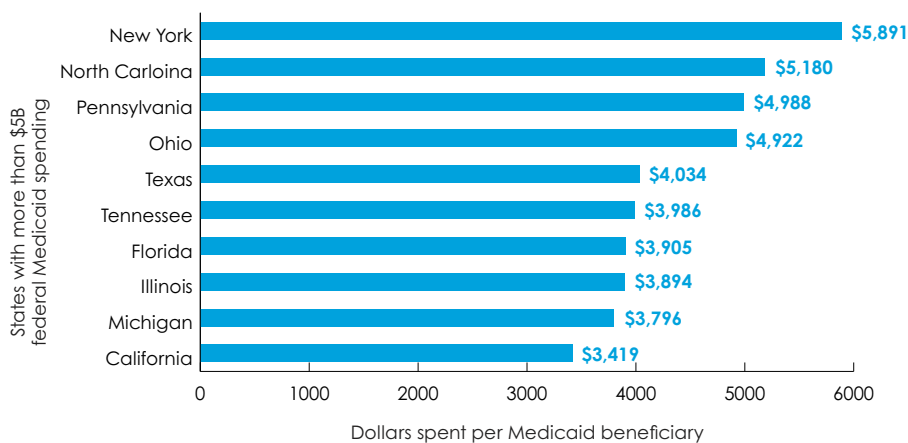
⁶ Vernon Smith, "Medicaid in 2007 and Beyond: Context for Medi-Cal Policy Development." Presentation to the California Working Committee, February 28, 2007.

⁷ Peter Harbage, "Playing Catch-Up: California Can Improve Medi-Cal Access and Coverage By Obtaining Available and Additional Federal Support." Blue Shield of California Foundation, February 2007.

This low funding creates several ripple effects throughout the healthcare system, including poor access to care providers (discussed below) and a shifting of cost from public programs to the privately insured. The cost shift occurs when providers know they will not receive enough reimbursement for treating patients in public insurance programs, so they charge higher prices to private insurers who are better able to pay.

The public program cost shift is only one aspect of a broader cost shift in our healthcare system that includes increasing costs for public and private payers to compensate for unreimbursed care to the uninsured.⁸ This total cost shift in California has been estimated to be anywhere from less than three percent to more than 10 percent.⁹

chart one:
2005 federal medicaid spending per medicaid beneficiary



Source: Peter Harbage, "Playing Catch-Up," Blue Shield of California Foundation, February 2007

The low funding also has led to the ad hoc development of a safety net funding system built on a patchwork of sources. At the federal level, there is the Disproportionate Share Hospital program, and in California (as in Massachusetts) there is the Safety Net Care Pool (SNCP). At the state level in California, there is a hodgepodge of dollars, including realignment, county match, Proposition 99, and Tobacco Litigation Settlement dollars. Some counties operate public hospitals and clinics, others contract with private providers. Some counties focus on primary care, others also provide

⁸ Peter Harbage and Len Nichols, "A Premium Price: The Hidden Costs All Californians Pay in our Fragmented Health Care System," New America Foundation, December 2006

⁹ Len M. Nichols and Peter Harbage, "Estimating the 'Hidden Tax' on Insured Californians Due to the Care Needed and Received by the Uninsured," New America Foundation, May 21, 2007

hospital-based inpatient care. Every county makes direct expenditures in support of their Section 17000 obligation under California law to serve as providers of last resort for uninsured patients.¹⁰

The sources of funds are so varied that significant time and effort are devoted to managing and understanding these sources. As the cash flow from one source changes, the cash flow of other sources of funds can increase or decrease.

perverse financial incentives

Perhaps the most critical challenges in our existing healthcare system are the perverse financial incentives that reward safety net care providers when certain populations remain uninsured. This is a particular issue for public hospitals, which receive specially designated state and federal funds for serving as a primary source of care for the uninsured. Reform efforts which decrease the number of uninsured must also look at how to better align other sources of revenue for safety net providers. Expanding coverage should make the financial structure of our healthcare system more rational and support better health outcomes.

high levels of uninsured low-income adults

In addition to paying for coverage and services for low-income and at-risk residents, the Medi-Cal program is an important source of funding for uncompensated care for the uninsured. Of California's 6.5 million uninsured people, nearly half, or 3.18 million, are childless adults, and so are most likely ineligible for current Medi-Cal programs.¹¹ Numerous studies have shown that the uninsured are less likely to have a usual source of care, more likely to delay seeking needed care, and thus more likely to have poor health status.

The uninsured are more likely to have preventable hospital stays than the insured, at a cost of more than \$3,000 per stay.¹² When the uninsured finally seek the care they need, they are likely to use California's safety net hospitals and community clinics. More than 30 percent of uninsured adults with incomes under 100 percent of the federal poverty level (FPL)

10 Under Section 17000 of California's Welfare and Institutions Code, county governments – not the state – are ultimately responsible for care of the uninsured. Counties have discretion in how to meet their responsibility. For more, please see National Health Law Program, California Summary, undated. www.healthlaw.org/library.cfm?fa=download&resourceID=61147&print

11 Insure the Uninsured Project, April 25, 2007

12 Lucien Wulsin, Jr., "The Safety Net: Caring for California's Uninsured." Insure the Uninsured Project, Presentation to the Working Committee, April 25, 2007.

cite community clinics and hospitals as their usual source of care, whereas approximately 44 percent of this group of uninsured report having no usual source of care.¹³

inadequate access to care

“Coverage does not necessarily mean that people have access to health care.”

Santiago Muñoz, Associate Vice President for Clinical Services Development at the University of California

While Medi-Cal beneficiaries have better access to care than the uninsured, their access to care is more restricted than privately insured Californians. One reason is California's low Medi-Cal provider reimbursement rates. California has kept reimbursement rates low in an effort to save state General Fund dollars, even though it has had the effect of lowering federal matching funds for the state and discouraging providers from participating in Medi-Cal.

A substantially low proportion of doctors participate in Medi-Cal, which has a lower physician participation rate than many other Medicaid programs across the country.¹⁴ As a result, there are fewer doctors available to Medi-Cal beneficiaries than the privately insured. For example, as shown in Chart Two below, there are only 46 primary care physicians per 100,000 Medi-Cal beneficiaries, compared to the ratio of 70 to 100,000 for the general population. This is directly tied to low reimbursement rates, as California found when it increased rates for obstetric services and found increased provider participation.¹⁵

chart two: physician participation, medi-cal vs. california overall per 100,000 population in urban areas

provider type	medi-cal participation rate	california overall participation rate
Primary Care	46	70
Medical Specialist	4	10
Surgical Specialist	5	15
Ob-Gyn	15	12

Source: California HealthCare Foundation, "Medi-Cal 101" 2005

¹³ California Health Interview Survey, 2005

¹⁴ Andrew Bindman, et al., "Physician Participation in Medi-Cal 2001," Medi-Cal Policy Institute, May 2003

¹⁵ Peter Harbage, "Playing Catch-Up: California Can Improve Medi-Cal Access and Coverage by Obtaining Available and Additional Federal Support," Blue Shield of California Foundation, February 2007

Medi-Cal's eligibility and enrollment rules make intermittent coverage common for beneficiaries. This is another barrier to accessing care, as beneficiaries who do not have continuous coverage are "more likely to lack a usual source of care and have unmet health needs."¹⁶

fractured and precarious safety net

"Status quo is unsustainable, so doing nothing is not an option."

David Kears, Director of Alameda County's Health Services Agency

Working Committee members seemed to be in general agreement that a waiver must not just be about expanding coverage to childless adults, but that it should also help strengthen and rationalize California's healthcare system to help it function better for Medi-Cal beneficiaries and the uninsured.¹⁷

A recent report by the Insure the Uninsured Project best summarizes the state of the safety net:

"... the uninsured seek and receive care in disconnected public and private settings; some of that care is compensated by an array of public programs and some by the cost shift to the privately insured. Funding is inadequate to the needs of the patients, inequitably distributed, distributed in disconnected silos and not likely to increase absent reform."¹⁸

The current system is interconnected yet fragmented. Federal and state Medi-Cal dollars are used to support care for the uninsured across the state, and yet every county uses and accounts for those dollars in a different way. California's limited resources available to support Medi-Cal and the safety net encourage competition, not trust, between stakeholders. The fragmentation also occurs in part because of Section 17000, as each county is ultimately responsible for deciding how best to serve as the provider of last resort.

¹⁶ Marsha Gold and Erin Fries Taylor, "Public Programs: Access to Physicians in California's Public Insurance Programs," California HealthCare Foundation, May 2004

¹⁷ Comments to the California Working Committee, April 25, 2007

¹⁸ Insure the Uninsured Project, "Safety Nets and Coverage Expansion: ITUP Recommendations – Summary July 2007"

At the same time, changes to one aspect of the safety net system have a ripple effect. Moving funding from the safety net to expand coverage may reduce the uninsured burden on the safety net providers. But it would also reduce available federal dollars and could impair the safety net's ability to care for the remaining uninsured population, as well as provide other services that are hallmarks of safety net providers, like trauma, burn care, and medical education.

why california needs a waiver

Because California's safety net is interconnected, a waiver to cover childless adults will likely impact how the system as a whole is financed and structured. This is both an opportunity and a challenge to address comprehensive reform by crafting a waiver that will allow the state to confront the formidable obstacles the system faces and achieve the four goals put forth by the Working Committee: maximize federal dollars, expand coverage, improve care, and strengthen the safety net. Real change will come from comprehensively addressing all the challenges identified by the Working Committee.

state plan amendments

In recent years, changes have been made to Medicaid law to provide states with greater flexibility in tailoring their programs through a State Plan Amendment (SPA), avoiding the elaborate process of designing and negotiating a budget neutral waiver. For example:

- The 2005 Deficit Reduction Act (DRA) allows states to:¹⁹
 - Increase cost sharing;
 - Offer some populations benchmark benefit packages that are different from full Medicaid mandated benefits; and
 - Change asset tests to determine eligibility.
- The 1997 Balanced Budget Act:²⁰
 - Eliminated minimum payment standards for states in paying hospitals, nursing homes, and community health centers; and
 - Allows states to require beneficiaries to enroll in managed care.
- Existing law also allows states to raise or lower Medicaid provider payments. Increasing provider payments will be key to maximizing federal dollars for California with or without a waiver.

¹⁹ Kaiser Commission on Medicaid and the Uninsured, "Deficit Reduction Act of 2005: Implications For Medicaid," Kaiser Family Foundation, February 2006

²⁰ Andy Schneider, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997," Center on Budget and Policy Priorities, September 1997

Many Working Committee members seemed to believe that California should seek to achieve as much improvement as possible in Medi-Cal through SPAs before seeking a waiver. This is because states are guaranteed the flexibilities afforded through SPAs which can also generate additional federal matching funds.

section 1115 waivers

Section 1115 waivers must be negotiated with the federal government and are subject to various requirements, including budget neutrality caps on federal matching funds. There are, however, some program changes that can only be achieved using a Section 1115 waiver, including expanding coverage to uninsured childless adults and exploring non-traditional financing arrangements that will be necessary to comprehensively reform California's safety net.²¹

More importantly, a Section 1115 waiver is intended to be a tool for innovation. Many accepted features of today's state Medicaid programs originally began as 1115 waiver demonstration projects, including prospective payment systems for hospitals, managed care, and, recently, replacing institutional care with home- and community-based services.²²

California's 2005 Section 1115 Hospital Waiver has not helped address the fundamental challenges facing our health system. Under that waiver, California hospitals are now reimbursed on a cost basis. Supplemental spending through the Safety Net Care Pool is held flat over the five years of the waiver. There are ongoing concerns as to whether or not the waiver adequately funds safety net hospitals.²³

A new, comprehensive Section 1115 waiver based on covering childless adults is a critical mechanism which will allow California to reform and expand its Medi-Cal program to provide better care to more Californians, including:

- **Insuring Childless Adults:** This largest segment of California's uninsured adult population, and predominant user of safety net resources, can only be covered by Medi-Cal through a waiver.

21 Peggy Handrich and Pris Boroniec, "State Health Reform: Principles, Examples and Approach for California." Sellers Feinberg, Presentation to the Working Committee, March 28, 2007.

22 Cynthia Shirk, "Shaping Public Programs through Medicare, Medicaid and SCHIP Waivers: The Fundamentals," National Health Policy Forum Background Paper, September 15, 2003

23 For more information on the 2005 Medi-Cal Waiver, including detailed analysis of the financing issues, Please See: Peter Harbage, Andy Schneider, and Jennifer Ryan, "California's Medicaid Hospital Financing Waiver: A Three-Part Perspective," California HealthCare Foundation, April 2006. <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=120048>

- **Supporting the Safety Net:** The safety net (both public and private providers) will benefit from having a wider base of insured patients. A strong cash flow into the safety net will help enable system change.
- **Receiving Credit for Past Successes:** California has long been a leader in implementing cost containment initiatives in its Medi-Cal program, such as the Selective Provider Contracting Program. With a new waiver, California can seek to use those savings to help cover additional people, much the way other states have for similar programs. Today, much of those savings have simply reduced California's state spending, as well as federal match. With a waiver, these savings and federal dollars could be captured and redirected to other uses. For example, New York recently received budgetary credit from the Centers for Medicare and Medicaid Services (CMS) for a prescription drug program based on a California initiative and used the savings to fund a coverage expansion waiver.²⁴
- **Increasing Federal Support for Innovation:** Waivers are an opportunity for the federal government to make investments in states to achieve system change, including prevention and wellness programs and new quality initiatives like primary care case management (PCCM).
- **Developing Systems of Care:** County programs have long been the provider of last resort for the medically indigent. A Medi-Cal expansion will create a better system to develop and support local initiatives to improve care for those populations by better integrating primary, chronic, and inpatient care. A Medi-Cal expansion will also support the important role of private hospitals in the safety net system.
- **Anticipating Greater Flexibility from a New Administration:** A new federal administration will come into office in January 2009, approximately 18 months before California's current waiver expires. This is just enough time to prepare to work with new CMS leadership which may be more open to the concept of a California childless adult waiver.

refining and continuing california's 2005 waiver

Research is needed on what changes might be made to the 2005 waiver, and their potential impact on the safety net. Significant funding is at stake in this waiver renewal, including the as-yet-unclaimed \$360 million in federal incentive funds to shift to mandatory managed care for the Aged, Blind, and Disabled.

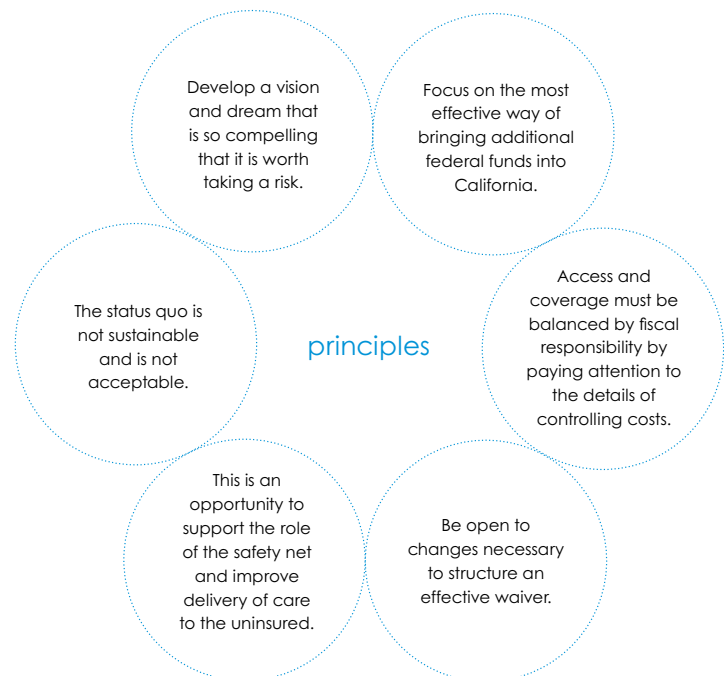
²⁴ Stan Rosenstein, Comments to the California Working Committee, June 27, 2007

section 3: principles for waiver development

The Working Committee was established on the assumption that California's safety net health system faces significant challenges. In a year of broad attention to health reform, the hope was that there could also be extraordinary thinking around changing and improving the safety net through a childless adult coverage waiver. Working Committee members generally felt that six principles could be used to guide the creation of a waiver.

Each member of the Working Committee represents an important element of California's healthcare system, from public hospitals to counties to advocates and other key stakeholders. Each member also came to the Working Committee with a particular set of knowledge and expertise, as well as an organizational point of view. The purpose of this set of principles was to provide a framework for Working Committee members to use in thinking about the compromises and hard choices necessary for real change in the system.

These six principles form the basis for the recommendations made by Harbage Consulting in this report.



section 4: developing the scope of the waiver: expanding coverage

A consistent focus of the Working Committee was on the goal of expanding Medi-Cal eligibility to more of California's uninsured population. California's Medi-Cal and SCHIP programs have already taken advantage of federal regulations to expand eligibility to large numbers of low-income children and parents. A Section 1115 waiver is the only venue for California to expand eligibility beyond populations already covered by Medi-Cal rules.

There are four questions California must answer in designing this coverage expansion:

1. What are the target populations the waiver would cover?
2. What benefits will be offered?
3. What kind of cost sharing will be required?
4. How will services be delivered to coverage expansion populations?

In discussing these questions, Working Committee members did not engage in debating the nuts and bolts. Instead, Working Committee members engaged in understanding the scope of options available under a waiver, as well as what other states have chosen to do. This may have been due, in part, to the fact that any final determination of who is eligible, the benefits they will be offered, and how they will receive services depends in large part on final budgetary considerations.

It is also worth noting that, historically, California is more likely to try to expand eligibility and covered benefits, where possible, instead of opting for a more limited or less expensive benefit package.

what target populations would the waiver cover?

“In California, the idea of just covering childless adults is a good idea and something people have really wanted...from our perspective we are happy to see an expansion, period.”

*Angela Gilliard, JD, Legislative Advocate at the Western Center on Poverty and Law*²⁵

Many states have already taken advantage of opportunities to expand coverage through Medicaid, but Section 1115 waivers are an increasingly popular option for states to expand coverage even further.²⁶ One appealing feature of a waiver is that it allows states to cover uninsured individuals not otherwise eligible for Medicaid or federal subsidies, most often low-income childless adults.

Many states now use waivers to cover childless adults through their Medicaid program, including Arizona, Hawaii, Massachusetts, Michigan, and Vermont. Others including Illinois, Pennsylvania, and Washington also have used their waiver to cover children. Working Committee discussions focused narrowly on possible eligibility limits within the childless adult population.

current programs

Federal law requires state Medicaid programs to cover some populations and makes a federal match available for certain expansions of those populations. California covers all mandatory and some optional populations. There are currently 150 eligibility categories for California's public health coverage programs, each with slightly different factors and documentation to determine eligibility.²⁷ The following populations are eligible for either Medi-Cal, Healthy Families, or other public programs:²⁸

- Low-income families participating in CalWORKS;
- Seniors and people with disabilities receiving Supplemental Security Income with incomes up to 125 percent of poverty;
- Pregnant women up to 300 percent of poverty;

²⁵ Angela Gilliard, Comments to the California Working Committee, April 25, 2007

²⁶ Samantha Artiga and Cindy Mann, “Coverage Gains Under Recent Section 1115 Waivers: A Data Update.” Kaiser Commission on Medicaid and the Uninsured, August 2005. <http://www.kff.org/medicaid/upload/Coverage-Gains-Under-Recent-Section-1115-Waivers-A-Data-Update-Issue-Paper.pdf>

²⁷ Insure the Uninsured Project, “Safety Nets and Coverage Expansion: ITUP Recommendations.” July 2007

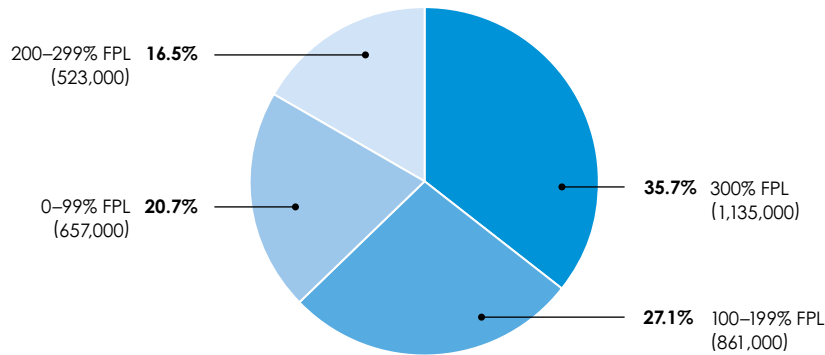
²⁸ California HealthCare Foundation, “Medi-Cal Facts and Figures: A Look at California's Medicaid Program.” May, 2007

- Infants and children up to 250 percent of poverty;
- Children in foster care and receiving adoption assistance; and
- Low-income Medicare beneficiaries.

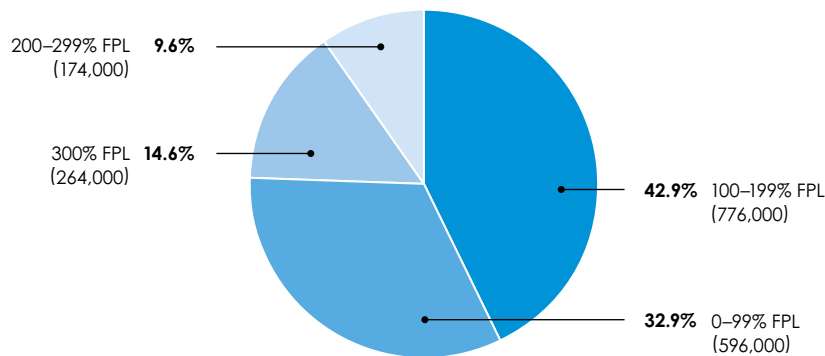
California currently has approximately 6.5 million uninsured adults and children. Many are currently eligible for a public program, but not enrolled. Of those not currently eligible for public coverage, the majority are childless adults.²⁹ Chart Three below shows the breakdown of uninsured adults in California by income level.

chart three:

Uninsured adults without minor children living at home by income, 2005
Total = 3,176,000



Uninsured married adults with children living by income, 2005
Total = 1,810,000



Source: CHIS 2005
 Insure the Uninsured Project, April 25, 2007

²⁹ Lucien Wulsin, Jr., "The Safety Net: Caring for California's Uninsured." Insure the Uninsured Project, Presentation to the Working Committee, April 25, 2007.

reform proposals

California has considered Medi-Cal eligibility expansion proposals in the past, including the 2007 health reform proposals. California's previous proposed coverage expansion through a Section 1115 waiver was not implemented, but would have expanded Medi-Cal and Healthy Families eligibility to parents with incomes at or below 200 percent of poverty.³⁰ Governor Schwarzenegger's original health reform proposal would have covered childless adults with incomes up to 100 percent of poverty and made subsidies for purchasing private insurance through a pool available for individuals with incomes of up to 250 percent of poverty.³¹

Building on the plan of the governor and the Democratic Legislative Leadership, the final healthcare compromise bill (ABX1 1), as passed by the Assembly in December 2007, proposed expanding Medi-Cal and Healthy Families eligibility to children and parents with incomes of up to 300 percent of poverty and included a provision to cover childless adults.³²

options

Under a waiver, California can use a number of characteristics to define eligibility for the Medi-Cal program expansion, including:

income

- For children and adults, California currently has income limits for at or below 300 percent of poverty, depending on the public program in which they are enrolled.
- Pregnant women are covered at the highest income limits, and Medi-Cal limits for other adults tend to be lower, at 100 to 150 percent of poverty.
- Current adult income limits are higher than the Medicaid mandated level.

assets

- Medi-Cal currently uses an asset test to determine eligibility.
- Some state coverage expansions, including that of Massachusetts, have not applied an asset test to new populations.

30 Kaiser Commission on Medicaid and the Uninsured, "Key Facts: California Section 1115 Waiver." April, 2003. <http://www.kff.org/medicaid/4103-index.cfm>

31 Office of California Governor Arnold Schwarzenegger, "The Governor's Detailed Health Care Proposal." January 2007. http://www.fixourhealthcare.ca.gov/Governors_HC_Proposal.pdf

32 California State Assembly Democratic Caucus, "Fact Sheet on AB 8." July 18, 2007. <http://democrats.assembly.ca.gov/members/a46/pdf/AB8FactSheet2.pdf>

access to employer-sponsored insurance

- Restricting Medi-Cal coverage expansion to individuals without access to employer-sponsored insurance can help prevent crowd-out, where employers stop offering health coverage because their employees become eligible for state programs.
- Some low-income employees cannot afford their employer's coverage but would remain ineligible for Medi-Cal with this restriction.

age

- Currently, 19-to-21-year-old adults can be covered through a state plan amendment, meaning 21-to-64-year-olds would need to be covered under a waiver.
- However, if California wanted to provide benefit or cost sharing packages for the 19-to-21-year-old population that are different than the full Medi-Cal package, this group would need to be covered under the waiver.

enrollment caps

- An enrollment cap would limit the state's financial liability in expanding coverage by closing the program after a set number of enrollees.
- Some states have enrollment caps, including Massachusetts (60,000) and Utah (25,000), but others do not, such as Arizona and New York.
- Enrollment caps can be controversial, as they arbitrarily exclude otherwise eligible beneficiaries.

Narrowly defining the newly eligible population through higher income, asset, and access tests could help keep costs low and make it easier to find funding, or could allow the state to offer a more comprehensive benefit package in a Medi-Cal expansion. Alternatively, broadening eligibility may be one way to use Medi-Cal to reach more uninsured Californians and achieve greater system reform.

recommendations

California should determine what segment of the uninsured, childless adult population has the greatest current healthcare needs. Coverage expansion programs targeted at this population can be effective at changing service utilization patterns for those individuals, shifting them from expensive emergency department-centered care to routine care settings.

California should also use a waiver as an opportunity to streamline program eligibility rules. Current eligibility rules are confusing, creating unnecessary administrative complexities and costs for the state and beneficiaries, which can lead to breaks in coverage and medical treatment. As the Insure the Uninsured Project has called for, California also should seek to create a "'bright line' – a consistent income distinction between Medi-Cal and Healthy Families, as opposed to the zigzag eligibility that currently divides family members between different programs, plans, and family doctors."³³

lessons from other states: target populations

- Most states only expand coverage to childless adults up to 100 percent of poverty, including Arizona, Hawaii, Massachusetts, New York, and Oregon.
 - Other states go higher: 125 percent of poverty in Maine, 150 percent in Utah and Vermont.
 - Other states go lower: 50 percent of poverty in the District of Columbia, and 35 percent in Michigan.
 - Most states use asset tests in addition to income tests, with Massachusetts being a key exception.
 - Massachusetts also decided to limit the population to the long-term unemployed, defined as 12 or more months of unemployment.³⁴
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³³ Insure the Uninsured Project, "Safety Nets and Coverage Expansion: ITUP Recommendations," July 2007

³⁴ Beth Waldman, "Steps to a Childless Adult Waiver in California," Bailit Health Purchasing, LLC, Presentation to California Working Committee, April 25, 2007

what benefit packages will be offered under the waiver?

“From the planning side to the implementation side, we need to make sure we are able to provide a suite of services to beneficiaries that is worth their while.”

Louise McCarthy, formerly of California Primary Care Association³⁵

Medicaid's statewide and comparability requirements mean that all beneficiaries in a certain eligibility category must be offered the same benefit package. That benefit package must include services required by Medicaid, and may include certain Medicaid-approved optional benefits. One characteristic of Section 1115 waivers is that states can define benefit plans that differ from the mandated and/or optional Medicaid package, and still receive a federal match for providing those services.

current programs

California currently offers beneficiaries every optional service available for a federal match in addition to the required Medicaid benefits. This has been a decision made over time by the California legislature. Chart Four shows a partial list of the required and optional services offered by Medi-Cal.

chart four:

required services

- In/outpatient hospital
- Physician visits
- Lab tests and x-rays
- Early and periodic screening, diagnosis and treatment for children
- Family planning consultations and supplies
- Federal Qualified Health Center clinics
- Certified nurse practitioners
- Nursing home care
- Home health services
- Nurse midwife services
- Pregnancy-related services

optional services

- Prescription drugs
 - Vision services
 - Dental care
 - Medical equipment and supplies
 - Case management
 - Adult day health
 - Personal care services
 - Physical therapy
 - Intermediate care facilities for mentally retarded
 - Inpatient psychiatric care for children
 - Rehabilitation for mental health and substance abuse
 - Home health care therapies
 - Hospice
 - Occupational therapy
 - Chiropractic
-

³⁵ Louise McCarthy, Comments to the California Working Committee, April 25, 2007

reform proposals

The governor's original 2007 health reform proposal would have provided individuals under 100 percent of poverty with the same benchmark plan constructed through the Deficit Reduction Act (DRA) flexibility available to parents covered through a SPA. A product more like what is available on the commercial market was proposed for individuals above 250 percent of poverty, who would have purchased those plans through a purchasing pool.³⁶ The Democratic proposal, AB 8, would have offered Medi-Cal and Healthy Families benchmark plans to newly eligible beneficiaries, in an approach finally adopted in the Assembly-passed compromise bill.³⁷

options

There is no set formula for states in building a benefit package using the flexibility under a waiver. However, benefits are generally grouped in three tiers:

full medicaid benefits

- Some states choose to simply offer coverage expansion beneficiaries the same benefits available to their regular Medicaid populations. These benefit packages are understood as "full" Medicaid benefits but can differ from state to state, reflecting each state's unique combination of mandated and optional benefits offered in their traditional Medicaid program.
- For California, this package could contain all mandated and optional benefits.

reduced medicaid benefits

- Some states choose to offer coverage expansion populations slightly fewer benefits than their standard Medicaid package. With waiver flexibility, states can choose to offer any combination of benefits and may even drop otherwise mandated benefits.
- California may choose to reduce the number of Medicaid optional benefits for their coverage expansion population, as several other states have done, and still offer comprehensive coverage.

³⁶ Stan Rosenstein, Statement to California Working Committee

³⁷ California State Assembly Democratic Caucus, "Fact Sheet on AB 8," July 18, 2007.
<http://democrats.assembly.ca.gov/members/a46/pdf/AB8FactSheet2.pdf>

limited benefit packages

- The most limited benefit packages only cover preventative, routine, and/or catastrophic care.

expanded medicaid benefits

- States can also use waivers to receive a federal match for benefits not otherwise matchable, and so offer additional benefits to coverage expansion populations.

benefit packages tied to income levels

- Assuming Medi-Cal was expanded to uninsured adults above and below 100 percent of poverty, different packages could be offered to different segments of that population.
- For example, the medically indigent population would likely need a more comprehensive benefit package than the general population of uninsured, childless adults.

The benefit package offered to individuals under a waiver expansion is a key part of the cost calculation. Limiting the benefits, or making benefit packages look more like products on the commercial market, may help lower costs, which in turn may allow the state to expand coverage to greater numbers of individuals. This has been an approach favored by CMS in recent years.³⁸ The concern with limiting benefits would be that some Medi-Cal recipients might not have access to a medical benefit they need. However, in determining benefit packages, California should consider more than just the cost.

- Benefits must be meaningful enough to lower the costs of uncompensated care to the safety net and for the uninsured to find value in them and seek coverage.
- If benefits are too rich, individuals may drop employer coverage in favor of enrolling in the public program, causing crowd-out.

One resource for considering benefit package design is Sacramento Health Decisions. Led by Marge Ginsberg, their research has focused on trade-offs people consider in selecting health insurance benefits, including the specific considerations of the uninsured.³⁹ In general, the research

³⁸ Stan Rosenstein and Teresa Sachs, Comments to the California Working Committee, June 27, 2007

³⁹ For an overview of the Sacramento Health Decisions project, please see <http://www.sachealthdecisions.org>. For information on the uninsured, please see: California HealthCare Foundation, "Designing Coverage: Uninsured Californians Weigh the Options," Issue Brief, June 2007. <http://www.chcf.org/documents/insurance/DesignCoverageForUninsured.pdf>

regarding the uninsured has shown a preference towards coverage that offers the greatest value, such as preventative care. A preference for dental care was also identified.

should mental health services be included in the benefit package?

Historically, California has operated with a bifurcated mental health system, with counties running most mental health programs and the state managing Medi-Cal. But several questions were raised about whether mental health and substance abuse programs should be part of the waiver benefit package and integrated with traditionally covered health services, even if that means that the waiver population has a stronger benefit than the non-waiver population.

Committee members felt that mental health can be very expensive, especially for full, equal access. There was general discussion that a basic benefit could be as much as \$250 per member per month (PMPM). There are two options for including mental health services in the benefit package:

- Provide similar services to what counties currently provide, focusing on the most seriously mentally ill; or
- Provide a broader benefit designed to keep any beneficiaries with mental health needs productive and out of institutions.

Adding a mental health benefit could help draw down additional federal dollars, but it also adds some complexity. First, the inclusion of mental services in the benefit package may cause a population shift from the Medicaid entitlement program into the waiver program, which has spending limits. Other states that have operated similar programs have seen this shift, particularly in the disabled population. In addition, counties are currently mandated to provide these services. Some counties may perceive that it is in their best interest to resist a shift of mental health benefits to Medi-Cal.

recommendations

Benefit package design is always controversial. California's political leaders have a history of wanting to offer an increasingly comprehensive Medicaid benefits package, and have expanded that package over time to include all optional services. The concern with reducing the package for the non-mandatory expansion population is that a needed benefit would be dropped. The trade-off is that fewer benefits typically mean reduced costs.

The benefits with the most actuarial impact are inpatient, prescription drugs, and long-term care. The question for California is one of cost. If the full Medicaid package can be funded, then full benefits should be offered. However, limited resources may require the state to offer waiver populations a limited benefit package in order to expand coverage while containing costs.

lessons from other states: benefit packages

States have taken advantage of the wide range of options available to them in designing benefit packages. For example:

- **Full:** Maine, Arizona, and the District of Columbia offer the full, traditional Medicaid benefit.
 - **Reduced:** Massachusetts, New York, and Vermont offer reduced Medicaid benefits which generally include mandated acute care services, but not optional services such as long-term care, non-emergency transportation, or dental coverage.
 - **Limited:** Utah, Hawaii, Michigan, Oregon, and Utah all offer more limited benefit packages that cover only preventative and primary care services.⁴⁰
-

what cost sharing should be required?

Under Medicaid, services cannot be denied for failure to pay, and cost sharing is generally minimal. However, many states have some cost sharing, generally in the form of co-payments, to enable individuals to take some responsibility for their own health. Recent changes to federal law have already given states more flexibility in asking beneficiaries to share costs, but cost sharing is also an important feature of constructing a waiver.

current programs

California's Medi-Cal cost sharing is currently in the form of nominal co-payments for some services, including:⁴¹

- Physician office visit: \$1
- Inpatient hospital: \$1
- Non-emergency services received in an emergency room: \$5

⁴⁰ Beth Waldman, "Steps to a Childless Adult Waiver in California," Bailit Health Purchasing, LLC, Presentation to California Working Committee, April 25, 2007

⁴¹ California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007

options

some cost sharing, on sliding scale

- If the expansion goes high enough up the income ladder, some populations may be able to make significant contributions to their premium costs.
- Linking cost sharing to an individual's ability to pay may prevent high costs from keeping an individual from enrolling, or delaying or avoiding needed care.
- Some cost sharing schemes may allow the state to build in incentives and rewards for healthy behaviors.

no cost sharing

- No cost sharing would remove all financial barriers to seeking care but may increase costs or be politically untenable for higher income populations.

Most cost sharing in Medicaid is nominal – just a few dollars for select services. In addition, individuals cannot be denied service for failure to pay. As a result, individuals do not contribute a significant portion of the program's costs. Some populations are completely exempt from cost sharing, including children and the institutionalized. The goal is simply to engage individuals in taking responsibility for their health care. Higher cost sharing may only be realistic if a coverage expansion would include higher-income individuals who may reasonably be expected to take greater responsibility for their own health.

recommendations

In designing cost sharing levels for a Medi-Cal coverage expansion population, California should consider the following principles, as presented to the Working Committee by consultants from Sellers Feinberg.⁴²

Cost sharing should:

- Be affordable, and based on patients' ability to pay;
- Discourage unnecessary care without keeping patients from delaying needed care;
- Encourage individuals to make healthy lifestyle choices; and
- Limit crowd-out.

⁴² Peggy Handrich and Prís Boroniec, "State Health Reform: Principles, Examples and Approach for California," Sellers Feinberg, Presentation to California Working Committee, March 28, 2007

lessons from other states: cost sharing

Most states have only expanded coverage to childless adults up to 100 percent of the federal poverty line, and so have very limited cost sharing requirements for this very low-income group. For example:

- Most states do not have premium or enrollment fees. Several exceptions include Oregon, with premiums on a sliding scale of \$9 to \$20; Utah, with annual enrollment fees on a sliding scale from \$11 for general assistance members to \$50 per year for individuals at 50 to 150 percent of poverty; and Vermont, with premiums from \$11 to \$50 PMPM, based on income.
 - More common are nominal co-payments, similar to those through Medicaid, which are required by Arizona, Massachusetts, and Michigan.
 - Utah's coverage expansion program is an exception in requiring significant cost sharing from beneficiaries, as well as offering a limited benefit package.⁴³
-

how will services be delivered to coverage expansion populations?

"This is an opportunity to improve how care is delivered to really low-income populations and to the uninsured. But it takes money. It takes resources."

Melissa Stafford Jones, President and CEO of the California Association of Public Hospitals and Health Systems

CMS does not require states to use their traditional Medicaid service delivery systems for their expansion programs, but most do so. Most states also choose to enroll expansion populations in their managed care, rather than fee-for-service, programs.

current programs

California's Medi-Cal services are delivered through multiple delivery systems, depending largely on a beneficiary's county of residence and medical needs. Managed care is mandatory for some populations, including children, pregnant women and non-disabled parents, but voluntary for most elderly and disabled. Only 22 of the state's 58 counties have managed care available, in other counties all beneficiaries are enrolled in fee-for-service. Just less than half of beneficiaries, or 48 percent, are enrolled in managed care.⁴⁴

⁴³ Beth Waldman, "Steps to a Childless Adult Waiver in California," Bailit Health Purchasing, LLC, Presentation to California Working Committee, April 25, 2007

⁴⁴ California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007

There are three basic ways California counties operate their Medi-Cal managed care plans.⁴⁵

- **County Organized Health Systems:** In these counties, the county governments operate their own managed care plans and contract with the state on a per beneficiary capitated basis. Enrollment in managed care is mandatory for most Medi-Cal beneficiaries in the five counties with a COHS.
- **Geographic Managed Care:** In both GMC counties (Sacramento and San Diego), the state contracts with multiple managed care plans, and pays for beneficiaries on a capitated basis. Enrollment in managed care is mandatory for some Medi-Cal populations in these counties.
- **Two Plan:** In Two Plan counties, beneficiaries have an option of participating in a county-run or commercial managed care plan. Enrollment in managed care is mandatory for some Medi-Cal populations in these counties.

California's current Medi-Cal managed care system has faced a number of problems, including low provider-reimbursement rates and the additional administrative costs and complexity for beneficiaries resulting from the multiple layers of the managed care models.⁴⁶

options

In determining how to deliver services for expansion populations, California can keep its current system or work to find innovative new options for beneficiaries.

- **Choice Within Current Medi-Cal Service Delivery System:** Allows counties to determine how to provide services, possibly saving some upfront administrative set-up costs but would maintain a fragmented and regionalized system where not all enrollees have access to the same service delivery options.
- **Exclusive Enrollment In Public Hospitals and Community Clinics:** Public hospitals and clinics already treat a majority of the uninsured, childless adults. This would build on their experience, stabilize their patient mix and expand beneficiary access to primary and preventive services

45 California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007, and California HealthCare Foundation, "Fact Sheet No. 8: Medi-Cal Managed Care," March 2000. <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=20396&subtopic=CL367&subsection=medical101>;

46 Debbie Draper, Marsha Gold and Julie Hudman, "Managed Care and Low-Income Populations: A Case Study of Managed Care in California." Kaiser/Commonwealth Low-Income Coverage and Access Project, December 1999

beyond those that are currently offered. It would also limit choice for those newly insured beneficiaries. (More details in Section 5: "Developing the Scope of the Waiver: Strengthening the Safety Net.")

- **Mandatory Managed Care:** Mandatory managed care is one way to try to limit costs and meet federal budget neutrality conditions.⁴⁷ Because managed care is not available in all California counties, some beneficiaries would not be subject to the mandate.
- **Statewide Managed Care:** California, like Vermont, could offer a new, state-run, statewide managed care plan. This would create more consistency for beneficiaries, and it could broaden access to managed care for traditional Medi-Cal beneficiaries.

California's stakeholders, including many Working Committee members, have concerns around access in managed care networks, including the historic use of managed care to limit care and thus lower costs. At the same time, there is some indication that managed care is working to help keep some Medi-Cal beneficiaries healthy. A 2004 study by the California HealthCare Foundation showed that the rate of preventable hospitalizations was one-third lower for adult Medi-Cal beneficiaries eligible for managed care through participation in CalWORKS than comparable beneficiaries in fee-for-service delivery systems.⁴⁸

The larger challenge in California's current Medi-Cal service delivery system may not be managed care per se, but that actually multiple service delivery systems are widely decentralized across the state. While this allows local governments to try new, innovative programs and tailor their approach to their community, it is an unnecessarily complex and uncoordinated approach.

recommendations

California should explore the opportunities and obstacles around creating a statewide managed care plan given its potential to increase options and improve quality for both new and existing Medi-Cal beneficiaries. The state should also explore exclusive enrollment in the public delivery system, in particular during a transition period in implementing reforms under the waiver.

⁴⁷ Beth Waldman, "Steps to a Childless Adult Waiver in California," Bailit Health Purchasing, LLC, Presentation to California Working Committee, April 25, 2007

⁴⁸ Andrew Bindman, et al., "Managed Care and Low-Income Populations: A Case Study of Managed Care in California," California HealthCare Foundation, February 2004. <http://www.chcf.org/documents/policy/PreventableHospitalizationsInMediCal.pdf>

lessons from other states: service delivery

Most states simply deliver services to their childless adult expansion populations through the same methods used to cover traditional Medicaid populations, which vary from state to state. Some states, such as Maine, Michigan, and Oregon, offer choice of service delivery for expansion beneficiaries. Otherwise, states generally offer one of four options:

- **Traditional Managed Care:** Arizona, the District of Columbia, Hawaii, Maine, Michigan, Oregon, and New York.
 - **A Single State-Run, State-Wide Managed Care Plan:** Vermont.
 - **Primary Care Case Management (PCCM) Programs:** Massachusetts and Maine.
 - **Fee-For-Service:** Maine, Michigan, and Oregon.⁴⁹
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⁴⁹ Beth Waldman, "Steps to a Childless Adult Waiver in California," Bailit Health Purchasing, LLC, Presentation to California Working Committee, April 25, 2007

section 5: developing the scope of the waiver: strengthening the safety net

California's safety net is both highly interconnected and highly fragmented. Changes in the financing of one part of the system can have an unanticipated impact on other parts of the system. Yet the care delivery system itself is fragmented. As a result, significant improvements to the system can only come from fundamentally restructuring how services are delivered and funded.

current program

The challenges facing Medi-Cal and the safety net have already been discussed in detail. To summarize, the five specific challenges discussed by the Working Committee are directly linked to the goals for a waiver:

- Low federal funding;
- Perverse financial incentives that already exist in the system and were memorialized under the 2005 hospital waiver;
- High numbers of uninsured, low-income adults ineligible for current Medi-Cal programs;
- Inadequate access to care for beneficiaries; and
- A fragmented and precarious safety net.

options

In order to prepare the system to cover childless adults, a series of changes and issues related to public and private safety net providers must be considered. This is part of the challenge and opportunity provided by a waiver process. A childless adult waiver creates the chance to achieve positive system changes:

- **Transform the Healthcare System:** Waivers have frequently been used to restructure how public dollars are used to provide healthcare services to Medicaid beneficiaries and the uninsured. For example, waivers can encourage the use of primary and preventive care instead of emergency department use by redirecting funding from supporting uncompensated care to covering the uninsured. Another example is the Los Angeles County waiver, first approved in 1995–96, which promoted the use of outpatient clinics over inpatient care.

- **Consolidate the System's Funding Streams:** As previously described, California's safety net relies on a patchwork of existing funding. Bringing all funding streams under one waiver could allow the state to consolidate how dollars come into the system and promote a better understanding of how the system works.
- **Receive Full Credit for Dollars Spent:** Another symptom of California's fragmented safety net funding structure is that not all county health spending receives the federal matching dollars it is eligible for. Bringing that spending in under a waiver could help boost federal dollars for California.
- **Revisit the 2005 California Hospital Waiver:** The 2005 Section 1115 waiver provided temporary financial relief for California's safety net hospitals. At the same time, there have been concerns that the waiver also locked in low levels of future spending. The 2005 waiver is due for renewal in 2010, little more than two years away. While the 2005 hospital waiver could be renewed independently of a coverage expansion waiver, a new, truly comprehensive waiver is an opportunity to negotiate responsible funding for public and private safety net hospitals, in addition to rationalizing how those hospitals are funded.

key concerns and committee discussion

"A major portion of the patient population public hospitals serve is indigent adults, childless adults under 100 percent of poverty. We will still need to have a strong safety net in our state. There will always be some patients that stay in the safety net."

Melissa Stafford Jones, President and CEO of the California Association of Public Hospitals and Health Systems

California's safety net is held together by a fragile balance of funds. Decreasing funding for uncompensated care would likely hurt the ability of public hospitals and community clinics to meet their financial obligations. Because of the complicated funding mechanism that supports the safety net, those funds play a number of important roles in our healthcare system beyond providing care to the uninsured. These roles include serving the chronically ill – with their costly, ongoing care needs – and providing trauma, physician training and other services that support the entire system. These services will need to continue, even with expanded coverage of childless adults.

A top concern of the Working Committee has been the need to balance the goals of expanding coverage with strengthening and stabilizing the safety net. In particular, stakeholders expressed the desire to ensure that counties are adequately funded for the services they are required to provide under a childless adult waiver. This is a particularly complex challenge California must grapple with in determining the tough trade-offs and compromises necessary to build a waiver.

Working Committee members considered three steps to strengthen the safety net under a childless adult waiver, including the following options:

option 1: protecting disproportionate share hospital funding

As has been discussed, California's safety net relies heavily on Disproportionate Share Hospital (DSH) funding to provide services to both uninsured and underinsured patients – including many Medi-Cal beneficiaries. California also receives a particularly high federal matching rate of 87 percent on its DSH spending. Not only could these matching dollars be jeopardized under a new waiver, redirecting them from safety net hospitals to coverage could endanger those hospitals' ability to continue to serve the frictionally uninsured and make up for low Medi-Cal provider rates.

Working Committee members identified the need to protect California's DSH allotment. California should argue that the enhanced DSH payments are part of baseline spending, and therefore should continue to come into the state at the higher level, even under a new waiver. If the dollars are blocked under a waiver, then those lost dollars should, at a minimum, become part of the savings calculation under the budget neutrality waiver.

Another consideration is that DSH funds can only be used for uncompensated care. If health reform efforts resulted in universal (or near-universal) coverage, it is possible that the state would not have a sufficient level of uncompensated care to spend all available DSH funds. But under a waiver, California could seek permission from the federal government to use DSH funds to help cover the costs of purchasing insurance. Therefore, a waiver could be an important way for the state to maintain DSH funds flowing into the state.

option 2: delivering care through the safety net

The uninsured, including childless adults, make up a significant portion of public hospital and clinic visits, including more than 5 million public clinic visits and nearly 2.5 million public hospital outpatient visits.⁵⁰ Historically, public coverage or managed care expansions have spread the effected patient population from public hospitals and clinics to a broader array of providers at the community level. Coverage expansions under a childless adult waiver may lead to further concentration of the uninsured in an unsustainable patient base for public providers.

Beneficiary choice has historically been a major goal of waivers, with the Clinton administration aggressively pursuing policies that promoted access and choice within managed care. However, some have proposed that California could use a waiver to structure care delivery options for beneficiaries in order to limit disruption to safety net funding, at least during a transition period.

This approach would rely on the significant experience public facilities have in treating complex medical conditions and working with low-income populations. While this would limit the provider network for these beneficiaries, it would also limit funding disruptions to the safety net during the transition period under a childless adult waiver.

The additional revenue generated could give public providers the opportunity to transition to a more coordinated and sustainable delivery system. It could also ensure that they can continue to provide necessary services for the whole healthcare system, including trauma care and medical education. Policymakers have a number of options that could be incorporated into a waiver:

- **Allow Public Hospitals to Maintain Exclusive Enrollment of Childless Adults:** New coverage expansion beneficiaries could be enrolled in Medi-Cal and receive services through a limited network of public hospitals or community health centers. This would help keep those institutions competitive and create a viable patient mix. This exclusivity could be permanent, for a transition period of three to five years, or phased out as public providers reach benchmarks showing their improved ability to compete with private providers for patients. In exchange for the consideration given to safety net providers, the

⁵⁰ Insure the Uninsured Project. "The Safety Net: Caring for California's Uninsured." Presentation to the California Working Committee, April 25, 2007

federal (and possibly the state) government could ask for benchmarks of progress, as was done in the Los Angeles County waivers. The development of such benchmarks should be part of the larger stakeholder process.

There are other important and complex considerations, such as the capacity of public hospitals to absorb this population and the ability of beneficiaries to choose their provider. There is also the reality that beneficiaries will, as necessary, use the emergency room nearest to them, regardless of where they are assigned for care. This approach will always require some back and forth between private hospitals, and, in particular, private safety net hospitals.

- **Allow the Market to Respond:** Notwithstanding concerns about the previously uninsured, it could be argued that there are barriers that would guard against most patient shifts from the safety net, such as capacity issues and public hospitals' historic focus on cultural competency. While this does not guarantee a sustainable patient mix for public providers, it does maximize the ability of beneficiaries to choose their desired provider.
- **Delay Enrollment of Childless Adults into Medi-Cal Until the Public System is Modernized:** Instead of choosing between a policy of exclusivity or not, another option would be to delay the coverage of childless adults until after the public hospitals are given the resources to modernize and therefore compete on equal footing with the private market on cost and quality. This concern goes beyond "bricks and mortar." The concern is more in terms of business operations at public facilities. Conceivably, there could be a built-in delay that would allow time for public hospitals to transform while the waiver is being implemented. Alternatively, the early years of a waiver could provide dollars to transform the safety net.

option 3: increasing provider reimbursement rates

Private and public providers are reimbursed differently in Medi-Cal, so making compensation more equitable for each group will take two different forms.

- **Private Providers:** As previously discussed, Medi-Cal provider rates for physicians are significantly lower than Medicaid rates for other states and are closely linked to the low provider-participation rates in California's program. Increasing the number of Medi-Cal beneficiaries without increasing provider participation could create a significant barrier to accessing care in the Medi-Cal system. While California does not need a waiver to increase private provider payments, there was widespread agreement among Working Committee members that increases to Medi-Cal provider rates were a necessary component of reform, with or without a waiver. There is a need to increase reimbursement rates to private providers, including private DSH hospitals.
- **Public Providers:** Public hospitals are reimbursed directly by the federal government for services provided for Medi-Cal patients, and that reimbursement rate is 50 percent of the cost of delivering the service. The other half of costs must be met by counties, either through local or state funds. Public hospitals rely on DSH and SNCP funds to compensate for costs inadequately reimbursed or costs that the federal government will not match. Reimbursement increases are necessary to preserve and improve access to care.

recommendations

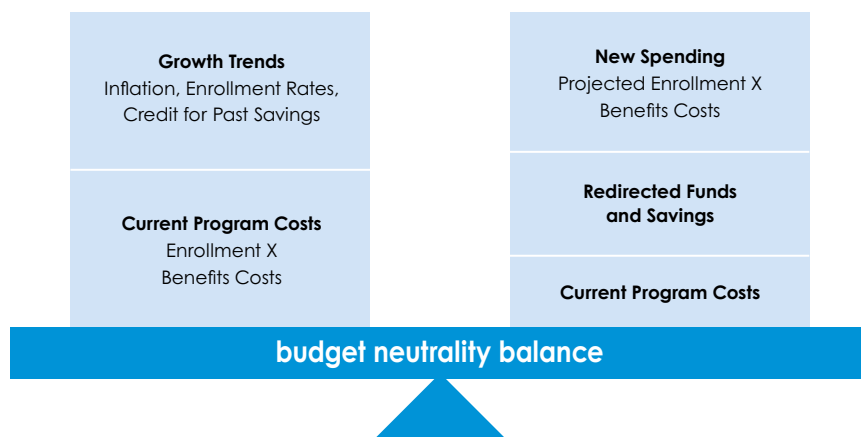
Given its crucial role in the current system, careful attention needs to be paid to any changes made to the safety net. Done poorly, there could be significant system and care disruption. However, California has a chance to cover childless adults and make other needed changes. It will take careful thought on how to make sure that safety net providers can have the chance to compete on equal footing with private hospitals to serve California's newly insured populations.

section 6: designing a budget neutral waiver proposal

A key feature of Section 1115 waivers is called budget neutrality, meaning that waivers cannot cost the federal government any more than the state's Medicaid programs would have cost in the absence of the waiver. Budget neutrality has been federal policy since 1983, but current rules were set by the Clinton Administration in the September 27, 1994, *Federal Register*. Those new rules gave states greater flexibility by calculating budget neutrality based on the five-year life of the waiver, rather than on an annual basis.⁵¹

California's first step in building a budget neutral waiver is negotiating with CMS the baseline, or "without-waiver" cost, of what the state's current Medicaid program would cost the federal government over the five-year term of the waiver. While based on historic spending rates, the baseline can also take into account other factors in projecting future costs. The state's coverage expansion or other waiver program changes – the "with-waiver" cost – must be equal to the "without-waiver" cost.

Because a coverage expansion is likely to cost the state more than its program would otherwise, the state must find savings or redirect current spending to make "room" for expansion costs in the baseline spending limit.



⁵¹ Cynthia Shirk, *Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers: The Fundamentals*, National Health Policy Forum Background Paper, September 15, 2003

what new spending will occur?

There are two types of new spending that may occur under a waiver for California. The first type of new spending is the costs that could not receive federal matching funds without a waiver, or “costs not otherwise matchable” (CNOM). This includes coverage expansions to populations not categorically linked to the Medicaid program, such as childless adults. This type of new spending is the target amount for which the state will need to find offsets in order to reach budget neutrality.

The second type of new spending is for expenditures that are allowed in Medicaid without a waiver, such as provider rate increases or coverage expansion for parents and children. This may not be applicable if California decides to move forward with these changes separately through a State Plan Amendment.

options

In determining the cost of expanding coverage to childless adults, the state will need to make assumptions about enrollment and program costs. The following options reflect the \$177 PMPM actuarial estimates by John Gruber of MIT that also were used to inform cost estimates of the major health reform proposals under consideration in 2007. The key variable in the options below is the estimated number of enrollees.⁵²

- 657,000 Childless Adults Under 100 Percent Poverty.
Cost Under Governor's Plan: more than \$1.39 billion
- 1,518,000 Childless Adults Under 200 Percent Poverty.
Cost Under Governor's Plan: more than \$3.22 billion
- 2,041,000 Childless Adults Under 300 Percent Poverty.
Cost Under Governor's Plan: more than \$4.33 billion

These estimates reflect the governor's proposal to provide childless adults with a benchmark benefits package, as allowed under DRA rules, and would shift if more or fewer benefits are offered.

⁵² Per Member Per Month Cost from John Gruber analysis for Governor's health reform proposal; numbers of uninsured from California Health Interview Survey, as reported by Insure the Uninsured Project to the Working Committee; Total cost calculations performed by author.

There are other ways California can affect these estimates, including, as discussed in Section 4: “Developing the Scope of the Waiver: Expanding Coverage.” See Chart Five below for a list of the variables which can be adjusted to manipulate the total cost of a waiver.

chart five: controlling new waiver costs

variable	to increase cost	to decrease cost
expansion population	Expand eligibility	Narrow eligibility
benefit package	Larger package	Smaller package
cost sharing	Higher beneficiary participation	Lower beneficiary participation
outreach and enrollment	Aggressive outreach, simple enrollment	No outreach, complicated enrollment process

committee discussion

Throughout the Working Committee, the target cost of the expansion to be offset through budget neutrality was a minimum of \$250 million. This number is based on the financing strategy of the governor’s original health care proposal, which included transferring approximately \$500 million from the Safety Net Care Pool. The final number would likely be different and reflect the ultimate waiver package independent of the broader reforms originally proposed.

what factors should be considered in the “without-waiver” baseline?

Building a baseline is complex because it is based both on historic spending and future projections. Each waiver does it a little differently, but the basic formula is the base population (the children, parents, and disabled categorically covered by Medicaid) multiplied by the per member cost, plus the state’s DSH allocation.⁵³

options and considerations

California’s goal will be to negotiate assumptions that result in a fair rate of cost increases for the Medi-Cal program. This could create a cushion of extra funding that can be redirected with a waiver to expand coverage.

⁵³ Beth Waldman, Presentation to California Working Committee, April 25, 2007

Inflation and enrollment rates

California should seek a fair and accurate rate of growth in the Medi-Cal program.

Credit for historically low baseline

- California's Medicaid spending is very low, both historically and in comparison to other states.
- It is possible that California could negotiate to receive a slightly higher baseline as a credit for historic savings.

Negotiating the baseline is an area where waiting for a new federal administration that may choose to support California could be beneficial. Ideally, a new administration would both value increasing investment in the Medicaid safety net while helping states expand coverage, and decrease the nation's number of uninsured.

There are some new spending increases that raise the baseline but do not help create budgetary room for new with-waiver spending. For example, increasing Medi-Cal provider rates, expanding coverage for children and parents, and bringing in additional federal matches for existing county programs must be counted in both the with- and without-waiver calculations.

committee discussion

Committee members were interested in negotiating a higher baseline, in particular by receiving ongoing credit for historically low spending. Determining how best to do so will need to wait until there is a timeline for working with the CMS.

what are potential sources of offsets?

"The difficulty comes from where the money to get the federal dollars comes from... when you get down to it, someone has to put money up and it's mostly local dollars. The real issue is that if you start giving up that billion, you have to make sure what you get in return."

David Kears, Director of Alameda County Department of Health

The coverage expansion will create costs greater than the without-waiver baseline, no matter how well California negotiates or how much in savings the state can capture by improving the efficiency of the existing program.

These costs also will need to be offset by redirecting how current funding streams, such as DSH, are spent. California will need to find a combination of savings offsets, redirected funding and possible new sources of matching funds to equal all new program costs in order to be budget neutral.

options

program savings

- In this approach, California would look at how to restructure current programs to lower costs, including possibly expanding the use of managed care, reducing benefits or raising cost sharing.
- CMS may be reluctant to acknowledge some of these methods as allowable budget neutrality savings, as many are savings that can be achieved without a waiver by using a SPA or DRA flexibility.
- California may also be able to negotiate some credit for ongoing savings, as the state has led the way in implementing innovative programs.

potential new matching sources

- The state and counties are currently operating programs that may be eligible for federal matching funds but are not receiving them. Identifying where more federal matching funds can be found could free some state and county health dollars for coverage expansions.
- Through research by Beth Waldman for the Working Committee, it seems clear that additional matching programs may be limited.

redirecting funding

- CMS has historically preferred using part of a state's DSH funding to pay for coverage expansions because they are intended to decrease the amount of uncompensated care at safety net hospitals DSH otherwise pays for.
- Redirecting DSH funds is difficult because so many safety net providers rely on that funding not only for uncompensated care, but also to help make up low Medi-Cal reimbursement rates and care for the undocumented.

possible new state funding

- Increasing state spending on Medi-Cal will generate new state and federal funding.

Below, we explore each of these possibilities in greater detail.

program savings

California has long been a leader in devising and implementing innovative programs to help lower costs in its Medicaid programs. California may use savings generated by new programs, or try to get credit for ongoing programs, to offset new with-waiver spending.

"For us, mandatory managed care is about the twin dragons of raising rates and fixing system access issues."

Angela Gilliard, JD, Legislative Advocate for the Western Center on Law and Poverty

options

managed care expansions

- Managed care is a method of generating savings that is popular among other states and CMS. California already enrolls approximately 50 percent of our Medi-Cal population in managed care.⁵⁴
- New savings may be achieved by expanding managed care to the Aged, Blind, and Disabled population, although there are some concerns that the system, as currently operated, may not be able to meet all their care needs. Governor Schwarzenegger's 2005 budget proposal estimated the state can save 5 percent of fee-for-service costs by switching to managed care. In total, the proposal estimated total annual savings of \$177 million, including \$89 million of General Fund savings, through a significant managed care expansion.⁵⁵
- In addition to the savings achieved, California may also be able to finally capture incentive funds from the 2005 hospital financing waiver. California's failure to expand mandatory managed care to the Aged, Blind, and Disabled population over the first two years of that waiver cost the state \$360 billion in federal incentive funds. Achieving managed care expansions now may make that money available to help offset the cost of a coverage expansion.

⁵⁴ California HealthCare Foundation, "Medi-Cal Facts and Figures," 2007

⁵⁵ California Department of Health Services, "Medi-Cal Redesign," January 2005, <http://www.dhs.ca.gov/mcs/mcpd/MCReform/PDFs/MC%20Redesign%201-12-05%20final%20updated.pdf>

quality improvement programs

- Discussed in greater detail in the next section of this paper, quality improvement programs, such as hospital-acquired infection prevention programs and programs to expand the use of health information technology to reduce medical errors, also can help contain costs.
- It is unclear how much savings these programs would generate, especially given the upfront investment needed to begin many quality-improvement programs.

reducing benefits or increasing cost sharing⁵⁶

- These program changes do not tend to generate large savings.
- Increased flexibility in making these types of changes under the Deficit Reduction Act (DRA) may mean they do not qualify as with-waiver savings.

ongoing savings

- One of California's challenges in generating savings with managed care is that the state has been a leader in expanding managed care, as well as in implementing other types of cost-savings programs. The state should try to get credit for ongoing savings generated by managed care expansions and other innovative program efficiencies that other states are just now implementing.⁵⁷

committee discussion

As already discussed, many Working Committee members have reservations about the use of managed care for high-risk Medi-Cal populations, although they did not necessarily share the same concerns for the likely healthier populations. Several Working Committee members asserted that managed care, if designed with the goal of coordinating and better managing care for patients, could be acceptable for greater numbers of beneficiaries. Others raised concerns about the use of managed care to create cost savings and its potential to limit access to needed care for beneficiaries.

This may be a particular problem for the populations left to move into managed care, including the Aged, Blind, and Disabled, who tend to need more care and services than other Medi-Cal populations.⁵⁸

⁵⁶ Vern Smith and Teresa Sachs, "Waiver Financing and Budget Neutrality Options," Health Management Associates, Presentation to the California Working Committee, May 30, 2007

⁵⁷ Comments to California Working Committee, June 27, 2007

⁵⁸ Comments to California Working Committee, June 27, 2007

Specifically, some members expressed concern with the idea that reductions in costs for this population would be used to fund coverage for childless adults.

The key concern is that this would limit beneficiary access to necessary care. There will likely need to be a number of significant changes to Medi-Cal and the healthcare system as a whole for mandatory managed care to win broad support in California.⁵⁹ The following are several conditions that may make mandatory managed care more acceptable for more Medi-Cal beneficiaries:

- Improved access and higher provider participation likely to be created by raising reimbursement rates;
- Improved continuity of care for beneficiaries; and
- Continued beneficiary access to safety net providers for care.

Much of the committee discussion around managed care focused on the negative perceptions of the operations of Medi-Cal managed care. Managed care, in an environment of improved access and sufficient funding, can help facilitate appropriate care and improve health status in an efficient manner. The question remaining for many Committee members was whether that ideal version of managed care would ever be able to supplant the reality many current managed care enrollees face. This would be a goal of reform but would require significant trust-building and system reform efforts.

new matching funds

Finding current state and county spending that is eligible for a federal match, but does not currently receive matching funds, may be another way to reach budget neutrality. However, because the federal match is available without a waiver, these funds may count against budget neutrality, NOT as savings to help reach budget neutrality.

⁵⁹ Comments to California Working Committee, May 30, 2007

options

Despite that challenge, Working Committee consultant Beth Waldman has identified some county programs that may be eligible for a federal match under a new waiver:

- County indigent care programs in counties without public hospitals (which otherwise receive matching funds through the hospital financing waiver);
- Mental health programs;
- Social services programs;
- Public health programs;
- State/county prison system; and
- Coverage initiatives going forward.

committee discussion

During the May Working Committee discussion, there was some agreement that one challenge of receiving new federal matching funds will be the federal government's ongoing desire to contain Medicaid costs. Another challenge is building trust between counties and the state so that the counties will feel comfortable sharing more information about their health spending. In her final report, Beth Waldman found that the additional available funds for matching are most likely limited.

reallocated funds

“Almost all of the children in Children's Hospitals have coverage of some kind once they get there. But the costs of their care aren't compensated appropriately, so our hospitals are very dependent on the supplemental funds that come through the Safety Net Care Pool.”

Diana Dooley, President and CEO of the California Children's Hospital Association

Most waivers include a reallocation of existing funds, usually funding coverage expansions with dollars previously dedicated to reimbursing providers and local governments for uncompensated care.

Reallocation is made more challenging in California because federal funding for our public hospitals is drawn down by county certified public expenditures (CPEs) rather than aggregated state spending. This means California public hospitals are reimbursed directly by the federal

government for their costs. As a result, much of the federal funding received by California cannot be redistributed without fundamentally changing how our public hospitals are financed.

options

California has two major streams of funds that could potentially be redirected to coverage.

disproportionate share hospital funds

- Redirecting DSH funds for coverage expansion may end up costing the state more than it would gain for two reasons. DSH is the only type of federal funding that can be used to pay for care for the undocumented, and California is unique in receiving an 87 percent federal match with DSH, which would possibly be reduced to 50 percent if the money was redirected under a waiver.⁶⁰
- The reasons California has to protect its current DSH funds are the same reasons the federal government will likely push for their reallocation into the coverage expansion.

safety net care pool

- Even under universal care, there will be frictionally uninsured individuals and individuals that will always stay uninsured. In addition, hospitals rely on SNCP funds to help compensate for public program underpayments for care.
- The SNCP is capped at current levels, thus incorporating changes to this funding stream in a waiver may allow the state to bring more money into the system.

committee discussion

Several Working Committee members asserted that there would likely always be a need for some supplemental funding for safety net care providers such as public hospitals. There was also agreement that California needs to develop good data on what populations safety net care providers will serve under a waiver as a way to make the case for continued DSH or SNCP funding for the safety net. While there were some concerns about redirecting “too much” of the SNCP funding, there was significantly more concern expressed about the need to protect current DSH funds. In fact, a number of respondents to a survey prior to the April meeting listed a redirection of DSH funds as a key concern.

⁶⁰ Stan Rosenstein, Comments to California Working Committee, June 27, 2007

lessons from other states: redirecting DSH

Redirecting DSH or supplemental funds that support uncompensated care is a funding mechanism preferred by CMS.

- A number of states that have used Section 1115 waivers to expand coverage have used redirected DSH dollars to fund coverage or subsidies, including Massachusetts and Indiana.⁶¹
 - Other states, including Massachusetts, actually used their waiver to create a pool of funding for safety net providers.⁶²
-

new state funding sources

Any new revenues raised or dedicated by the state to health care can help generate part of the state's share of new spending under a coverage expansion.

options

Taxes and fees must be broad-based, uniformly applied, and result in “winners and losers” to qualify as a new state revenue source under a waiver.

- **Provider Fees:** Provider fees are unlikely to achieve broad political support if they also must meet the federal requirement to create “winners and losers.”
- **Cigarette or Sales Tax:** A cigarette or sales tax would likely need to win a ballot initiative.

Bringing additional state dollars into the financing formula is likely to increase the state's chances of successfully negotiating a waiver with CMS as it will make the proposal seem more credible.⁶³

committee discussion

This was not an issue specifically addressed by the committee.

61 Peggy Handrich and Pris Boroniec, “State Health Reform: Principles, Examples, and Approach for California.” Sellers Feinberg, Presentation to the California Working Committee, March 28, 2007.

62 Beth Waldman, “Massachusetts Health Care Reform,” Bailit Health Purchasing, LLC, Presentation to California Working Committee, February 28, 2007

63 Peggy Handrich and Pris Boroniec, “State Health Reform: Principles, Examples, and Approach for California.” Sellers Feinberg, Presentation to the California Working Committee, March 28, 2007.

section 7: healthcare quality and the waiver

“The overall purpose of this group is to try to figure out how to have better health outcomes for the uninsured in California ... whether it is improving access to high-quality services or ensuring there is choice of quality provider or whether it is providing direct insurance.”

Catherine Douglas, President and CEO of Private Essential Access Community Hospitals

Historically, states have used Section 1115 waivers to contain costs, expand coverage, or attempt both. As Medicaid state spending has slowed in recent years, many states are turning their focus to improving quality in their programs. The primary reason for the Working Committee to consider quality is as a way to identify extra savings for budget neutrality. However, there are three reasons California may want to consider including quality improvement initiatives in a waiver:

- To achieve significant improvements in the Medi-Cal program for all beneficiaries;
- To explore new ways of finding savings to help reach budget neutrality; and
- To make California's waiver application more innovative and attractive to policymakers and stakeholders.

At the June Working Committee Meeting, consultant Jim Hardy of Sellers Feinberg gave a presentation outlining strategies for incorporating some of these value and quality improvement goals into a waiver, including:⁶⁴

- Managed care;
- Provider alignment;
- Consumer engagement;
- Improving the quality of care; and
- Leveraging buying power for quality and price.

⁶⁴ This section of the paper takes a slightly different format as Working Committee members engaged in shared learning on this issue, rather than broad discussion. Where appropriate, the paper will present the findings of a small group discussion on quality improvement discussions, but will not otherwise include a summary of Committee discussions. Jim Hardy, “Value and Quality Opportunities for the Medi-Cal Program.” Sellers Feinberg, Presentation to the California Working Committee, June 27, 2007.

managed care

Historically, managed care has been used in Medicaid waivers as a vehicle to contain costs. In his presentation, Hardy outlined the ways that managed care can be structured under a waiver to actually create a system of care for Medi-Cal beneficiaries that will improve health status and access to services. These steps also could be taken to show cost savings in fee-for-service delivery systems, but the structure of managed care organizations lends itself more easily to their implementation.

These goals can be achieved by requiring more of Medicaid managed care partners, including:

- **Supporting Advanced Medical Home Models:** There are many definitions of an advanced medical home, including primary care physicians who oversee and coordinate all care for patients. This may also be a team of well-coordinated hospital physicians for patients with more serious medical needs.
- **Better Management of Chronic Disease and High-Cost Episodes of Care:** An extension of medical homes, this is necessary to more effectively treat the small percentage of the population with chronic diseases who generate the largest health spending.
- **Provider Pay-for-Performance Programs:** This may be an effective and targeted way to implement increases in provider reimbursement rates.

Chronic care management, medical homes and similar types of reform are growing in popularity across the state. In keeping with the fragmented and multi-layered structure of California's healthcare system, there is little coordination of these efforts and little financial support from the government. In particular, federal Medicaid and Medicare programs provide limited support for chronic care programs or other innovations to improve care management.⁶⁵

provider alignment

Provider alignment reforms improve the system of care for patients outside of managed care. Changing how providers are compensated for their time and services can help incorporate care management techniques and increase preventive care in fee-for-service delivery systems.

⁶⁵ Erica Murray, California Association of Public Hospital, June 27, 2007

For example, Medi-Cal rate increases can use a pay-for-performance model and reward providers who employ medical home models or work in teams to better manage and coordinate care for their patients.

consumer engagement

States can use cost sharing and benefit design to encourage consumers to use care appropriately and manage their health. Some techniques include deductibles, co-payments and incentives. Consumer engagement is still a relatively new concept in health care, and there is still more to be learned about the most effective ways to provide the right incentives for consumers. Consumer engagement should not try to contain costs by creating incentives for consumers to delay or avoid care. For example, the chronically ill population may need unlimited pharmaceutical benefits in order to effectively manage their illnesses, which ultimately lower costs by preventing emergency department and hospital use.

quality of care

“For far too long, the state has been focused on what Medi-Cal is paying for health care, not on what it is buying.”

Little Hoover Commission, “A Smarter Way to Care: Transforming Medi-Cal for the Future”

The first step to improving the quality of care available to beneficiaries is to understand the care being delivered and health outcomes achieved. Then, Medi-Cal can effectively target quality-improvement initiatives, and reward providers who are delivering high-quality care. Making performance information public is another way of encouraging providers to improve.

To fairly and effectively measure care, the state must invest in collecting and measuring healthcare data. This will require the expanded use of health information technology, such as electronic medical records. Health information technology can also help improve healthcare quality by reducing medical errors and unnecessary duplication of efforts.

For example, e-prescription tools ensure patients receive the right medications at the pharmacy and can automatically alert physicians and pharmacists to possible adverse drug interactions with a patient's

other medications. However, health information technology poses high upfront capital costs, particularly for safety net providers, which may require some state subsidies.

During the June Working Committee small group break-out session, one group led by Jim Hardy discussed another type of innovative quality improvement programs that prevent hospital acquired infections. HAI prevention programs are already successfully operating in the state – including a California Children's Hospital Association program and the Institute for Healthcare Improvement's "5 Million Lives" initiative. There was some agreement that these programs could be expanded to hospitals statewide to improve quality and contain costs.

recommendations

Although a non-traditional source of funds, quality improvement could be an important part of the budget neutrality calculation. The discussion from Jim Hardy shows that achieving quality improvement is possible. Any future waiver should include efforts to improve coordination of care and changes to how care is delivered to encourage better health outcomes and improved access to quality services.

section 8: conclusion

Over the course of 2007, the Working Committee on Waiver Development and Medi-Cal Expansion carefully discussed the issues around the development of a childless adult waiver for Medi-Cal. With more than 30 members representing all different areas of the healthcare sector, the monthly gathering of this diverse group was a rare opportunity to bring stakeholders together.

This paper is the summary of that labor. By discussing the trade-offs needed to achieve such a waiver, the Working Committee looked at how the interconnectedness of the health system means that a complex series of considerations is needed to achieve change. The issues discussed here range from the nuts and bolts of waiver design to broad conceptual themes. The Working Committee allowed stakeholders to participate in shared learning that will hopefully become a foundation for trust and cooperation as the state moves forward with future health reform efforts. Together, California's stakeholders can use this paper as an important resource as they seek to improve the care our most vulnerable populations receive through Medi-Cal and the safety net.

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