

## **Introduction**

Medicaid waivers from the federal government grant states permission to experiment with their Medicaid programs in ways they and the federal government believe can make their programs more efficient and effective. California's existing §1115 Medicaid waiver expires on August 31, 2010, and the state is currently in the process of applying for its renewal.

As part of that process, the California Department of Health Care Services (DHCS) recently submitted an initial waiver proposal to the federal Centers for Medicare and Medicaid Services (CMS). The proposal focuses on expanding and integrating care in four main areas:

- (1) Enrollment of Seniors and Persons with Disabilities (SPDs) in managed care;
- (2) Coordination of care for those eligible for both Medicaid and Medicare;
- (3) Establishment of organized health care delivery models for children enrolled in the California Children's Services program; and
- (4) Expansion of the ten existing Coverage Initiatives (CIs) to cover Medically Indigent Adults (MIAs) in all counties.

CMS is currently reviewing the proposal, negotiating with DHCS, and will soon offer their official feedback. Once that is received, DHCS will then submit a final waiver application no later than September 1, 2010.

This paper summarizes the coverage expansion component of the waiver proposal, highlighting potential opportunities for various stakeholders.

## **Background**

All California counties currently cover MIAs. Some counties, particularly those with public hospitals, cover uninsured populations beyond simply the MIAs. Counties report spending at least \$1.8 billion total on indigent health care; this amount provides care to approximately 1.2 million uninsured individuals, mostly with very low incomes. Counties reported spending about \$300 per uninsured Californian or \$1500 per user of county health services.

Funding for this coverage comes from a mix of state realignment, county General Fund match, tobacco litigation settlement, tobacco taxes, federal Disproportionate Share Hospital (DSH) payments and Safety Net Care Pool (SNCP) funds. The respective shares of these funding streams devoted to indigent care differ widely by county. California counties also spend state and local money on care to MIAs in their mental health and public health

programs that could qualify for federal matching. Counties may also be spending local funds for the MIAs through local SB 12 programs and other county programs for the uninsured.

Under the existing §1115 waiver, California has had a very limited, \$180 million annual contribution from the federal government for MIA coverage. This funds the federal share of Coverage Expansion Initiatives (CIs) in ten counties that were selected on the basis of competitive grant applications.

### **Federal Opportunity Under Health Reform**

Effective April 1, 2010, federal Medicaid funding is available for coverage of MIAs and parents with incomes up to 133% of the federal poverty level (FPL). A number of states – including Maine, Vermont, Massachusetts, New York, Delaware, Arizona, and Oregon – already have §1115 waivers that extend coverage to this population and will therefore find participation in this quite easy. Other states, such as Washington and Minnesota cover their MIAs with no federal financing through their state Medicaid programs. With the passage of health reform and the availability of this new federal money, they are now eligible for federal matching.

### **Waiver Renewal**

California counties currently cover their MIA population in different fashions; they have very different eligibility rules, reimbursement rates, patient cost sharing, provider networks, rates of spending and access to services. Under the waiver, California could simply collect all these funds in a common pot and cover the MIAs through Medi-Cal managed care.

Many counties are not willing or ready to rapidly standardize their programs to a comparable state standard that meets federal criteria, but they do understand the need to prepare for 2014 when MIAs will be covered through Medi-Cal and the new Health Benefits Exchange with 100% federal financing. Counties' immediate challenges are to survive the loss of revenues and increases in demand for services as a result of the country's financial meltdown and high unemployment rate. Their medium term challenges are to be ready for full implementation of reform in 2014, and their long-term challenges are to define their future roles when indigent coverage is no longer a prime county responsibility.

Here is a brief survey of this situation in which California counties find themselves:

- Thirty-four counties, the small CMSP counties, stand out as nearly fully compliant with federal rules governing Medicaid. Minor program modifications would be needed.
- Some counties, such as Orange and San Diego, are reasonably close to compliant as well since they have open provider networks. However, their county programs have additional eligibility requirements that would violate federal Medicaid laws, and their reimbursement levels may not meet federal Medicaid standards.

- Public hospital counties for the most part exclude private sector hospitals, doctors and (in some counties) community clinics, a practice that clearly does not comply with federal Medicaid law.
- “Hybrid” counties such as Santa Barbara and Tulare have public outpatient clinics and exclude many private practitioners from reimbursement for outpatient care. They do include private providers for reimbursement of costly inpatient services.
- “Block grant” counties, like Fresno and Merced limit their funds to a single hospital. They would also fail to meet federal Medicaid access, benefits and freedom of choice requirements.

California’s waiver proposal would allow counties to receive federal matching funds for their expenditures on care to uninsured MIAs up to 200% of the federal poverty level. Because federal law now provides the opportunity to cover the MIAs up to 133% of FPL, California’s waiver expansion proposal for the MIAs up to 133% of FPL would not be subject to a budget neutrality cap (typically based on current Medi-Cal spending plus a growth factor). The expansion between 133 and 200% of FPL would appear to be subject to a budget neutrality cap.

The proposal would require counties to upgrade their programs in several respects:

- Eligibility determination processes will need to become compatible with the Medicaid program.
- There must be adequate access to primary care (defined as a patient to primary care physician ratio of 2000:1).
- Patients must have a designated medical home.
- It appears that counties must include community clinics (the waiver request does not specify whether one, some or all clinics in a county must be included). There is a specific waiver provision in the current request that would exempt counties from the federal requirement to pay FQHC clinics for their reasonable costs.
- Counties may be required to upgrade covered services equal to the federal benchmarks of inpatient and outpatient care, mental health and prescription drugs.

Despite these constraints, counties would be permitted under the waiver request to maintain many of their unique features that do not comply with federal Medicaid laws:

- Counties are not required to meet federal standards for patient cost sharing.
- Counties are not required to increase nor reduce their existing eligibility standards and sliding fee schedules that do not meet federal standards to a common statewide denominator.
- Counties may continue to exclude private hospitals and doctors.
- Counties are not required to increase or reduce their reimbursement levels to a common denominator based on costs, nor are they required to meet federal standards for reimbursement levels.
- Counties can continue to cap local spending.

Local match could be in the form of Intergovernmental Transfers (IGTs) or Certified Public Expenditures or a mix of both. County governments generally prefer IGTs. This is an issue that will need to be negotiated with the federal government to assure that all the funds are used for care to the indigent uninsured, rather than being diverted to other purposes as has previously happened pervasively in other communities.

There are several limitations on waiver financing. First, counties cannot match a federal dollar with a federal dollar. Second they cannot double dip – i.e. use a local matching dollar twice. Each county should do a careful analysis of what funding is available for the match. Third, Medicaid matching is not available for non-emergency care to new legal immigrants and the undocumented. Counties need to make a very careful analysis of their spending to see what qualifies and what does not.

This component of the waiver proposal is a major financing opportunity for California's uninsured and to develop building blocks for California's counties and for local safety nets. If approved, counties could use their local expenditures to cover MIAs with a federal Medicaid match. This assumes they are interested in putting in place the building blocks and structures of federal reform and many appear to be very interested. This could provide important leadership for states, such as Texas, Florida, and Indiana that pay for care and coverage of their MIAs through local programs.

## **Public Hospitals and the Waiver**

Public hospital counties have sought and secured important steps forward in California's waiver request that may or may not meet with federal approval. Here is a brief summary and explanation of some of these provisions:

- **Upper payment limit (UPL)** at 150%. UPL caps Medicaid reimbursements at hospitals' costs or the Medicare level, whichever is less. Public hospitals are reimbursed for their costs, but they (not the state) must pay the match. This particular provision is designed to give such hospitals some relief.
- **Global budgeting** consistent with the provisions of the recent federal reform. Global budgeting would allow counties to escape from the financial straitjacket of Medi-Cal payments which locks some public systems into disproportionate reliance on hospital based systems of care and does not provide counties with the incentive to invest in lower cost free standing clinics, which are vital to the primary care and prevention agenda of the new federal reform.
- Increased pool of funds for county investments in the services that are essential to success in federal reform – case management, health information technology and primary care.
- Large increase in the SNCP funding that can be used for inpatient and outpatient care to the uninsured. Such funds cannot be used for non-emergency care to the undocumented, rather, only for genuine emergency services.

Other counties have not yet identified, sought or secured specific provisions to assist with the transitional steps necessary for their safety net providers and programs. We would encourage local safety nets and counties to engage in a transparent planning process.

### **Local Managed Care Organizations**

The waiver request does not clearly state a position on the use of local managed care organizations (MCOs), which will be critical from 2014 going forward. Three counties (Contra Costa, San Francisco and San Mateo) already use their local MCOs to manage care for the MIAs. In our view the rest should begin to do so as that will be the coverage entity for the MIAs in 2014. There are references to providing actuarially based rates, “at risk” payments, pay for performance, reimbursement and delivery system reforms that may presage a role for local MCOs, but that is as yet unclear. Counties may wish to begin with an Administrative Services Only (ASO) agreement with their local MCO. From our perspective, the biggest weakness in the waiver is that it does not promote development of integrated delivery networks (IDNs) with the network of clinics, hospital and local MCOs. The early development of local and regional IDNs will be critical to safety nets’ abilities to compete on quality and price in the new Exchanges.

### **Looking Forward**

The timeline for implementation in the existing CI counties is January 2011 (or earlier if the county is ready). The timeline for the rest of the counties is June 2011 (or earlier if the county is ready). This opportunity is utterly dependent on the counties, the state and the federal government agreeing to a waiver as early as possible. Since the counties and the federal government each contribute half the allocated funds, there will be creative tension between some counties who might favor slow evolution of their systems and the federal government that may favor faster compliance with the federal reform framework. Any delay, however, will be extremely harmful to California’s uninsured.

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#### **Resources:**

California Section 1115 Comprehensive Demonstration Project Waiver: a Bridge to Reform (California Department of Health Care Services, June 2010) at [www.dhcs.ca.gov/provgovpart/Documents/A%20to%20Reform%206-10-2010.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/A%20to%20Reform%206-10-2010.pdf).

California Section 1115 Comprehensive Demonstration Project Waiver: Implementation Plan (California Department of Health Care Services, May 2010) at [www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx).

ITUP, Covering the MIAs: Counties, Federal Reform and a State Waiver (March 2010) at [www.itup.org/reports](http://www.itup.org/reports).

Roby, Dylan, et al. Creation of Safety Net Based Provider Networks Under the California Health Care Coverage Initiative: Interim Findings (UCLA Center for Health Policy Research, December 2009) at <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=389>.