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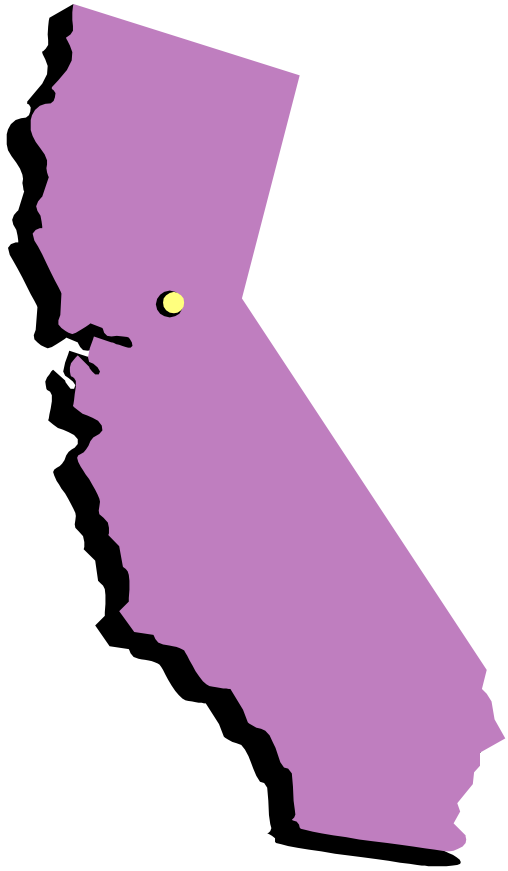
MEDI-CAL REDESIGN STAKEHOLDER REPORT



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I. Purpose of Medi-Cal Redesign Stakeholder Process

In January 2004 Governor Schwarzenegger announced his intention to seek federal approval to reform the Medi-Cal program in order to contain costs while retaining the State's commitment to providing necessary medical services to eligible low-income populations. The types of reform and changes that would be considered represent fundamental changes to the Medi-Cal system.

As part of the redesign process, the California Health and Human Services Agency (CHHS) sought extensive stakeholder input on the State's proposed concepts for changes to the program. This process recognized the critical role of Medi-Cal in the lives of millions of Californians, the complexity of the issues, severity of California's budget crisis and brevity of the proposed timeline for completion.

A. Principles of Medi-Cal Redesign

CHHS presented the following principles as the framework for the redesign of the Medi-Cal program.

1. Protect eligibility for those people who are currently eligible
2. Maintain essential services and align coverage with the private sector
3. Continue services to children as a Medi-Cal priority
4. Increase personal responsibility for certain categories of Medi-Cal beneficiaries by requiring them to share in the cost of services
5. Promote work participation by continuing coverage of the working poor and allowing people to continue to maintain Medi-Cal coverage while their work income increases
6. Improve program effectiveness and accountability by promoting managed care.

B. Objectives of Medi-Cal Redesign Process

The Redesign process was developed to encourage stakeholder involvement with the California Department of Health Services (DHS) and CHHS as they assess the feasibility of Redesign concepts. The objectives of the redesign process included:

1. Simplify Medi-Cal eligibility
2. Modify benefit structure
3. Incorporate beneficiary cost sharing

4. Expand organized delivery systems, i.e., managed care, disease management

5. Identify new sources of federal funding participation and potential efficiencies in the system.

C. Description of Existing Medi-Cal Program

California has participated in the federal Medicaid program since 1965. Medicaid, known as Medi-Cal in California, is a joint federal-state program that pays for health care for certain financially needy individuals. The Medi-Cal program provides health care coverage for approximately 17 percent of California's population.

Medi-Cal provides health and long-term care coverage to approximately 7 million low-income children and their parents, and to seniors and people with disabilities. Nearly 764,000 people who are age 65 or older, and approximately 767,000 non-elderly people with disabilities are enrolled, representing about 24 percent of the estimated 2004-05 Medi-Cal caseload. Most of the seniors and people with disabilities on Medi-Cal (79 percent) are recipients of SSI/SSP benefits and receive Medi-Cal coverage automatically.

Overall costs per Medi-Cal beneficiary in California are among the lowest in the nation, according to reports published by the federal government and Kaiser Family Foundation. In fiscal year 2001, services in California cost $4,607 per beneficiary versus a national average of $5,475 per beneficiary. By comparison, Texas' cost per beneficiary was $5,343, New York's was $6,487, and Florida's was $4,857. According to the California HealthCare Foundation, the average state spends $763.49 per resident on Medicaid annually, while California's expenditures per resident are only $702.06.

Like all state Medicaid programs, Medi-Cal has seen significant program growth and cost increases over the past several years. Medi-Cal costs have grown 40 percent in the last 5 years. These increases are mostly the result of increased program enrollment due to program expansions and increased health care costs that have been experienced by all states as well as by private insurance. Medi-Cal spending trends have paralleled trends in private health insurance. Moreover, national studies show that Medicaid per capita costs are lower than private insurance after adjusting for differences in enrollee income, age, health status and other factors.

D. Federal Section 1115 Waiver and Medi-Cal Redesign Process

DHS intends to seek a federal Section 1115 Medicaid Demonstration Waiver to provide California with the flexibility to redesign Medi-Cal, allowing it to continue to maintain coverage of people currently eligible, provide essential care, and be affordable to the State. The federal government has the authority to waive parts of the Social Security Act that governs Medicaid in order to allow states to initiate "research and demonstration" projects to further the goals of Medicaid and the State Children's Health

Insurance Program (SCHIP, known as Healthy Families in California) via what is known as a Medicaid Section 1115 demonstration waiver. These waiver projects enable states to use federal funds in ways that would not otherwise be permitted. Generally, states have implemented Section 1115 waivers to test strategies for expanding coverage. More recently, though, states have sought these waivers to reduce state spending by changing their Medicaid programs and using Medicaid or SCHIP funds to refinance existing coverage. California currently has two Medicaid Section 1115 waivers, one for Los Angeles County and the other for family planning services.

The State anticipates that a waiver, if granted, will allow the State to reform the Medi-Cal program to attain maximum flexibility in benefit coverages for those who are currently eligible. Implementation of Medi-Cal reform has the potential to impact every provider, beneficiary and program currently in place.

II. Stakeholder Process Description

A. Purpose and Goals

The Redesign discussions with stakeholders were divided among five workgroups:

- Aging and Disabilities Issues
- Benefits and Cost sharing
- Eligibility Simplification
- Finance and Cost Savings
- Organized Delivery Systems and Managed Care.

The Finance and Cost Savings workgroup met three times and the other workgroups met four times during March and April 2004. The workgroups discussed benefit design and cost sharing; eligibility and simplification; organized service delivery, including managed care expansion; aging and disability issues; and other financing and cost savings options, including options to obtain additional federal funding, cost savings and system efficiencies. Two of the workgroups, Financing and Cost Savings and Aging and Disabilities Issues, were added in response to stakeholder feedback. Stakeholders volunteered as participants, representing their interest groups, organizations or provider groups, health plans, jurisdictions and themselves, if consumers.

The stakeholder process had two goals: to provide an opportunity for a wide range of stakeholders to respond to concepts for change presented by DHS and to suggest Medi-Cal program and policy changes. Stakeholders were asked to provide input within the context of Agency program goals of maintaining eligibility for those currently eligible, providing essential services as part of Medi-Cal program and ensuring that Medi-Cal remains affordable for the State in future years.

The anticipated outcomes of the stakeholder process were to:

1. Provide feedback on Administration concepts for changing the Medi-Cal program.
2. Identify advantages and disadvantages to consumers and providers of suggested Medi-Cal program changes.
3. Recommend strategies for cost-savings as well as opportunities for new federal funding.
4. Propose approaches to streamlining the current Medi-Cal system and propose new efficiencies in the program.

B. Timetable for Stakeholder Process

After two initial stakeholder meetings organized and facilitated by CHHS in late January and early February 2004, Secretary Kim Belshé established a timeline for more in-depth stakeholder participation and feedback that began in early March and was to be completed by early May. The workgroup process demanded a very structured timeline. The timeline was intended to provide stakeholders with the opportunity to provide input on the state's concepts for Medi-Cal Redesign before the State's actual proposals were developed and submitted to the Legislature in mid-May 2004 as part of the state budget process. Workgroup meetings dates and topics:

- January 26, 2004 Kick-Off Stakeholder Meetings, Sacramento
- February 4, 2004 Kick-Off Stakeholder Meetings, Los Angeles
- March 11, 2004 Kick Off Conference Call with Stakeholders
- March 16, 2004 Benefits/Cost sharing; Meeting 1
- March 16, 2004 Eligibility Simplification; Meeting 1
- March 17, 2004 Aging and Disability Issues; Meeting 1
- March 17, 2004 Organized Delivery/Managed Care; Meeting 1
- March 24, 2004 Financing and Cost Savings; Meeting 1
- March 30, 2004 Benefits/Cost sharing; Meeting 2
- March 30, 2004 Eligibility Simplification; Meeting 2
- April 1, 2004 Aging and Disability Issues; Meeting 2
- April 1, 2004 Organized Delivery/Managed Care; Meeting 2
- April 8, 2004 Financing and Cost Savings; Meeting 2
- April 14, 2004 Benefits/Cost sharing; Meeting 3
- April 14, 2004 Eligibility Simplification; Meeting 3
- April 15, 2004 Aging and Disability Issues; Meeting 3
- April 15, 2004 Organized Delivery/Managed Care; Meeting 3
- April 20, 2004 Financing and Cost Savings; Meeting 3
- April 27, 2004 Aging and Disability Issues; Meeting 4
- April 27, 2004 Organized Delivery/Managed Care; Meeting 4
- April 28, 2004 Benefits/Cost sharing; Meeting 4
- April 28, 2004 Eligibility Simplification; Meeting 4
- May 7, 2004 Stakeholder Report Completed.

C. Workgroup Structure

Multiple methods were used throughout workgroup meetings to frame issues, foster discussion and capture stakeholder feedback. People could participate in one of three ways: by attending in person, and therefore being able to ask questions, provide feedback and participate in small group discussions; via teleconference; or by listening to a live audio webcast or digital replay of individual sessions. Replays of all meetings were available through a toll-free line within two hours of each meeting's completion; they will continue to be available until June 15, 2004. Those participants who listened to the teleconference or webcast could submit comments via the website.

Workgroup sessions were organized around major topics identified by the State and foundation funders. DHS staff, health plan representatives, county officials, advocates, providers and experts made background presentations, participated in panel discussions, identified best practices and shared experiences from within California and other states.

Small group discussions at each of the workgroup meetings offered a forum for in-depth conversations to reflect on information and ideas presented, and to examine the benefits and difficulties of the concepts that were proposed by State officials. Written summaries were prepared following each of the workgroups, including comments provided in person at the sessions and via the website. The workgroup discussions were sequential and built on the work of prior meetings.

Accessible site logistics and special accommodations were made available for persons with disabilities.

Attendance by Workgroup, Date and Method

Date	Topic	In Person	Audio Web	Telecon-ferencing	Total
3/16/04	Benefits and Cost Sharing	135	65	74	274
3/16/04	Eligibility Simplification	128	40	44	212
3/17/04	Organized Delivery Systems and Managed Care	120	35	30	185
3/17/04	Aging and Disabilities Issues	105	39	49	193
3/24/04	Finance and Cost Savings	112	25	23	160
3/30/04	Benefits and Cost Sharing	104	18	25	147
3/30/04	Eligibility Simplification	118	19	35	172
4/1/04	Organized Delivery Systems and Managed Care	100	23	19	142
4/1/04	Aging and Disabilities Issues	104	19	20	143
4/8/04	Finance and Cost Savings	112	20	42	174

Date	Topic	In Person	Audio Web	Telecon-ferencing	Total
4/14/04	Benefits and Cost Sharing	90	27	19	136
4/14/04	Eligibility Simplification	89	25	13	127
4/15/04	Organized Delivery Systems and Managed Care	90	34	14	138
4/15/04	Aging and Disabilities Issues	88	15	11	114
4/20/04	Finance and Cost Savings	77	15	22	114
4/27/04	Organized Delivery Systems and Managed Care	91	23	19	133
4/27/04	Aging and Disabilities Issues	93	19	13	125
4/28/04	Benefits and Cost Sharing	116	23	14	153
4/28/04	Eligibility Simplification	113	20	11	144

D. Website: www.medi-calredesign.org

A new website was created for the purpose of posting workgroup meeting materials including meeting dates, times, locations and agendas; any materials distributed at the meetings; and written summaries from each meeting. All meeting summaries were posted within 72 hours of each workgroup. The website was updated regularly in order to offer participants access to changes, as well as providing an overview of the redesign process, schedule of events, list of registered participants, resource links, online contact and email registration. Multiple opportunities for feedback and comments were available throughout the process on www.medi-calredesign.org. The website had approximately 3,000 to 5,000 “hits” per day throughout the stakeholder process (March 5 to May 2) with a low of 100 hits and high of more than 8,000 hits on any given day, approximately 150,000 hits during the six week workgroup period. (Each time an individual directs their web browser to the website is counted as a hit.)

E. Role of Stakeholder Participants

Stakeholders in the workgroups (see Attachment 1) participated in discussions on changes within Medi-Cal based on the State’s Redesign principles and provided recommendations for program and policy changes. Participation was voluntary and notice of the process was announced by Secretary Belshé to thousands via mailing lists from CHHS and the California HealthCare Foundation.

Participants were asked to review background information and prepare their thoughts in response to session topics and questions that were posted on the website in advance of each session, and to review the summaries of each of the prior workgroup meetings. During the meetings and throughout the process, stakeholders were asked to voice their values, concerns and priorities.

Tension often permeated the sessions, as participants were asked to respond to general concepts, rather than specific proposals. The State's intention was to gather early feedback before developing their proposals. This approach caused concern for many stakeholders as data, cost information and analysis were often limited.

Approximately 640 stakeholders participated in the process by attending, or joining at a distance, at least one workgroup, while many participated in multiple workgroups. They represented a diverse group of California public health professionals, consumers, advocates, legal organizations, health plans, providers, counties and state employees. Stakeholders came from a variety of perspectives with different expectations. Participants were not asked to reach consensus or agreement on their ideas.

F. Role of Foundations

The California HealthCare Foundation and The California Endowment supported the Medi-Cal Redesign Stakeholder Process by providing funding for meeting facilities, refreshments, audio-visual and sound equipment, accessible accommodations, technology, expert testimony, facilitation and recording. Through a Memorandum of Agreement with the California Health and Human Services Agency, the foundations actively participated in the development of meeting agendas, identification of speakers, and by lending expertise on key Medi-Cal issues. Senior foundation staff attended all workgroup sessions.

G. Role of State Staff

The State staff who participated in each workgroup meeting represented the California Health and Human Services Agency, the Department of Health Services and the Department of Mental Health. Senior leadership from the Health and Human Services Agency and the Department of Health Services participated in planning sessions and all stakeholder meetings.

H. Role of Facilitator and Disability Consultants

Bobbie Wunsch of the Pacific Health Consulting Group was engaged as the facilitator of the Medi-Cal Redesign Stakeholder Process. Ms. Wunsch's role included coordinating the locations and facilities for all meetings, registering participants, responding to website inquiries and telephone calls, developing the agendas and materials, and inviting speakers for each workgroup session. Ms. Wunsch also facilitated each of the workgroup meetings and prepared summaries of each workgroup session. She carried out her role in collaboration with DHS and CHHS senior staff, the California HealthCare Foundation and The California Endowment.

The facilitator's role was to:

1. Establish a forum for a diverse group of participants to study and discuss problems as well as establish relationships among their colleagues and peers

2. Balance the need to ensure that workgroup participants had an opportunity for meaningful input while maintaining focus on the issues at hand
3. Ensure structured and constructive interaction between workgroup participants and State staff
4. Identify and manage issues requiring further follow-up and action
5. Access expertise and technical assistance on the best practices in Medicaid and waiver design.

In addition, Brenda Premo and June Isaacson Kailes of the Center for Disability Issues and the Health Professions at Western University of Health Sciences were engaged to provide consultation on program and physical access recommendations, communication and alternative formats, access to the website for persons with disabilities and assistance with planning and facilitation of the Aging and Disability Issues Workgroup.

I. Role of Experts

Identifying and involving a variety of experts was critical to the process. Individuals who were invited to participate included:

- Experts in the complex provisions of the Medicaid program, federal and state requirements, and the experiences of other states with comprehensive waivers
- Experts in health care cost sharing mechanisms such as premiums and co-pays, and those with particular knowledge about how the affordability of cost sharing mechanisms affect patients' health care decisions
- Experts in the financing aspects of Medicaid waivers including determination of cost neutrality, issues related to potential expenditure caps, and methods to enhance the State's federal funding levels.

Experts' presentations were posted on www.medi-calredesign.org.

III. Key Concepts of Medi-Cal Redesign

The Department of Health Services presented four primary Redesign concepts for stakeholder feedback during the stakeholder process:

1. Creation of a tiered benefit structure in which beneficiaries with lower incomes would receive all core and optional benefits with no additional payments, while those with relatively higher incomes would access the optional benefits with cost sharing. Chiropractic and acupuncture would be eliminated as benefits for all beneficiaries.

2. Development of a system of increased co-payments, premiums and co-insurance for Medi-Cal beneficiaries with disposable incomes, increasing the current co-payment, initiating premiums and adding co-insurance on optional benefits.
3. Early Periodic, Screening, Diagnosis and Treatment (EPSDT) service and cost reduction by clarifying the terms “medical necessity” and “ameliorate.”
4. Expansion of managed care statewide and to larger numbers of people, including possible mandatory enrollment of people with disabilities and seniors.

Materials describing all of these concepts are located at www.medi-calredesign.org. The purpose of this report is to summarize the feedback of the stakeholder participants to these concepts, as well as to capture the major themes of the discussions.

IV. Cross-Cutting Themes of Stakeholder Participation

Major themes emerged in response to the State’s proposed concepts during stakeholder feedback, both in workgroups and via participant feedback submitted on the website. While consensus and agreement were not the goals of the sessions, the following themes seem to cut across many of the issues discussed by the stakeholders. While this is not intended to be representative of each and every issue or comment, it is intended to represent the discussions throughout the workgroups.

The following themes and the participant feedback that follows reflect a summary of the discussion and commentary from stakeholders at workgroup sessions and via comments posted on the website. These comments are not directly attributable to any one individual or group, nor do they reflect a consensus opinion, but are a compilation of many voices. Again, this report’s purpose is to provide a summary of stakeholder feedback. Detailed summaries of each meeting are available on www.medi-calredesign.org.

• Benefits, Eligibility and Administrative Simplification

- **Theme 1** The benefit tier structure concept adds complexity and cost, rather than simplicity and savings to the program.
- **Theme 2** Cost sharing is a way to reduce utilization, and, for low-income patients, particularly those who are elderly and disabled, typically deters use of both essential and non-essential services, thus undermining its purpose.
- **Theme 3** EPSDT is an essential service for children and results in cost saving in other systems.
- **Theme 4** Numerous opportunities exist to simplify eligibility requirements and processes that would result in administrative cost savings.

- **Managed Care Expansion and Service Delivery Improvement**

- **Theme 5** Efforts to expand managed care while reducing state expenditures and improving quality of care should be done in a way that does not jeopardize safety net providers.

- **Theme 6** Choice is paramount for elderly and disabled Medi-Cal beneficiaries. Improving the quality of healthcare must be the goal of any reform in the Medi-Cal program that serves seniors and people with disabilities.

- **Theme 7** Standards must be established that ensure accessibility and effective communication as well as the provision of auxiliary aids and services, transportation and individualized accommodation in the delivery of health care services for people with disabilities.

- **Theme 8** Improvement of care coordination and chronic disease management can reduce Medi-Cal costs, whether in managed care or the fee-for-service (FFS) system. Coordination and management of care must aim to improve health and foster home and community-based living, furthering the goals of the Olmstead decision.

- **Revenue Maximization and Cost Savings Ideas**

- **Theme 9** A Section 1115 waiver could result in spending caps on federal Medicaid payments, which could limit long-term federal funding, causing further budget crises.

- **Theme 10** Many opportunities were suggested to maximize revenues and optimize cost savings that could reduce or eliminate the need to cut benefits or introduce cost sharing.

- **Benefits, Eligibility and Administrative Simplification**

Theme 1. The benefit tier structure concept adds complexity and cost, rather than simplicity and savings to the program.

The State's proposed tiered benefit concept identified three benefit tiers, with differing co-payments, premiums and co-insurance levels. Rather than simplifying the process—a stated goal of the Redesign process—participants were concerned that the benefit tiers would add an additional layer of bureaucracy to the eligibility process. The participants raised questions about why the tier proposal was not tied to specific goals or outcomes. Many felt a cost-benefit analysis should be conducted to determine if this

approach would decrease program costs or increase revenues after implementation, administration and maintenance costs.

Participants expressed concern that the proposed tiered benefit structure seemed to add complexity to the enrollment process, adding additional screening tests to a process that already serves as a barrier to many eligible Californians. Having to assess which tier and which benefits are available at which level of premium would require additional county workers or delays in those eligible for the program becoming enrolled. Workgroup participants were encouraged by Health-e-App/One-e-App and similar interactive Internet-based applications designed to simplify and expedite the enrollment process for Medi-Cal, Healthy Families and other similar programs. Although findings related to cost were not available, results from the Health-e-App pilot test found high user satisfaction and a significant reduction in elapsed time from start to finish of the application process. Participants noted that federal match of 75 percent of costs is available to establish these electronic gateways, and that local foundation funding was potentially also available.

Another enrollment topic voiced in workgroups was the efficiency and potential cost savings associated with allowing an applicant to select his/her health plan and primary care physician at the time of Medi-Cal enrollment. Under the current process that exists in Medi-Cal managed care counties, a person who enrolls in Medi-Cal is given up to 30 days after enrollment to choose a managed care plan. To assist the enrollee, the enrollment contractor mails a packet at a cost of about $5 per mailing. The state currently spends about $8 million on such mailings per year. Other participants indicated that they opposed this idea on the grounds that it does not allow beneficiaries sufficient time to find an appropriate provider. A Legislative Analyst's Office (LAO) analysis indicates that the state could achieve significant savings by allowing new enrollees who have already decided on a health plan to enroll when they apply for Medi-Cal.

Centralizing eligibility functions statewide was also discussed by workgroup participants. Research suggests that the additional step of sending applications back to the counties results in time delays and additional administrative cost.

Theme 2. Cost sharing is a way to reduce utilization, and, for low-income patients, particularly those who are elderly and disabled, typically deters use of both essential and non-essential services, thus undermining its purpose.

The State's proposed benefit tier structure concept included increased co-payments as well as new premiums and co-insurance for certain beneficiaries. The Kaiser Commission on Medicaid and the Uninsured, PricewaterhouseCoopers—consultants to Oregon for its Section 1115 waiver, and a representative from the State of Oregon presented evidence that heightened concerns that increased cost sharing would reduce both enrollment in the Medi-Cal program and utilization of appropriate services. Participants stated that the imposition of premiums could lead to significant numbers of

beneficiaries losing access to Medi-Cal, which would limit their access to preventive care and treatment of chronic conditions—thereby adversely affecting safety net providers.

Participants reiterated that asking providers to collect co-payments, while deducting them from provider reimbursements, was tantamount to making additional provider cuts. Each time provider rate cuts are made, some providers stop accepting Medi-Cal patients, and access to health care for beneficiaries is further constricted. Participants expressed concerns that premiums could result in increased administrative costs and burdens in collecting premiums, tracking payment and processing terminations from the program.

Participants stated that cost sharing for Medi-Cal beneficiaries did not take into account that, by definition, Medi-Cal beneficiaries are very low-income. Any increase in co-payments could lead to beneficiaries foregoing needed health care. A 20 percent co-insurance for health services, particularly for many of the services and supplies needed by people with disabilities, such as wheelchairs and disposable medical supplies, would be burdensome and potentially result in an erosion of their health status. Participants recommended that durable medical equipment (DME) be excluded from any cost sharing proposals for seniors and people with disabilities.

Theme 3. EPSDT is an essential service for children and results in cost saving in other systems.

The State presented the concept of redefining the terms “medical necessity” and “ameliorate” within EPSDT eligibility and services. EPSDT is a comprehensive benefits package for children that includes a broad array of diagnostic and treatment services. This includes all health care and treatment, according to the Social Security Act, that is required to “correct or ameliorate defects and physical and mental conditions uncovered by [EPSDT] screening services.” In other words, it includes all services a provider thinks are medically necessary. The concept presented by the State at the workgroup meetings states that the “definition used to determine whether EPSDT services are medically necessary would be revised to provide greater specificity of the term ‘ameliorate.’” Participants expressed concern that the State’s proposal to reduce EPSDT appeared to be driven by the perception that outpatient costs are increasing disproportionately, without taking into account simultaneous cost avoidance and cost savings in other areas. Participants were concerned that short-term cost savings proposals did not account for the shifting of costs to other parts of the system nor were cost avoidance aspects of EPSDT counted by the State when they considered Redesign options. Participants requested that the State develop demand forecasts of the increases in service needs in other sectors, should this concept be implemented.

Participants expressed concern that because poor children have worse health than other children, any constriction on EPSDT services above the current authorization guidelines would have a profound effect on this vulnerable population. Participants

commented that the Redesign focus for specialty mental health has been the growth in EPSDT. A concern was expressed that the rising costs were based on an artificially low baseline and that costs would not appear as dramatic if the starting point were different. Participants suggested that the State focus instead on whether the program can be made more efficient and cost-effective.

Theme 4. Numerous opportunities exist to simplify eligibility requirements and processes that would result in administrative cost savings.

The State's benefit tier structure concept would add an additional step to eligibility determination. The Medi-Cal program has been built incrementally over 38 years with a vast array of categorical programs, many with different income and asset standards and methodologies. Currently, there are at least 165 categories of Medi-Cal eligibility, many with different income and asset standards and methodologies. For example, in some circumstances a vehicle is considered part of the applicant's assets and in other cases, the same vehicle is considered exempt. Simplifying the rules for eligibility was promoted in several workgroups, and focused on three strategies: reducing variability in the income rules; reducing documentation requirements to determine income and/or assets; and eliminating the assets test.

The simplification of rules regarding income determination generated positive feedback. Participants emphasized, however, that simplification resulting in a net loss of eligibility was of significant concern, since this would shift the costs of caring for additional uninsured persons to the counties.

The concept of expanding the use of self-declaration of income and/or assets, both of which are already allowed under certain conditions, was discussed. A report by the Lewin Group[1] suggested that implementing self-declaration of income alone, or in concert with self-declaration of assets, creates some savings in work time for eligibility workers but the increase in enrollees would not result in a net savings. The same report found that self-certification of assets alone would increase enrollment modestly among persons already eligible for Medi-Cal, and would generate enough administrative savings to provide a net reduction in cost to the State.

A Kaiser Family Foundation study of 10 states' Medicaid programs[2] demonstrated that elimination of the asset test resulted in administrative cost savings, as well as improved productivity of eligibility workers, and a friendlier and more accessible enrollment process. It also set the stage to enable states to adopt automatic eligibility determination systems. A New York City study found that roughly 40 percent of administrative costs

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[1] file:///C:/Documents%20and%20Settings/nance/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ALWFYD09/295,18,Potential enrollment and cost impacts of selected simplification options

[2] Smith, Vernon K. and Ellis, Eileen, and Chang, Christina "Eliminating the Medicaid Asset Test for Families, A Review of State Experiences," Kaiser Family Foundation, April 2001. http://www.medi-calredesign.org/pdf/Kaiser_Simplification_Brief.pdf.

associated with enrolling a child in Medicaid or SCHIP could be saved if documentation requirements were simplified.[3] However, the Lewin study found that eliminating the assets test, while reducing administrative costs, would increase program enrollment and result in an increase in overall State costs.

Participants identified several ways to achieve simplicity and cost savings, including shortening the application form, as New York has done; eliminating the asset test, mid-year status reporting requirements and deprivation requirements; implementing One-e-App; and instituting self-certification at provider offices. Participants proposed that the State count all available income and treat it in the same way for all applicants. Participants supported reducing the number of aid codes and the rules governing them.

Participants also promoted the idea of combining or integrating Healthy Families, Medi-Cal and Access for Infants and Mothers (AIM), thereby reducing confusion and administrative costs. They suggested using Medi-Cal coverage for children and parents up to 133 percent of the federal poverty level (FPL), applying Healthy Families coverage above that level and subsuming Medi-Cal share of cost into Healthy Families for parents. Participants also recommended interfacing with sister programs that are also using income guidelines, such as the Free and Reduced Price Lunch program, Food Stamps, Family PACT, Children's Health and Disability Prevention (CHDP) Gateway and CalWORKs.

- **Administrative Simplification**

The medical provider community in California perceives the processes for Medi-Cal treatment authorization requests (TARs) to be overly burdensome. A study by Outlook Associates for the California HealthCare Foundation[4] found that for services that require prior authorizations, Medi-Cal takes either the same amount of time or longer than other organizations to pay its providers as measured from the date of service. In addition, more than 80 percent of TARs are approved, which calls into question the cost-effectiveness of the TAR program overall.

Based on this information and corroborated by anecdotal evidence from providers, workgroup participants urged that the State review and streamline current TAR system to eliminate ineffective TARs; consider a change in the limit of the number of drugs that can be obtained without a TAR; develop a standard set of adjudication guidelines or use a standard computer program for all adjudicated TAR services; accelerate the implementation of the new internet-based TAR system (e-TAR); and consider shifting responsibility for TARs to providers.

Participants were also vocal regarding opportunities to streamline provider enrollment, including deeming primary care clinics to be enrolled providers during the licensure

[3] In the New York study, the only documentation required for enrollment is proof of identify from the applying family member.
[4] http://www.chcf.org/topics/medi-cal/index.cfm?itemID=21204&subTopic=CL262&subsection=medi-cal.

process and eliminating duplication between the licensure and provider enrollment processes for Medi-Cal, Medi-Cal presumptive eligibility, CHDP and CPSP.

Another area of emphasis suggested by the workgroup participants was to consider one eligibility processing system for the entire state. The current model enlists staff in 58 counties and two state agencies to determine eligibility, which offers enormous opportunities for adding costs, complexity and potential errors. Additionally, the local eligibility process makes it difficult for beneficiaries to maintain coverage when they relocate to another part of the state.

Workgroup participants noted that competitive bidding and sole-source contracting for ancillary services such as laboratory, pharmacy and DME, and contracting with fewer, more cost-efficient providers, might result in substantial savings and give better control of fraud and abuse.

• Managed Care Expansion and Service Delivery Improvement

Theme 5. Efforts to expand managed care while reducing state expenditures and improving quality of care should be done in a way that does not jeopardize safety net providers.

The State proposed to expand Medi-Cal managed care statewide as well as to additional populations, potentially making it mandatory for most, including senior and disabled populations. Presentations by safety net providers raised the specter of further pressures on county and other disproportionate share hospitals (DSH) throughout California, if managed care were expanded geographically and/or became mandatory for seniors and people with disabilities. Without the ability to access DSH and SB1255 funds, these safety net providers will face greater financial crises. A decrease in the number of fee-for-service inpatient days with the expansion of managed care would result in SB1255 funding cuts, putting these institutions at risk.

Participants recognized the potential adverse affect of managed care expansion on the public hospitals. Participants also noted that it was unreasonable to expect seniors and people with disabilities to be responsible for maintaining DSH hospitals if it meant denying them the choice to access potentially higher quality care at other facilities, in or out of managed care. Some participants responded positively to the State's information on a PCCM (primary care case management) model that might be implemented. Whether mandatory managed care is implemented for the aging and disabled populations, it was suggested that providing care management for this group of beneficiaries should be available both in the fee-for-service program and in managed care.

Participants were mixed in their support of mandatory vs. voluntary enrollment of aged, blind and disabled Medi-Cal beneficiaries in managed care. Some noted that managed care had the potential to improve patients' access to quality care and save state dollars.

Research presented to the workgroups suggested that Medi-Cal managed care has improved access to physician services, increased physician reimbursement in many counties and has improved access to outpatient and preventive care. County Operated Health Systems (COHS) plans have improved the coordination and delivery of services to the aging and disabled populations. It was also noted that different models for managed care were at varying stages of readiness and appropriateness for caring for the senior and disabled low-income populations.

Participants were concerned about the capacity of a managed care program to serve people living in rural areas where there are already limited provider networks. Participants cautioned that it would be essential to heed the lessons learned by Medicare HMOs in suburban and rural areas. These systems had little or no experience with managed care in lower density population areas and were unable to establish adequate provider networks. Participants urged that plans moving into rural areas be required to make a long-term commitment to their communities, as opposed to past experience when plans left after a few months.

A regional, rather than county-focused, model was discussed. Although some participants recognized that expansion may be logical for existing Medi-Cal managed plans, this expansion might require a Section 1115 waiver or change in federal law. Some COHS expansion is possible under the current enrollment limit and current waiver.

In order to encourage voluntary enrollment into managed care, participants recommended that DHS fund consumer assistance programs that advise beneficiaries about their options to join managed care. These programs would also be able to explain the pros and cons of joining a plan, based on the individual beneficiary's unique circumstances.

Another issue relates to dis-enrolling managed care enrollees who subsequently become eligible for Medicare. It is estimated that two-thirds of current elderly and disabled enrollees could be transferred to Medicare Advantage, at significant cost savings.

Theme 6. Choice is paramount for elderly and disabled Medi-Cal beneficiaries. Improving the quality of healthcare must be the goal of any reform in the Medi-Cal program that serves seniors and people with disabilities.

While managed care has the potential to offer some benefits to seniors and those with disabilities, a central message from participants was that in order to ensure that beneficiaries receive appropriate health care, they must be able to choose care that is appropriate for their needs. Choice means access to providers from a wide range of disciplines and who are informed about the often complex health problems of this group, as well as access to a health plan that includes adequate benefits.

Access to healthcare for elderly and disabled enrollees has two distinct meanings. The first refers to the ability of beneficiaries to seek services from a provider network that includes knowledgeable primary care physicians and specialists, and adequate coverage by the plan. Equally important, the second means that health care settings must be accessible and able to accommodate patients with a variety of disabilities.

Participants also recognized that many disabled beneficiaries are capable of managing their own health care, and that many have long-term relationships with their providers that should be allowed to continue.

While cost savings is the State's primary interest in redesigning Medi-Cal, participants expressed the view that the primary goal and outcome of any reforms of the Medi-Cal program should be improvement in the quality of care received by everyone who is eligible, including people with disabilities and those who are elderly. Improved care reduces hospitalizations and emergency room visits, thus lowering costs while improving the health of beneficiaries.

Ideas included:

- Making enrollment of new and qualified Medi-Cal providers a top priority. Currently there is a substantial backlog in processing provider application paperwork. Providers who are willing to participate in Medi-Cal should be authorized to do so as quickly as possible.
- Setting provider rates at levels based on sound actuarial data.
- Training provider office staff about TAR and billing processes in order to reduce administrative costs associated with resolving these issues, which would lower provider frustration with the program.

Theme 7. Standards must be established that ensure accessibility and effective communication as well as the provision of auxiliary aids and services, transportation and individualized accommodation in the delivery of health care services for people with disabilities.

Participants expressed the need for standards that would guide effective implementation of access both in fee-for-service and managed care service delivery systems. Participants identified essential components of a quality system of health care delivery: architectural accessibility in health care facilities; wheelchair-accessible and conventional transportation for non-emergency medical visits; communication access such as sign language interpreters; materials in alternative formats for people with vision impairments; and other individualized accommodations such as accessible scales, adjustable-height tables and lifting teams or mechanical lifts to assist a wheelchair user transfer to an exam table.

In addition to calling for the setting standards for accessibility and accommodation, participants identified the need to increase the capacity of providers to comply with these standards. Both managed care and fee-for-service plan administrators must find new incentives and methods to assist their provider network members to create an accessible physical environment in which to serve patients, as well as methods to accommodate the diverse needs of this group. Participants observed that Medi-Cal recipients with disabilities and those who are elderly within both managed care and fee-for-service systems have problems locating accessible and qualified primary care providers and specialists who can accommodate their individual disabilities.

Theme 8. Improvement of care coordination and chronic disease management can reduce Medi-Cal costs, whether in managed care or the fee-for-service system. Coordination and management of care must aim to improve health and foster home and community-based living, furthering the goals of the Olmstead decision.

Participants expressed that the intent of the *Olmstead* decision, community-based living and care, and meaningful community integration, must be a driving principle in any redesign of Medi-Cal for seniors and people with disabilities. Home and community-based living rather than institutionalization must be the goal. Participants called for implementing the state Olmstead Plan by, among many things, shifting Medi-Cal long-term resources into home and community-based services and creating incentives for health providers to establish and maintain relationships with community organizations that support community living.

Using case management techniques to respond to and support the needs of targeted users, particularly the elderly and disabled population, was a priority for participants who noted the importance to the individual as well as the potential cost-savings of removing the bias towards institutionalization and moving towards care in the community, with appropriate coordination of care. Workgroup members called for improved coordination of care with other programs. Such coordination is especially critical in meeting the long-term community integration mandate of Olmstead.

For patients who are not disabled but nonetheless have multiple health needs due to chronic medical conditions, participants suggested expanding the concepts of disease management. The disease collaborative sponsored by the California Primary Care Association (CPCA) was presented as a model that has demonstrated health care savings by improving provider and patient management of the chronic condition, resulting in fewer emergency room visits. It has been applicable in both managed care and fee-for-service settings.

Recent guidance (February 2004) from CMS encourages states to implement disease management programs. California is currently in the process of developing a Disease Management Waiver to test the efficacy of providing a disease management benefit to Medi-Cal beneficiaries. The Disease Management Waiver will be a pilot study which will

provide eligible individuals with a range of services that enable them to remain in the least restrictive and most home-like environment while they receive the medical care necessary for their health and well-being. Waiver participants are limited to the ABD population who are not enrolled in managed care or Medicare. Evaluation of the pilot study will be completed in January 2008.

Participants reviewed the research regarding the cost-effectiveness of disease management programs and found that although providers of disease management can reduce the cost of care, there are inadequate financial incentives and reimbursements for doing so. Under current Medi-Cal policy, many disease management best practices, for example group visits and case management, are not currently reimbursable. A disease management bundle of services could include group visits, case management, health education, nutrition, clinical information systems management and other ancillary services central to disease management.

Participants encouraged the Medi-Cal program to maximize the use of case management for persons with chronic conditions, so these beneficiaries receive an appropriate level of care in a community setting, that enables them to maintain and improve their health status.

• Revenue Maximization and Cost Savings Ideas

Theme 9. A Section 1115 waiver could result in spending caps on federal Medicaid payments, which could limit long-term federal funding, causing further budget crises.

The State proposed developing a comprehensive Section 1115 waiver to provide flexibility in redesigning the Medi-Cal program. Participants expressed reservations about federal spending caps or a block grant for Medi-Cal, which could be harmful to California, even if they provide short-term fiscal relief. Under a Section 1115 waiver, the federal government requires a state to demonstrate budget neutrality: federal Medicaid spending under the waiver must not be higher than it would have been in the absence of the waiver. The chief concern with this requirement is that it would place a limit on federal Medicaid funds available to the state for the entire Medi-Cal program over the next five years. Any cap in funding could result in federal Medicaid payments no longer being tied to the actual costs California incurs in operating the program.

Theme 10. Many opportunities were suggested to maximize revenues and optimize cost savings that could reduce or eliminate the need to cut benefits or introduce cost sharing.

Ideas to maximize revenue and increase cost savings were plentiful. While nearly 200 ideas were presented (see Attachment 2), strategies can be categorized into eight general areas:

- **Move state general fund and county programs into Medi-Cal, which makes those expenditures eligible for federal matching funds.**

Federal match for Medi-Cal expenditures is approximately 50 percent. Participants suggested a wide range of programs for inclusion in Medi-Cal: CHDP services, CMSP and county health services, EAPC, mental health, IHSS and children's services not currently eligible for Federal Financial Participation, developmental services, aging services, school health and special education services. Some of these changes could be accomplished at the state level; others require a state plan amendment or federal waiver.

Representatives from Los Angeles County presented a new idea to maximize revenue for the care of low-income adults. State and local expenditures for CMSP and county health services totaled nearly $1.5 billion in FY 2000-01. These funds provide health care for 1.5 million adults who are ineligible for Medi-Cal due to lack of categorical linkage. Much of this funding could be eligible for federal matching if the state seeks and secures a federal Section 1115 waiver, as New York, Massachusetts, Oregon, Arizona and Tennessee have already done. Waivers allow states to use their Medicaid programs to generate savings through the implementation of managed care programs, with reinvestment of savings into expanded coverage. A waiver could thus greatly increase the purchasing power of local and state funds to extend access to more persons. Federally-approved coverage expansions have allowed the benefit levels of the newly covered to be less generous than the mandatory Medicaid populations, thus, the scope of the new coverage could be tailored to the availability of overall financing. County staff who have proposed this concept envision that individual counties would have flexibility to define the benefit package over a basic minimum scope of services and to define the provider network.

- **Access unused Healthy Families funding and move current programs into Healthy Families to provide match.**

Healthy Family expenditures draw down the higher federal match available through SCHIP. Many of the same programs recommended for inclusion in Medi-Cal were also recommended for inclusion in Healthy Families. Most commonly suggested were expanding Healthy Families to include medically needy families, the AIM program, covering families up to 300 percent of the federal poverty level, and children of share of cost Medi-Cal.

- **More aggressive use of existing Medi-Cal programs can bring in more federal match.**

Such programs include Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM) areas such as juvenile justice, foster care, immunization registry and immunization outreach activities, elder and child abuse prevention and monitoring. It was noted that simplifying the MAA program would encourage greater participation, notably within schools. However, stakeholder participants also suggested caution be exercised to avoid past federal audit exceptions.

- **Maximize other federally funded sources of coverage.**

Suggestions were offered to increase the amount and type of federal dollars possible. Three examples included:

  - At the present time, California is unable to draw down several million dollars in federal funds annually for services to Native Americans, in accord with approved Indian Health Service (IHS) and CMS guidelines. CMS has communicated that the State can draw down FFP for eligible services provided to appropriately identified Native Americans.

  - Passage of the federal "Immigrant Children's Health Improvement Act" (ICHAI), to provide a federal match for Medi-Cal and Healthy Families for qualified legal immigrant children and pregnant women.

  - Extension of last year's Medicaid federal fiscal relief through a short-term continuation of the enhanced matching rate (FMAP).

- **Explore the use of provider taxes.**

Workgroup participants noted that in several states, provider taxes supply a portion of the financing for public programs and expansions.

- **Manage the drug rebate program aggressively.**

Stakeholder participants urged DHS to consider all available methods of collecting available drug rebates—hiring additional staff, redirecting current staff resources and utilizing the state hearing process for intractable disputes.

- **Pursue pharmacy cost-savings.**

Opportunities to realize cost savings without threatening access to services or quality of care were suggested within the pharmacy benefit portion of the Medi-Cal program. Suggestions for cost savings revolve around three concepts: pharmacy benefit management (PBM) to encourage use of the most effective drugs in a cost efficient

manner; reductions in payments to pharmacists to bring reimbursement in line with that of commercial plans; and strategies to reduce fraud.

Drug costs are a key driver of continually increasing health care costs in both the private and public sector. According to CMS, national expenditures on prescription drugs were projected to grow to 14.3 percent in 2002, 13.4 percent in 2003 and 11.2 percent in 2004. Although this growth rate may be slowing, it outstrips every other health care category by a ratio of 2:1.

In order to contain costs while maintaining access to prescription drugs, workgroup participants suggested contracting with a PBM company. PBMs use a range of price discounts, rebates, utilization controls, use of generics and other methods for encouraging appropriate utilization. Evaluations of PBMs in other states have shown cost reductions of 3 – 30 percent, depending on the strategies employed. Given annual drug expenditures in the fee-for-service Medi-Cal program of $4.7 billion, a modest projection of 10 percent reduction in costs produces an estimated $470 million in savings.

Recognizing that Medi-Cal currently reimburses pharmacies at a rate that generally exceeds commercial plans, stakeholders suggested reducing both the dispensing fee and the amount paid for the medication. Reducing the dispensing fee from the current $3.55 to $2.30, which is equivalent to commercial plan reimbursement, is estimated to result in a savings of $62.5 million annually. Reducing the amount paid for the actual drug from the average wholesale price (AWP) less 10 percent, to AWP less 15 percent is estimated to generate an additional estimated savings of $265 million per year. This change is consistent with commercial plans, which vary considerably, but are generally in the range of 13 – 16 percent less than AWP.

It is estimated by DHS that as much as one third of the cost of prescription drugs for the Medi-Cal program is attributable to fraudulent billing for services and products.[5] Several workgroup participants promulgated concepts related to additional on-site pharmacy audits, as well as more stringent review of pharmacies as a condition of participation in the Medi-Cal program.

- **Fraud Detection**

Fraud detection was raised for a number of aspects of the program: most significantly in pharmacy and DME. Participants noted that it was essential for DHS to work closely with law enforcement to improve the detection rate. Participants recommended that the department offer incentives, such as sharing in some of the recovered funds, to encourage their participation.

[5] The figure of 1/3 in fraudulent billings comes from this document -- http://www.medi-calredesign.org/pdf/finance_pharmacyideas.UnitedPharma.Network.doc.

VI. Redesign Process Evaluation

An evaluation form was distributed at the last meeting of each workgroup, soliciting feedback on the process and outcomes. Of the 119 responses so far, 51 percent said the process met their expectations, 23 percent said that it had exceeded their expectations and 25 percent said it had not met their expectations. Two-thirds thought the process had done a very good or excellent job of ensuring that multiple voices were heard – 69 percent felt that participant involvement was very good or excellent; 58 percent thought it was a very good or excellent use of their time. When asked about the outcome of the meeting, 19 percent noted that they would not know until they saw the finished product, and only a third thought the process was likely to have a very good or excellent effect on the State's proposal. Participants thought the process itself went smoothly. Most found the facilitation, registration, administration and facilities to be very good or excellent.

There seemed to be, throughout the process, an ongoing tension between the State's presentation of concepts for which they wanted early feedback and participants' desire to have concrete proposals to evaluate and respond to. There was general disappointment in the lack of data and analysis which accompanied the presentation of the concepts preventing the ability to provide informed feedback. At the beginning of the process and during the evaluation, many participants expressed concerns that the waiver application had already been written and their feedback was an empty exercise, despite repeated assurances from senior State officials that this was not the case.

Suggestions for the next phase of the Redesign process included that the State provide more specific data and analysis; invite more consumers and providers to participate; make the workgroups smaller while maintaining a representation of stakeholders; and hold meetings on the same topics in northern and southern California to minimize travel costs for participants.

VII. Attachments

Attachment 1	**Stakeholder Participant List**
Attachment 2	**Cost Savings Ideas**
Attachment 3	**Benefits Workgroup Summaries and Stakeholder Feedback**
Attachment 4	**Eligibility Workgroup Summaries and Stakeholder Feedback**
Attachment 5	**Organized Delivery System/ Managed Care Workgroup Summaries and Stakeholder Feedback**
Attachment 6	**Aging and Disability Issues Workgroup Summaries and Stakeholder Feedback**
Attachment 7	**Financing and Cost Savings Workgroup Summaries and Stakeholder Feedback**
Attachment 8	**General Stakeholder Feedback**