

Fact Sheet: California's 1115 Medi-Cal Waiver

**California Working Families Policy Summit
January 12, 2011**

BACKGROUND ON MEDICAID WAIVERS

Under a Medicaid waiver, the federal government waives certain Medicaid requirements, thereby giving states flexibility in the operation of their Medicaid program – Medi-Cal in California – to allow states to test new approaches and demonstration projects to improve care. Section 1115 is the section of the Social Security Act that allows the federal government to grant Medicaid waivers.

To obtain a waiver, a state negotiates with the Centers for Medicare and Medicaid Services (CMS) about which Medicaid provisions might be waived, what innovations the state is proposing, and how the state plans to achieve “budget neutrality” (a requirement that waivers not cost the federal government more with the waiver than without the waiver). The negotiations are memorialized in the “Special Terms and Conditions” which constitute a contract between CMS and the state. In addition, the state adopts authorizing legislation to implement the waiver.

A SHORT HISTORY OF CALIFORNIA'S RECENT MEDICAID WAIVERS

In the past six years, California has negotiated two 1115 waivers with the Centers for Medicare and Medicaid Services (CMS), one which launched implementation in 2005 and the most recent which was just approved by CMS in 2010. In addition, California has other waivers that, for example, address how Medi-Cal mental health benefits are delivered or home and community-based services are provided.

California's 2005 Medi-Cal Waiver

In August 2005, California entered into a hospital financing waiver. This waiver delineated the methods for hospitals to be paid for care to Medi-Cal and uninsured patients. It established a Safety Net Care Pool for public hospitals which subsidized uncompensated care costs for uninsured individuals. In addition, the 2005 waiver provided federal funds to expand coverage to “childless adults”¹ under a Coverage Initiative project which has provided financial support to ten counties.

California's 2010 Medi-Cal Waiver

California's newly approved waiver, entitled the “California Bridge to Reform,” began November 1, 2010 and will be in effect for five years. If the requirements and milestones are met, it is slated to bring \$10 billion in federal funds into California.

¹ Only certain categories of people have traditionally been eligible for Medi-Cal: children, parents, pregnant women, seniors and persons with disabilities. Other adults, traditionally called “childless adults” have not been eligible for Medi-Cal regardless of how low-income they are.

Fact Sheet: California's 1115 Medi-Cal Waiver Western Center on Law & Poverty

The waiver's major components include:

- Establishing **Low-Income Health Programs** (LIHPs) which allow counties to draw down federal matching dollars to provide coverage to childless adults if they meet certain requirements.
- Requiring mandatory enrollment of **Seniors and Persons with Disabilities** (SPDs) on Medi-Cal into Medi-Cal managed care plans.²
- Requiring the Department to establish organized health care delivery pilot models for children with special health care needs who are eligible for both **California Children's Services** and Medi-Cal.
- Continuing the **Safety Net Care Pool** to provide funding for public hospitals, a delivery system reform incentive pool, state health care programs, as well as the Health Care Coverage Initiative. The waiver also implements a global payment demonstration project for hospitals.

State Legislation to Implement the 2010 Medi-Cal Waiver

In addition to being approved by the Centers for Medicare and Medicaid Services, the changes to the Medi-Cal program in the waiver must be authorized through state implementing legislation.

On October 7, 2010, the California Legislature passed legislation governing California's 1115 Medi-cal Waiver – AB 342 (Pérez) and SB 208 (Steinberg). AB 342 contains the provisions to implement Low-Income Health Programs (LIHPs) and SB 208 contains the provisions about mandatory enrollment of Seniors and Persons with Disabilities (SPDs), the California Children's Services pilot projects, dual eligibles, hospital provider fees, and hospital financing. AB 1628, the corrections trailer bill, also passed the Legislature and requires that adult inmates receiving inpatient hospital services be enrolled into LIHPs or Medi-Cal. Then-Governor Schwarzenegger signed all of the Medi-Cal Waiver legislation into law.

California's Special Terms and Conditions

The other legal document governing the waiver is the Special Terms and Conditions which constitute the contract between CMS and the State. It lays out specific requirements for everything from making sure there are enough doctors in the Medi-Cal managed care plans to what benefits must be provided in the Low-Income Health Programs (LIHPs).

PROGRAM COMPONENTS OF THE 1115 MEDI-CAL WAIVER

The primary program components that will be implemented through the 2010 Medi-Cal Waiver are as follows.

Coverage Expansion through the Low-Income Health Programs (LIHPs)

There are two different programs that make-up the LIHPs:

- Medicaid Coverage Expansion (MCE) for people with income at or below 133% of the Federal Poverty Level (FPL); and
- Health Care Coverage Initiative (HCCI) for people with income between 134% and 200% FPL.

² Medi-Cal managed care plans are health plans with a closed network of doctors that the patients have to go to in contrast to "regular" or fee-for-service Medi-Cal where patients can go to any Medi-Cal doctor.

Program Eligibility

People between the ages of 19 and 64 who are citizens or qualified immigrants and who are not eligible for Medi-Cal or Medicare are eligible for LIHPs. Counties decide whether to participate in the LIHPs. If they do participate, they receive federal matching dollars on a 1:1 basis. Counties may set income limits below 133% FPL. Counties are required to first fully serve their lower-income MCE population (up to 133% FPL) before they can have an HCCI for county residents up to 200% FPL. There is an exception to this requirement for counties that already have HCCIs. They can continue serving people enrolled in their HCCIs.

Benefits, Cost Sharing and Due Process

The waiver terms and conditions require LIHPs to provide certain benefits to enrollees including emergency care, hospital services, physician services, medical equipment and supplies, laboratory services, physical therapy, medications, and mental health benefits. More benefits must be covered for MCEs than HCCIs. Counties may only require MCE enrollees to pay the Medi-Cal copays whereas they can require HCCI enrollees to pay up to 5% of their income toward the cost of their health care.

LIHPs must cover out-of-network emergency services, and enrollees cannot be billed for this care. The waiver terms and conditions specify network adequacy standards and timeliness standards by which enrollees must receive services in any closed county network of providers. The state Department of Health Care Services (DHCS) must propose notice and hearing rights for LIHP enrollees which meet minimum standards of prior notice and hearing rights set by CMS.

Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care

Beginning in June 2011, the state will begin to mandatorily enroll Seniors and Persons with Disabilities (SPDs) into Medi-Cal managed care plans in the fourteen counties that currently have Geographic Managed Care or Two-Plan Model managed care.³ SPDs are already in managed care in counties with County Organized Health Systems.⁴ No changes in the delivery system are being made in counties with no Medi-Cal managed care plans; they will continue with a fee-for-service model.

Mandatory enrollment will be limited to those SPDs who only have Medi-Cal. Those with other health coverage, including Medicare, will not be required to enroll in managed care.

Plan Readiness & Accessibility Standards

The Department of Health Care Services (DHCS) must assess and ensure readiness of the county plans to meet the needs of Seniors and Persons with Disabilities (SPDs) including access, quality of care and care coordination for beneficiaries.

The state must ensure that Medi-Cal health plans comply with state and federal disability accessibility laws. In addition, the DHCS must develop a facility site review tool which the plans must use to assess the accessibility of providers. Plans must post the results of the facility site review tool on their websites and update the information.

³ In Geographic Managed Care, Medi-Cal beneficiaries can choose among a variety of commercial health plans. With the Two-Plan Model Medi-Cal beneficiaries have a choice of two health plans – a publicly-run “local initiative,” and a privately-run commercial plan.

⁴ Under the County Organized Health System model, a county forms an agency which contracts with the state Medi-Cal program to provide services to almost all Medi-Cal beneficiaries living in that county.

Network Adequacy & Continuity of Care

County plans must ensure and monitor whether they have a sufficient network of doctors and other providers to serve the Seniors and Persons with Disabilities (SPD) population including primary care physicians, specialists, professional allied, and medical supportive personnel. At least 30 days before a plan can enroll SPD Medi-Cal patients, the state must officially certify to the Centers for Medicare and Medicaid Services (CMS) the adequacy of the plan's network of providers. CMS can stop enrollment if it determines a plan's network of providers is not adequate.

Beneficiaries can continue to see a provider who does not contract with their new plan if the provider will accept the higher of either what the plan usually pays its network providers or the rate the doctor got in "regular" or fee-for-service Medi-Cal.

Outreach, Education & Communication

The Department of Health Care Services (DHCS) must develop an outreach and education program to inform Seniors and Persons with Disabilities (SPDs) of their enrollment options and their consumer rights under the waiver. Beneficiaries will receive an initial informing notice about mandatory enrollment in March 2011, and enrollment will begin in June 2011. The waiver lays out communication requirements, including alternative formats and information that meet the needs of different SPD communities and limited-English proficient consumers. DHCS must also conduct a sensitivity training for health plan and DHCS staff regarding the needs of SPDs.

Plan Assignment / Enrollment

After the initial informing notice, beneficiaries will receive an enrollment packet and have 60 days to pick a plan on their own. If they do not pick a plan, one will be chosen for them. Based on claims data, the DHCS will identify the provider the beneficiary saw most often and will assign them to a plan with this provider. If that data match is not possible, beneficiaries will be assigned a plan.

Needs Assessment and Care Coordination

DHCS must provide health plans with utilization data for each beneficiary when they are enrolled so the plan can identify beneficiaries with greater needs. Plans must assess beneficiaries' health needs and develop individual care plans for a host of care coordination services, coordinating care across all settings. Plans must also take into account the behavioral health needs of enrollees including facilitating communication between health and mental health providers. Finally, plans must include behavioral health services as part of the care management plan, when appropriate.

DHCS must develop performance measures for health plans, including specific measures for Seniors and Persons with Disabilities (SPDs). DHCS must also report to the Legislature on the project overall and provide information on health outcomes of enrollees.

PILOT PROJECTS FOR DUAL ELIGIBLES

SB 208 authorizes DHCS to develop pilot projects to coordinate care for dual eligibles who have both Medi-Cal and Medicare coverage, but the waiver terms and conditions do not have any provisions related to changing the system of care for dual eligibles. DHCS established a *duals workgroup* and may seek to amend the waiver to allow for enrolling dual eligibles into managed care.