

Low-Income Consumer Advocates' Recommendations for California's Next 1115 Waiver

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INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

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California's next 1115 Medicaid waiver presents a unique opportunity to improve health outcomes for poor state residents through expanded coverage and delivery system advancements and innovations. Advocates for low-income consumers have developed some proposals we hope the state will pursue in this waiver. We believe that the lives and health of poor Californians can be improved through a better and more cost-effective Medi-Cal program.

A. Expansions / Improvements

1. Medi-Cal Eligibility Floor

Medi-Cal's complexity is often cited as a barrier to enrollment and retention and a cause of administrative waste, as the layers of calculations and procedures workers must go through to determine eligibility are truly labyrinthine. However, the vast majority of successful Medi-Cal applicants do not need to utilize the more nuanced income deduction rules to get in and could qualify with a more basic initial income screen, keeping the nuanced rules in place for those who need it. A waiver is the ideal vehicle to examine these issues. We propose creating an initial income eligibility floor for all Californians regardless of age, linkage, health status, or other category. All applicants and recipients, including childless adults as described below, would be deemed income eligible if their incomes fell at or below 150% of the Federal Poverty Level (FPL), for example, without investigating their eligibility under various deductions that might qualify persons with incomes much higher under today's rules. Because most people who are ultimately found eligible would be captured by this initial simplified income test, only those whose gross incomes exceed 150% would need the full income eligibility processing, and counties would retain the ability to perform nuanced calculations for these individuals/families to determine eligibility. All existing avenues of eligibility, including income deductions and exemptions, would remain for all applicants and recipients without expansion or reduction. For example, if a worker (or computer program) sees that the family's pay stubs alone fall below 150% FPL, it is not necessary to calculate child support, child care, self-employment expenses, let alone investigate more complex issues such as which income came from which source or which family member or what portion is from self-employment, disability payments, or public assistance.

This simplified initial income test would be easier to understand both for applicants and eligibility staff and is expected to reduce administrative costs as well as enrollment barriers. It could also save significant funds on data entry and the county staff work necessary to seek and obtain verifications for deductions that don't end up mattering for a particular family who gets in the "easier way." This proposal would also necessitate some Share of Cost relief so that persons with incomes one dollar over 150% FPL would not have a Share of Cost amounting to half of their gross incomes, violating principles of affordability and essentially making their Medi-Cal unusable.

2. Childless Adult Expansion

Following the examples of other states, like Oregon, Massachusetts, and Arizona, California could expand Medi-Cal eligibility to medically indigent adults without categorical eligibility through a new 1115 waiver. An 1115 waiver is the only way to draw down federal dollars for this population. Currently, there are 1,077,000 childless adults in California between the ages of 19 and 64 with income below 150% FPL who have no health insurance.¹ The elimination of categorical eligibility requirements for people with incomes below 150% of the poverty level would provide important benefits that will help communities better address the needs of low-income individuals.

Offering expanded Medi-Cal eligibility would equalize access to care across the state, rather than relying on a patchwork of coverage throughout our 58 counties. With statewide uniform Medi-Cal coverage, access to healthcare would not depend on county residency.

In fact, expanding eligibility would remove multiple obstacles that leave far too many vulnerable people uninsured. It would strengthen Medi-Cal to fulfill its role as a safety net for many groups, including:

- Low-income people who use the emergency department as their source of primary health care and who, as a result of seeking care in a setting not meant to provide ongoing management of medical and behavioral health conditions, experience worsening health;
- Low-income people with disabilities and chronic health conditions who do not meet the stringent SSI/Medicaid definition of disability but who nevertheless need medical care;
- Poor mothers with health or behavioral health problems whose children have been placed in foster care;
- Young people aging out of foster care;² and
- Low-income people at risk of homelessness, housing instability, unemployment, disability and worsening poverty due to deteriorating health conditions and lack of treatment.

Many childless adults do not meet the rigorous SSI/Medicaid definition of disability, even if in clear need of medical treatment. Others do meet the SSI/Medicaid definition of disability, but are unable to obtain a disability determination because proving disability requires multiple appointments and extensive medical documentation, and is therefore often difficult for people with mental illness or who lack the stability needed to maintain appointments, keep regular contact with medical providers, or retain personal medical histories.

¹ 2007 California Health Interview Survey data: <http://www.askchis.com>. This data may be derived by entering “entire state of California” and using the main topic “current coverage – currently insured” under the topic insurance coverage, comparing by “family and marital status – family type” under the topic “demographic” and restricting the population to the ages of 19-65 (does not include 65) with incomes of 0-150% FPL. Once the results are generated, the boxes “single, no kids, uninsured” and “married, no kids, uninsured” will amount to this number.

² Though California has a program to provide Medi-Cal to foster youth until their 21st birthday, not all youth stay enrolled due to burdensome paperwork requirements and there is no entitlement to Medi-Cal after age 21 related to foster care status.

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Data from the Centers for Disease Control and National Health Interview Survey confirm that people who are uninsured are far less likely to have a source of usual care and far more likely to have unmanaged chronic conditions.³ People who are uninsured and lack access to a regular source of medical care are at greater risk of becoming severely and permanently disabled and in need of expensive, long-term care. Indeed, for childless adults with worsening chronic conditions, untreated medical conditions could generate higher costs to Medi-Cal in the long-term, both in acute inpatient and in skilled nursing facility costs, when these individuals become sicker and then qualify for Medi-Cal based on age or disability. A Harvard study of Medicare beneficiaries found that previously uninsured adults experienced significantly worse health conditions and used more medical services once eligible for Medicare than previously insured beneficiaries. Researchers concluded that providing earlier health coverage for people currently uninsured has, "considerable social and economic value" due to improved health outcomes and less use of expensive acute care services once insured.⁴

In the meantime, hospitals are consistently burdened with covering costs of care for uninsured people. Hospitals spend more than \$8 billion in services per year without compensation. Uncompensated care contributed to the closure of over 65 emergency rooms in California from 1997 to 2007.⁵ County hospitals are particularly affected, as counties not only provide healthcare to uninsured residents, they often house trauma and burn centers.

These trends were borne out in San Mateo County's childless adult expansion. The Urban Institute conducted an evaluation of the first year of operation of San Mateo County's Access to Care of All (ACE) program, looking at the health needs and usage patterns of the ACE participants. They found that a very high proportion of the ACE enrollees have significant chronic health conditions, particularly those enrollees in the 55 to 64 year old age bracket. Fully 60% of enrollees in this bracket have a diagnosis in the "endocrine, nutritional, metabolic and immunity disorder" category. In addition, a high percentage of ACE enrollees in all age brackets have hypertension, diabetes, or both (40.7%).

Utilization rates for newly covered childless adults were relatively high for the first year of operation, though were generally below the annual usage rates nationally for Medicaid enrollees. Almost one-third of this population had an emergency room visit within a six month period.⁶ Overall, usage rates for ambulatory care for this previously uninsured group were also relatively high during the first year of the expansion, but here too they remained below usage for the Medi-Cal population.⁷ The generally high usage of ambulatory and outpatient services by this group

³ *Uninsured Americans With Chronic Health Conditions: Key Finding From the National Health Interview Survey*, (2005), available at: http://www.urban.org/UploadedPDF/411161_uninsured_americans.pdf.

⁴ McWilliams, Michael, M.D., et. al., "Health of Previously Uninsured Adults After Acquiring Medicare Coverage." *J. Amer. Med. Assoc.* Vol. 298, No. 24. Dec. 26, 2007 (emphasis added).

⁵ California Medical Association, Press Release, "San Jose Hospital Shut Down Underscores Need For Proposition 67," Sept. 8, 2004.

⁶ In comparison, 39.7% of Medicaid enrollees utilize the emergency room within a 6 month period, while 18.1% of uninsured adults in the United States and 17.4% of privately insured adults will visit the emergency room in a six month period (Health US, 2005).

⁷ The HPSM HEDIS study found that ACE enrollees had 24.84 visits per 1000 member months as compared with 27.97 ambulatory visits per 1000 member months for HPSM Medi-Cal enrollees ages 19 - 64. On the other hand, the HEDIS study found that outpatient visits by ACE members surpassed outpatient visits by HPSM Medi-Cal enrollees

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suggests that once services are available to the previously uninsured group of childless adults, they will access care more regularly and thereby decrease their usage of costly emergency room services.

Both the authors of the Urban Institute Study and the Health Plan of San Mateo hypothesize that one reason for the generally high usage of all medical services by this previously uninsured group of childless adults is that there exists a pent up demand for medical care. If this is the case, one would expect to see that need, and consequently the high usage, decrease over time. Another factor in the relatively high usage of medical services by this population is the high incidence of chronic medical conditions such as diabetes and hypertension. This fact underscores the need to establish a medical home model for the treatment of the medically indigent adult population.

As uninsured people are much more likely to have preventable hospital stays and emergency room visits, visits to every emergency department have increased substantially in recent years, and more of these visits are resulting in inpatient admission. As a consequence, hospitals overcrowd and emergency departments are forced to divert patients, threatening the health of Californians compelled to face longer trips and protracted waits.

Expanding Medi-Cal eligibility, with ensuing greater access to primary and preventive healthcare for those using significant high-cost care, would reduce unnecessary emergency department use and thus decrease ambulance diversions. It will help community clinics, public and private safety net hospitals, and physicians sustain and even strengthen the services they provide by paying for many of the uninsured adults who cannot afford to pay for their own services or buy their own coverage.

In improving health outcomes, preventing avoidable hospital and emergency department use, and reducing uncompensated care, expanded Medi-Cal eligibility to low-income childless adults makes sense. It is a first step to assuring that the right care is delivered at the right time in the right setting.

Income Levels and Affordability

We propose expanding Medi-Cal coverage to childless adults with incomes up to 150% FPL. This is in keeping with one of the health reform proposals at the federal level and is necessary to afford meaningful access. At this income level people cannot afford premiums or cost sharing.

Consistently, studies show that low-income persons cannot and will not use their health coverage if the co-pays, premiums, and other out of pocket costs exceed what they can afford. As outlined in *Charging the Poor More For Health Care: Cost-Sharing in Medicaid*, the Center on Budget and Policy Priorities gathers relevant literature to show why adults in this income range cannot and should not be required to pay any cost-sharing.⁸ A RAND study showed that any cost-

ages 19 – 64 (678.36/ 1,000 member months for ACE enrollees versus 569.48/1,000 member months for HPSM Medi-Cal enrollees ages 19 – 64.)

⁸Leighton Ku, Center on Budget and Policy Priorities, available at: <http://www.cbpp.org/archiveSite/5-7-03health.pdf>.

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sharing at all in this income bracket led to poorer health among low-income adults and exacerbated chronic conditions such as hypertension and diabetes, compared to those in this bracket who were not required to pay any co-pays or other cost-sharing.⁹ A study in Tennessee showed that low-income patients who were required to pay something were 20% less likely to see a doctor or get their medications from a pharmacy than low-income patients charged nothing, and 2/3 of those who couldn't pay the co-pay simply went without their medications after being unable to obtain no-cost drugs another way.¹⁰

Even charging 1% of a person's income (\$15 for an individual at 150% FPL) lowers enrollment by 16%, and charging 3% (\$45 at 150% FPL) lowers enrollment by half. A 5% threshold (discussed in various health reform circles, and \$75 at 150%) is completely untenable, as it would lower enrollment by 74%.¹¹

Furthermore, any assessment of affordability cannot ignore the fact that Medi-Cal beneficiaries already pay significant amounts, often exceeding what they can afford, in out-of-pocket costs not covered by the program. The Medical Expenditure Panel Survey conducted by the Department of Labor shows that non-disabled, non-elderly adults pay at least 2% already in non-covered out-of-pocket costs.¹² Comparing this to the affordability indices above, it becomes clear that at this income level, people are already stretched far beyond their means and cannot support cost-sharing in Medi-Cal.

In addition, federal Medicaid and CHIP laws prohibit or nearly prohibit any cost-sharing for this population. CHIP limits cost-sharing for persons under 150% to only very nominal charges and prohibits any cost-sharing under 133% FPL in states that provide CHIP at that level. These programs set these standards in acknowledgement of the affordability data above. Similarly, California should not seek a waiver that imposes cost-sharing on the lowest-income people as it would jeopardize their health and even their lives.

Delivery System

To successfully improve health outcomes for low-income adults, they must have access to an effective delivery system with a regular source of care and community-based services. A carefully crafted health care home model and frequent user program are important for both childless uninsured adults and currently eligible Medi-Cal beneficiaries with high medical needs who have difficulty accessing necessary services or obtaining coordinated care. Below, we outline our recommendations for a health care home model and frequent user program. In the section about health care homes, we look to the current Coverage Initiatives as a useful laboratory of models for providing care under a coverage expansion. Safety net providers play a key role in serving this population but we would not want to see poor childless adults locked into a closed network without the ability to choose their providers.

⁹ *Id.* At 8, citing the *RAND Health Insurance Experiment* and Joseph Newhouse, *Free for All: Lessons Learned from the RAND Health Insurance Experiment*, Cambridge: Harvard, 1996.

¹⁰ Ku, *supra*, at 2, 10.

¹¹ Judith Feder and Larry Levitt, *Choices Under the New State Health Insurance Program: What Factors Shape Cost and Coverage?* Policy Brief for Kaiser Commission on the Future of Medicaid, 1998.

¹² Ku, *supra*, at 3.

B. Programs that Require Up Front Investment but Result in System Savings and Improvements

1. Providing a Health Care Home¹³

Most seniors and persons with disabilities (SPD) on Medi-Cal receive services through the fee-for-service (FFS) model. This is an effective delivery system to the extent that it provides access to a wide range of primary care providers and specialists and enables individuals to keep their own doctors. This is particularly important because managed care organizations cannot guarantee access to physicians who specialize in the vast variety of serious medical conditions that affect seniors and persons with disabilities. However, the state does not assist FFS beneficiaries with finding doctors or, for the most part, with the coordination of their FFS care and many have difficulty locating doctors to meet all their medical needs. Less than half of doctors in urban areas in California accept new Medi-Cal patients.¹⁴ Furthermore, even those beneficiaries who have doctors may not have one provider who has taken on the role of coordinating their treatment, including prescription drugs. Those with chronic or multiple disabling conditions are often left on their own to navigate the services they need and piece together the coordination of their care.

A “health care home” can give individuals a provider of care who is also responsible to function as a repository of information regarding multiple health conditions and treatments, a central point of inquiry and information for other providers – clinical and non-clinical, and a provider who can give referrals if needed. The provider of this “health care home” can be an independent physician, including a specialist, a medical group, a regional coalition of physicians, mental health professionals, and social service providers, a community clinic, or a hospital outpatient clinic.

A definition of medical home developed by several provider organizations is “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”¹⁵ Health care homes serve many functions: care management, disease specific case management, medication management, maintenance of medical records, and provision of screening and referral services. According to the *Joint Principles of Patient-Centered Medical Homes*, a medical home should include the following, differentiating it from managed care:

- Patients should be able to choose, leave and change their health care home;

¹³ While the term “medical home” is often used, we have chosen to use “health care home” to denote the importance of providing care for the whole person including linking consumers to needed social services and behavioral health care – in addition to physical health care services.

¹⁴ Bindman, et. al., *Physician Participation in Medi-Cal, 2001*, University of California, San Francisco, 2003.

¹⁵ *Joint Principles of Patient-Centered Medical Home*, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, March 2007.

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- Patients should be able to choose whether to join a health care home, which would provide incentives to the health care home to conduct outreach and engagement, particularly important for beneficiaries with unmanaged chronic conditions and other high-cost high-need beneficiaries;
- The health care home should not act as a gate keeper, preventing patients from seeking care “outside the network” or requiring a referral for specialty care;
- Health care homes should offer care/case management to coordinate care, as well as a means of linking (rather than just referring) patients to medical and social services;
- The intensity and scope of services the health care home offers should vary according to need;
- Care should be integrated “across elements of a health care system;”
- The health care home should provide an assessment of the patient’s needs (medical, behavioral, and social services needs), along with a plan to address the needs;
- Staff of the health care home should be culturally competent; and
- The health care home should plan for hospital or acute care discharge.¹⁶

Several states have developed medical home models for their SPD population, including North Carolina, Minnesota, Indiana, Rhode Island, and South Carolina.¹⁷ The health care home provider receives a monthly fee (in addition to whatever FFS fees the provider may receive for medical services) to perform the specified coordination functions, and often a bonus if they meet national quality measures or standards.¹⁸ Providers have to be trained to fulfill these functions and evaluated. If crafted correctly, such a model could improve care for FFS beneficiaries and be a source of savings for other parts of the waiver.

One Size Doesn't Fit All

Having a health care home will go a long way toward improving care for many SPDs and reduce costs as well by ensuring a usual place to receive care and having their care tracked and coordinated. As described below, for “frequent users,” a primary clinic or doctor alone is not enough to improve their health and avoid unnecessary treatment. They will need more intensive, social service supports and interventions. Targeting more intensive interventions for populations with uncontrolled chronic illnesses and those with complex conditions that put them at risk of complications, hospitalization, and poor outcomes has been identified as an organized delivery system “best practice.”¹⁹ For some SPDs who live in counties with managed care, these beneficiaries have the option of joining a fully capitated managed care plan and may choose to do so if there is an adequate network and they decide the plan can provide sufficient access.

In a state as diverse as California, with varying types of providers, safety net systems, hospitals, mental health professionals, and managed care options, we would urge that there be a variety of models to meet the needs of SPDs. The health care home could consist of a number of providers

¹⁶ *Id.*

¹⁷ Bella, et al, *Purchasing Strategies to Improve Care Management for Complex Populations: A National Scan of State Purchasers*, Center for Health Care Strategies, March 2008 at 10-11.

¹⁸ Brink, Susan. “Living in a ‘Medical Home.’” Kaiser Health News. Sept. 11, 2009.

¹⁹ McCarthy, Douglas and Kimberly Mueller. “Organizing for Higher Performance: Case Studies of Organized Delivery Systems.” Commonwealth Fund, pub. 1288, Vol. 21. July 2009.

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in a regional collaborative or network, with the capitated rate offered to community social services providers.

Many other states, smaller and less diverse than California, still offer a multitude of coverage choices from FFS to primary care case management, from a medical home model to managed care plans. Pennsylvania, Texas, Rhode Island, South Carolina, and Washington all have a range of choices for SPDs.²⁰ We propose that SPDs remain in the FFS system. SPDs should be provided a health care home and be given a choice of doctors and clinics in their community. In addition, the services offered to particular populations, such as frequent users, should be more intensive, and capitated rates paid for these services should be higher.

Most of the states that have established medical homes allow for separate FFS payments for face-to-face visits with physicians or mental health professionals, in addition to a capitated or bundled rate for non-physician services (care coordination, case management, transportation, medication monitoring, and other services needed to stabilize the beneficiary's health). Some states are also currently implementing a "risk pool" that allows providers to share in savings from measurable favorable outcomes or national standards, such as reduced hospitalizations, provided patient satisfaction meets a certain threshold. Payment systems also incorporate incentives for serving people with complex medical, behavioral, or social conditions, like a higher capitated or bundled rate. The Patient-Centered Primary Care Collaborative advocates for this type of a three-part model that includes FFS payment, a "bundled care coordination fee" for coordination of care and health IT that is risk-adjusted to remove disincentives from serving people with complex conditions, and a "performance-based component" that rewards health care home providers for achieving specified milestones.²¹ Several states, including New York, now use predictive modeling to determine beneficiaries who would most likely benefit from care coordination services and to identify the intensity of services the beneficiary needs, providing the state with the tools to target medical home resources.²²

To be recognized as a health care home, which would entitle a provider to receive this stratified capitated rate, the state should require the provider to meet certain standards. These standards should include, among others, community linkages to social services or a regional network of community-based specialty and social service providers, access to or experience with serving underserved communities, and case management to client ratios that are no higher than 1:25 for patients with certain complex conditions (determined by predictive modeling that assesses risks or by emergency department or hospital referral). Minnesota passed legislation last year to create health care homes and is now in the process of developing standards for "certifying" a health care home.²³ Under the Minnesota legislation, a health care home must offer services to all

²⁰Id. at 9.

²¹See www.pcpcc.neg/content/proposed-hybrid-blended-reimbursement-model.

²² New York Request for Proposals for Office of Health Insurance Programs, No 0801031003, "Chronic Illness Demonstration Projects (Feb. 2008). See also Billings, John. "Predictive Modeling for High-Cost Beneficiaries in New York." Center for Health Care Strategies. Aug. 2008.

http://www.chcs.org/publications3960/publications_show.htm?doc_id=700481; Billings, John and Maria Raven, et. al. "Medicaid Patients at High Risk for Frequent Hospital Admissions: Real-time Identification and Remedial Risks." J. Urban Health. 86, no. 2, 230-41. 2009.

²³ Minnesota has published their proposed standards, which include recertification after years one and two based on performance outcomes, at <http://www.health.state.mn.us/healthreform/homes/proposedrule090706.pdf>.

patients they serve with complex or chronic health conditions.²⁴ Minnesota also stratifies capitated fees paid to health care homes by thresholds of “care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination.”²⁵

Lessons Learned from the Coverage Initiatives

California's current 1115 waiver funds ten counties to run pilot “Coverage Initiatives” to expand health coverage. This provided funding to public hospitals to serve uninsured consumers and served as a laboratory for different county models. Counties had very different experiences structuring and implementing their initiatives. The structure chosen by some county pilot programs offer potential lessons on effective health care home models. In Orange County, two dozen non-profit clinics and some private doctors served the role of a patient's primary care provider. In San Mateo County, the County Hospital and a network of County outpatient clinics and pharmacies provided all care, with the county contracting with other hospitals and medical providers to provide members with care not available at county facilities.

Counties also had very different experiences when implementing the logistics of their Coverage Initiatives. San Mateo County extended health coverage to uninsured adults by building upon its existing 17000 program, which resulted in a quicker implementation of the program than counties that chose to implement their Coverage Initiatives by building entirely new programs. Los Angeles County had a difficult time “ramping up” their Coverage Initiative – illustrating the complexity and effort necessary to develop whole new county programs with eligibility criteria, networks, rules, etc. The variation in experiences and outcomes of the Coverage Initiatives shows that a county-specific solution to expanding health coverage is not practical or most cost-effective. Now that we have had the laboratory of the various local Coverage Initiatives, it is time for a statewide program that uses the existing Medi-Cal program as its foundation. Expanding Medi-Cal to childless adults utilizing a uniform, existing structure is more efficient – building on current Medi-Cal systems – and more equitable – providing the same benefits statewide rather than having one's benefits be determined by their county of residence.

2. Frequent User Programs: Bending the Cost Curve as Part of Health Care Home Model

No matter the delivery system, a subset of individuals exist in nearly every community who consume a disproportionate amount of health services with no improvements to health outcomes. Among these individuals, frequent users of avoidable emergency room visits experience a combination of complex physical ailments, behavioral health challenges, and social barriers to appropriate care. To meet Medi-Cal reform goals of controlling costs and improving health outcomes, particularly among high-cost existing and potential new Medi-Cal beneficiaries, the state must address the needs of frequent users of emergency departments (EDs). According to the California Department of Health Care Services, over 28,000 Medi-Cal beneficiaries who suffer from at least two diagnostic categories (a chronic medical condition, a mental disorder, or a

²⁴ Statutes of Minnesota § 256B.0753, Subd. 3(b).

²⁵ Statutes of Minnesota § 256B.0753, Subd. 1.

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substance abuse disorder) received ED treatment at least five times in one year or eight times in the two years ending December 2007.

Strategies designed to address complex needs of frequent users have succeeded in improving health outcomes and reducing acute care costs. While other states have struggled to enroll frequent users through telephonic and mail interactions or traditional medical home models, programs that help frequent users address the social barriers they experience in accessing appropriate care result in considerable decreases in frequent users' avoidable consumption of hospital services. A frequent user initiative operating in six geographically-diverse California counties reduced frequent users' ED visits by 30% after one year and 61% after two years of participant enrollment, inpatient admissions by 14% after one year and 64% after two years, and the number of days spent in the hospital by 2% after one year and 62% after two years.²⁶ Other frequent programs have yielded similar outcomes.²⁷

Based on conservative estimates, frequent users avoided hospital costs of \$3,841 per beneficiary after a year of receiving intensive interventions and \$7,519 per beneficiary per year after two years of gradually less intensive interventions.²⁸ Taking into consideration the costs of programs designed to address the needs of frequent users, enrolling even 10,000 beneficiaries into these programs statewide could conservatively avoid Medi-Cal program costs of over \$13.5 million a year within a two-year startup.

Moving beneficiaries into medical or health care homes should match need with interventions provided. A health care home model that offers more moderate services to people who are relatively treatment compliant, and initially intensive services to frequent users would allow the state to cushion baseline costs of a waiver, while also offering a mechanism for the state to achieve milestones in reducing avoidable acute or crisis care.

Effective models of care for frequent user patients, models that result in significant reductions in the use of costly hospital emergency and inpatient care, demonstrate these populations require the following:

- Identification of participants through appropriate data systems (i.e., predictive modeling),
- Community-based programs that:
 - Are client-centered, integrated and flexible,
 - Conduct outreach and offer services in a range of settings, and

²⁶Linkins, Karen, Brya, J., and Chandler, D. *Frequent Users of Health Services Initiative: Final Evaluation Report*. August 2008. www.frequenthealthusers.org.

²⁷A San Francisco General Hospital study found that providing frequent users with a multidisciplinary team that included intensive case management services reduced ED visits by 40% within the first year, as compared to a control group that received usual care. Shumway, Martha, et. al., "Cost Effectiveness of Clinical Case Management for ED Frequent Users: Results of a Randomized Trial." *Am. J. Emergency Med.* April 2007. A New York study similarly found significant decreases in acute care costs among high-cost Medicaid participants in intensive multidisciplinary team services. Birnbaum, Michael, Halper, D. "Rethinking Service Delivery for High-Cost Medicaid Patients." *Medicaid Institute at United Hospital Fund*. March 2009.

²⁸Calculation based on average reductions in ED visits and inpatient days for Medi-Cal patients at rates the Office of Statewide Health Planning and Development (OSHPD) reported as average costs for hospitals connected to frequent user programs. Rates averaged \$305 per ED visit and \$2,161 per inpatient day. OSHPD 2006 data. www.OSHPD.gov.

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- Coordinate care for people with difficulties accessing treatment, as well as
- Linkage to community services, including permanent housing for those who are homeless or unstably housed.

Many people who become Medi-Cal beneficiaries as a result of a childless adult expansion will undoubtedly be frequent users. Uninsured frequent users share the characteristics of Medi-Cal beneficiaries who are frequent users: in addition to suffering from complex co-occurring medical and behavioral health disorders, they are usually very poor, they are often homeless or unstably housed, they tend to be socially isolated, and they are often unemployed and poorly educated.²⁹ Frequent user programs create unique opportunities for safety net hospitals and clinics to implement consistent strategies for patients with frequent and avoidable ED use, whether uninsured or enrolled in Medi-Cal. In fact, many frequent user programs have established strong partnerships between hospitals and community-based services, removing barriers that result from systems fragmentation, and ensuring continuity of care to uninsured patients.

Frequent users represent a small number of people among Medi-Cal beneficiaries and uninsured childless adults, but they also represent an opportunity to improve our health care delivery system and change financial incentives within the Medi-Cal program. Addressing the myriad of needs among frequent users will result in a program that engages some of the most difficult to engage beneficiaries, reduces costs, and improves health outcomes.

3. Improve Integration of Behavioral and Physical Health Services

The current Medi-Cal system creates a fundamental fragmentation of care for those individuals with substantial mental health care needs. The existing Specialty Mental Health Managed Care (1915(b)) Waiver has “carved out” mental health services from other physical health care services, requiring those individuals with mental health disabilities to navigate two entirely independent systems for their health care – the mental health plan for mental health treatment and the health plan or FFS provider for physical health care treatment.

What has resulted is a complex set of separate rules about eligibility and access limitations, services, providers, grievance and appeal rights. By their very structure, these systems make it virtually impossible to have effective care coordination for health and mental health needs, absent the availability of intensive case management services which are difficult to obtain from the Specialty Mental Health system. Further, these beneficiaries often ping-pong back and forth from health plans or FFS health providers to mental health plans, as neither take responsibility to provide and pay for their care. There is little, if any, coordination of care, let alone integration. The result is that these individuals end up in the emergency rooms more frequently for both health and mental health related crises, including substance abuse. The frequent users initiatives support the fact that prevalence of mental illness and/or substance abuse is common as a co-occurring disorder with other chronic health conditions that often land beneficiaries in the emergency rooms when they do not get the necessary mental or physical health care to keep them stable in the community.

²⁹ Linkins, Karen, Brya, J., and Chandler, D. *Frequent Users of Health Services Initiative: Final Evaluation Report*. August 2008. www.frequenthealthusers.org.

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The need for care coordination through an integrated behavioral health / medical home that is responsible for ensuring access to appropriate services and preventive care is even greater for this vulnerable population, as they face the added challenge of navigating two entirely separate Medi-Cal systems. They are already in mandatory managed care for their mental health services and their care would be even further fragmented if they were also forced into separate managed care plans for their health care.

Given the continuing separate Medi-Cal waiver for specialty mental health care, there must be greater accountability by the mental health plans to ensure that care is coordinated and that access to all necessary care and services is adequate, whether health or mental health services. Mental health plans should not face incentives to screen beneficiaries out of "specialty mental health" care under the waiver so that the beneficiary will be forced to seek care from a FFS health care provider or a health plan. In order to ensure better coordination of care and treatment for individuals who have behavioral health needs, the following specific recommendations should be included in any waiver proposal which includes a health care home model:

- Any health care home must specifically incorporate the individual's mental health providers, including any mental health case manager, and substance abuse providers on the health care home "team" to ensure that the mental health and substance abuse services provided under the Specialty Mental Health Waiver are coordinated for the individual.
- Any health care home provider must be responsible for the whole person – linking and coordinating care between specialty mental health services, physical health services, and substance abuse treatment as needed. Any risk pool or bonus payments for indices of improved health outcomes or cost controls should include measures of the beneficiary's entire health needs. These services should be provided in a coordinated manner so that the client is not refused services by any system based upon a referral to the other as being determined to be more appropriate. For example, if the mental health plan and/or provider is designated as the person's health care home, there must be an affirmative obligation on that plan/provider to coordinate with physical health care providers, in accordance with medical home principles. This would include a treatment team that includes physical health care providers, availability of the health care home provider 24/7, coordination of care by the health care home provider (including assistance in accessing care), and obtaining immediate appointments with the medical home provider. If the beneficiary's primary condition is a behavioral health condition, their health care home should be a community behavioral health center, if available in the community.

4. Prevention and Wellness: By Improving Health, Breastfeeding Reduces Healthcare Costs

All major medical authorities recommend that babies get no other food or drink other than human milk for their first six months and continue to breastfeed for at least the first one to two years of life. Breastfeeding has significant benefits for children's health, affecting both acute and chronic conditions, and breastfeeding also reduces the risk of breast and ovarian cancer and Type II diabetes for mothers. Improving access to Medi-Cal's breastfeeding support benefits would increase breastfeeding initiation and exclusivity and thereby significantly help to contain

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Medi-Cal program costs by reducing the number of medical visits, prescriptions and hospitalizations and related health care costs for children as well as women.

Low-income women with Medi-Cal who wish to breastfeed need improved access to lactation consultation (i.e., evaluation and management benefits) and breast pumps. According to the California Department of Public Health (CDPH), “[m]ost mothers know little about breastfeeding and have little access to culturally appropriate breastfeeding information and lactation services” and “[d]ue to the lack of social and professional support, mothers have little confidence and fear attempting to breastfeed.”³⁰

Improved access to breastfeeding support services for women with Medi-Cal could be achieved in the following ways. Although these recommendations could be adopted at state option, they should be included as part of the 1115 waiver to promote health and reduce spending for preventable conditions and diseases:

- **Hospital “baby-friendly” breastfeeding support policies:** As a condition of receipt of DSH or other Medi-Cal reimbursements, a hospital providing maternity care should be required to implement “baby-friendly” protocols, such as the model hospital breastfeeding policies recommended by the CDPH or the World Health Organization’s Baby Friendly Hospital Policies. Such measures significantly improve the likelihood that a woman will fulfill her intention to breastfeed exclusively.³¹
- **Lactation consultation and breast pumps:** DHCS should exercise the existing state option to include trained and qualified Peer Counselors and International Board Certified Lactation Consultants (IBCLCs) as provider types for Medi-Cal breastfeeding support services, regardless of whether they are doctors or nurses or otherwise licensed in the healing arts. The United States Preventive Services Task Force (USPSTF) has found that breastfeeding support interventions by lay as well as professional personnel significantly improve breastfeeding rates.³²
- **TARs for hospital-grade electric breast pumps:** DHCS requires an approved Treatment Authorization Request (TAR) to cover rental of a hospital-grade electric breast pump for more than 18 days although most women need them for longer (i.e., a WIC survey in 2008 showed most women needing these rented pumps for 60-90 days). TARs can result in delays or inappropriate denials of coverage. DHCS should remove this barrier to breastfeeding support by allowing the rentals for up to 90 days without a TAR.

³⁰ California Department of Public Health, Breastfeeding Program Fact Sheet MO-07-0009 BFP, <http://www.cdph.ca.gov/healthinfo/healthyliving/childfamily/Pages/BreastfeedingProgramFactSheet.aspx>, downloaded August 13, 2009.

³¹ “Hospital Practices and Women’s Likelihood of Fulfilling Their Intention to Exclusively Breastfeed”, *American Journal of Public Health*, Vol. 99, No. 5 (May 2009); “Depends On Where You Are Born: California Hospitals Must Close the Gap In Exclusive Breastfeeding Rates”, California WIC Association and the UC Davis Human Lactation Center (September 2008).

³² *Primary Care Interventions to Promote Breastfeeding*, USPSTF (October 2008); *The Power of Peer Counseling, A Policy Brief on Preventing Early Childhood Obesity*, the California WIC Association and the UC Davis Human Lactation Center (May 2009).

Data Shows That Breastfeeding Reduces Healthcare Costs

Scientific evidence shows that breastfeeding strengthens an infant's immune system and protects infants' health in many ways, by preventing disease and other adverse health conditions. Breastfed babies have fewer ear, respiratory and intestinal infections; less frequent allergies and asthma; and less risk of developing chronic diseases and conditions, such as sudden infant death syndrome, diabetes, leukemia and other childhood cancers, obesity and high cholesterol.³³

Childhood obesity is a major and costly public health concern.³⁴ Approximately 28% of California school-age children are overweight or obese. Children who are overweight or obese are at heightened risk of high blood pressure, high cholesterol, asthma, and Type-2 diabetes, among other serious physical problems. Being overweight or obese in childhood also increases the risk of obesity in adolescence and adulthood.³⁵

Experts at the Center for Disease Control and Prevention (CDC) estimate that 15% to 20% of obesity could be prevented through breastfeeding. Increasing breastfeeding in California could mean fewer overweight children and adolescents.³⁶ Health problems related to obesity are among the major drivers of rising health care costs.

Exclusive breastfeeding for just three months reduces health care costs for infants in the first year of life by up to \$475, compared to non-breastfed infants.³⁷ Breastfeeding rates among low-income women are increasing, but remain unacceptably low. Approximately 250,000 infants are born to Medi-Cal mothers each year; less than 45% of mothers with WIC in California breastfeed their babies at all during the first year, and only 11% exclusively breastfeed.³⁸ Significantly increasing breastfeeding rates among Medi-Cal women would therefore significantly reduce costs to the Medi-Cal program for medical care for children.

Breastfeeding also has positive impacts for the health of the mother, further reducing health care costs for women who breastfeed. Women who breastfeed their babies for longer periods accrue significant health benefits. Breastfeeding is linked to a reduction in risk for many diseases, such as breast and ovarian cancers, osteoporosis and Type II diabetes. The practice has a contraceptive effect, which can lengthen the time between pregnancies and help make the next child healthier. Early cessation of breastfeeding increases the risk of maternal breast cancer, ovarian cancer, and Type II diabetes.³⁹

³³ Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. Evidence Report/Technology Assessment No. 153.

³⁴ See, e.g., Kaiser Family Foundation, summarizing Washington Post series on childhood obesity epidemic (May 20, 2008).

³⁵ *Childhood Obesity in California*, California Center for Public Health Advocacy (August 2005), p. 5; Kids Data Fact Sheets, p. 8, citing California Dept. of Education DataQuest. <http://data1.cde.ca.gov/dataquest/>. Retrieved 04/21/08.

³⁶ Dietz WH. Breastfeeding may help prevent childhood overweight. *JAMA*. 2001;285:2506-2507.

³⁷ Ball TM, Wright AL. Health care costs of formula-feeding in the first year of life, *Pediatrics*. 1999;103 (4 pt 2):870-866.

³⁸ WIC ISIS Data, California WIC Division, California Department of Public Health (2008).

³⁹ Schwartz EB, Ray RM, Stuebe AM, Allison MA, Ness RB, Freiberg MS, Cauley JA. Duration of lactation and risk factors for maternal cardiovascular disease. *Obstet Gynecol*. 2009;113(5):974-982.

5. Procedural Simplification

The last decade or so has provided a laboratory in the states to learn what sorts of Medicaid simplifications have yielded cost savings, both administratively and in the cost of providing coverage and care. This analysis is particularly important for California which has adopted numerous federal options, state legislative changes, and innumerable modifications of Medi-Cal rules and procedures through a patchwork of All County Letters, resulting in dozens of aid codes with different rules for different applicants, beneficiaries, age groups, categories of persons, and application methods, leading to a complicated set of incongruous requirements often within the same family. While the conversation around Medi-Cal simplification often turns to costs, the greatest costs are to the poor, *eligible* Californians who lose their coverage, or access to it, simply because of complex requirements. Furthermore, dismissing procedural simplification as too costly neglects research showing that thoughtful simplification can save funds for the program as well.

“Churning” is the process whereby *eligible* beneficiaries are terminated from Medi-Cal due to confusion or paperwork requirements, only to re-enroll shortly thereafter, often with worsened health conditions and a need for more invasive, more expensive, and more amounts of health care.⁴⁰ A recent report analyzing churning among children showed that approximately 20% of children in Medi-Cal churn, usually for less than four months.⁴¹ The loss of coverage is problem enough, but this report by Dr. Gerry Fairbrother also showed that inefficiencies in providing care are introduced due to churning, adversely affecting quality of care. Dr. Fairbrother reports that it costs approximately \$2,000 to re-enroll a beneficiary back into Medi-Cal and managed care. For children alone, this amounts to \$120 million to re-process people already eligible.⁴² Most applicants re-enroll within four months and California provides retroactive eligibility for that entire period for persons who remained eligible. That, plus the fact that persons can be reimbursed for more expensive care through the *Conlan* process, equals cost savings for California if it could keep these persons enrolled without interruption. To do this, the paperwork requirements and procedural rules must be consolidated and simplified.

The seminal piece providing practical steps for procedural simplification to minimize churning and improve enrollment and retention was released by CMS in 2001, *Continuing the Progress: Enrolling and Retaining Children and Families in Medicaid*, urging states to undergo procedural simplifications to remove unnecessary and costly barriers to coverage, and summarizing developments in states that had already tried these reforms. Since then, many states have taken steps that attribute cost savings to procedural reform. For example:

- States can allow **self-certification of income** with some non-invasive follow-up using electronic databases or other similar methods. This has proven to reduce administrative costs in many states, while maintaining a low error rate.⁴³ A Lewin

⁴⁰ Gerry Fairbrother, *How Much Does Churning in Medi-Cal Cost?*, April 2005.

⁴¹ *Id.* at 4.

⁴² *Id.* at 7

⁴³ D. Holahan and E. Hubert, *Lessons from States with Self-Declaration of Income Policies*, United Hospital Fund of New York, 2004.; See also 100% Campaign, *Modernizing Enrollment Through Paperless Income*

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Group study showed that California could save \$6 million in administrative funds by allowing self-certification and a New York study showed a reduction of 40% in administrative costs.⁴⁴ A Michigan study showed the number of cases requiring staff follow-up dropped from 75% to 20%, an Ohio study showed processing time was cut in half, and several states reported increased worker productivity.⁴⁵

A study by the Center for State Innovation found that states fear simplification because of assumed increased caseload, yet simplification is essential for modernization and eliminating redundant processing steps. When Florida moved to a “paperless” process and allowed clients to “self-serve” for basic functions such as address updates, reduced documentation requirements, and allowed eligibility applications and renewals over the phone, it saved \$100 million in the first 5 years.⁴⁶

- **Self-certification of select resources** could also save administrative costs. The Lewin Group study showed that 57% of Californians with incomes under \$18,000 per year had net worth below 2,000, a figure below the assets limits for families, which starts at \$3,000.⁴⁷ Yet workers ask for vehicle registrations, bank statements, and numerous other written verifications of assets that do not end up disqualifying the vast majority of Medi-Cal applicants. Studies that show increased cost due to the supposed “woodworking effect” fail altogether to analyze the impact of allowing self-certification under an initial simplified resource threshold, similar to the income concept described above. If the figure is set to approximate the standard at which applicants end up becoming *eligible anyway*, the eliminated administrative savings skyrocket. By allowing families/individuals to self-certify when under the resource limit, then only requiring detailed documentation when families/individuals have resources over the limit or in a small audit subset, California could save administrative costs without enrolling persons who are ineligible today.
- Smaller, simpler changes can also bring administrative savings while lessening the paperwork burden on families. The state could put a **bar code** on all of its application forms, reporting forms, renewal forms, and other required paperwork. Advocates regularly report having to file administrative hearings to contest denials or terminations of Medi-Cal because the County lost an applicant’s paperwork. Taking such minimal steps would require some outlay of start-up funds but could greatly reduce worker time and costly hearings, not to mention improper denials and terminations. The state has already started modifying some forms to include bar codes, so the technology has already been implemented to do this program-wide.

Verification, October 2004, at

<http://www.100percentcampaign.org/fs/resource:id/xkozkudej1h1rk/xkp21gw2zvtxp4>

⁴⁴ 100% Campaign, *supra*, internal citations omitted.

⁴⁵ *Id.*, internal citations omitted.

⁴⁶ Center for State Innovation, *Simplifying Public Benefits*, September 2008, available at:

<http://www.stateinnovation.org/Publications/All-Publications/Simplifying-Public.aspx>

⁴⁷ *Simplifying Medi-Cal Enrollment: Technical Report in Income and Assets*, at 7 (2003).

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- California could also take steps to **improve coordination among Medi-Cal and other public programs** to better utilize information the counties already have received from applicants and beneficiaries, similar to strategies outlined in AB 963 (Ammiano, 2009). Studies have shown that an *ex parte* renewal saves administrative costs.⁴⁸ The entire cost of gathering pay stubs, vehicle registration, proof of in-kind income, and other similar requirements could be eliminated in Medi-Cal for persons who also apply for or receive Food Stamps, because the counties already have that information. All the county has to do is be given permission to toggle through to another screen to use the Food Stamp information.
- Similarly, California could automatically **use the Medi-Cal application to start a Food Stamps application** unless the family requests otherwise. Because Food Stamps is 100% federally funded and the County possesses nearly all of the information it needs on the Medi-Cal application to process Food Stamps, there would be little cost. Food Stamps utilization is very low in California, and injecting these federal dollars into family budgets is an anti-poverty measure that reduces the strain on other state-funded safety net programs.
- California could continue its efforts to **coordinate application renewal activities between county staff and managed care plans**. Managed care plans can update an applicant's address using a special MC 355 form, thereby minimizing the chance that the applicant will not get the county's mandatory reporting forms. This concept could be expanded to allow plans to accept other information, including renewal and reporting forms, to forward to the counties. Plans already are capable of obtaining a list of enrollees whose renewal dates are coming up, and this process could be expanded to allow facilitated renewal and troubleshooting to minimize loss of coverage. The ability to share information this way could be expanded to primary care clinics as well, expanding the "no wrong door" principle to incorporate the understanding that beneficiaries have more face-to-face time with their health providers than with county workers. The counties would still be responsible for processing all documents but the providers could facilitate gathering of these documents. Such a process should also maximize the use of information the plan or provider has already gathered for its own use, reducing the burden on the families and individuals.
- The **assets test** requires counties to compile dozens of documents for applicants and beneficiaries, when neither the state nor counties adequately track to what extent persons are actually found ineligible based on those documents. In fact, studies show that such a low percentage of persons have vehicles that would make them ineligible, stocks, bonds, jewelry, or many of the other items state law requires them to certify, that elimination of this test altogether or reform to simplify its rules would save the state and counties money.

⁴⁸ Rutgers Center for State Health Policies, *Accomplishments and Lessons from the State Solutions Initiative to Increase Enrollment in the Medicare Savings Programs*, May 2006, available at: <http://www.statesolutions.rutgers.edu/Reports/LSummermay06.pdf>.

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These are only examples, but the broader theme is that the cumbersome paperwork requirements are costly both to the counties and to the applicants and beneficiaries who lose access to care unnecessarily. A waiver should address this dynamic and include program efficiencies that improve access to Medi-Cal *and* reduce administrative costs.

C. Achieving Budget Neutrality While Improving Care

Advocates are well aware of the budget neutrality requirement in Medicaid 1115 waivers. We believe that many of the program improvements we seek can contribute to the budget neutrality equation. A health care home model, frequent user program, breastfeeding supports, and eligibility and enrollment simplification all have some upfront costs, but can achieve savings over time, as demonstrated above. Therefore, they are well-suited to achieve the twin goals of improving the Medi-Cal program and saving funds. In addition, we discuss other possible sources of savings below.

Sources of Savings Advocates Support

1. Score Credit for Already-Realized Savings from Medi-Cal's Low Costs.

California has one of the lowest per-beneficiary costs in the country. The State has already implemented a number of initiatives viewed as cost savers such as managed care for the families and children population. Our managed care, in particular, has very low reimbursement rates, but we failed to receive credit for expanding managed care enrollment. In other words, we have already realized significant cost savings and should not be forced to budget down from there in order to maintain budget neutrality. We would support, "getting credit" for these savings from the federal government in the waiver negotiations to maximize our baseline.

2. Structure Payments to Incentivize Outpatient Care.

Several states have redirected and/or pooled other funds to help fund their waivers. We support changing the current system which creates perverse incentives to provide care through hospitals rather than more clinically-appropriate and cost-effective methods. While hospitals have traditionally negotiated their reimbursement rates, outpatient rates have been frozen. This makes access to lower cost services more difficult for beneficiaries to access, thus raising expenditures for the program as a whole. Neither beneficiaries nor the state benefit from this scenario.

Sources of Savings Advocates Do Not Support

3. Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care Plans

There have been repeated proposals over the last few years to mandatorily enroll SPDs into managed care. While a good option to educate beneficiaries about in counties with Medi-Cal managed care (MCMC), advocates for Medi-Cal beneficiaries have opposed mandatory

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enrollment. Many SPDs have established relationships with providers who do not contract with the managed care plans; therefore, they could lose their doctors if forced into a health plan. DHCS is currently engaged in a pilot program to increase outreach and education to SPDs about their option to enroll in a health plan. That program will be evaluated in 2010. We should allow this approach to be studied to determine if it is effective and develop effective health care home and frequent user programs rather than forcing SPDs into plans that in some cases are not ready to take them.

In addition to taking away beneficiary choice, evidence suggests that moving all Medi-Cal enrollees into managed care programs might not even result in cost-savings. Although some studies have claimed that managed care provides care at a lower cost than FFS, a recent study in the *Western Journal of Preventive Medicine* found that MCMC programs were essentially cost-shifting the burden of expensive care and high-cost patients into the FFS system.⁴⁹ This cost-shifting occurs when the highest-cost patients who need the most extensive medical care are shifted from managed to FFS Medi-Cal. Additionally, managed care places a wide range of services outside of its scope through carve-outs which also, “limits the exposure of the MCMC program to higher cost services, more expensive specialty care, and less predictable overhead.”⁵⁰ This study found that the managed care plans were, “falsely promot[ing] the reduced monthly cost of care per enrollee as the result of cost-effective care management.”⁵¹ In reality, the study found that these claims of cost-savings were supported by little evidence and were “highly suspect” assertions.⁵² Rather than reducing average enrollee costs, the study concluded that managed care programs were simply shifting the burden of expensive care to FFS programs.⁵³ Once all enrollees, including the most high-cost enrollees, are required to be in a managed care program, the illusion of cost-savings will disappear.

For those Medi-Cal Managed Care programs that have managed to cut costs, there is evidence to suggest that this has come at the cost of decreasing quality of care. For example, a study of health outcomes of pregnant woman and infants in FFS compared with mandatory managed care concluded, “We find that MMC [mandatory managed care] reduced the quality of prenatal care and increased low birth weight, prematurity, and neonatal death. Our results suggest that the competitive FFS system provided better care than the new MMC system, and that requiring the participation of at least two plans did not improve matters.”⁵⁴ Additionally, a recent UCLA study found that there are wide disparities in the managed care system based on ethnicity, race, and language that, “can lead to a lower quality of care for the state’s minority populations, resulting in poorer health for these groups, as well as higher health care and social costs.”⁵⁵ These disparities included significantly lower quality of care for African Americans in 10 of the 16 care

⁴⁹ Riner, R. Myles, *Challenging the Cost Effectiveness of Medi-Cal Managed Care*. *Western Journal of Emergency Medicine*, May 2009, at 124.

⁵⁰ *Id.* at 127.

⁵¹ *Id.* at 124.

⁵² *Id.* at 128.

⁵³ *Id.*

⁵⁴ Aizer, et al., *Competition in Imperfect Markets: Does it Help California's Medicaid Mothers?* NBER Working Paper No. 10429, April 2004.

⁵⁵ Rivero, Enrique. *Study Finds Widespread Care Disparities in Medi-Cal Program*.

<http://www.newsroom.ucla.edu/portal/ucla/study-finds-widespread-healthcare-47494.aspx>, March 27, 2008.

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areas that were studied.⁵⁶ Providing less or substandard care is one way of decreasing average costs in the Medi-Cal program, but it is certainly not an effective long-term means to reduce overall costs in the system, nor an acceptable outcome.

Rather than move populations such as SPDs or frequent users with high health care costs to mandatory managed care with cost savings that are theoretical at best, savings on the cost of care for these populations could best be realized through health care homes and frequent user programs as needed.

Conclusion

Advocates are excited about the possibility of improving the Medi-Cal program to better serve the Californians who rely on it for their health care. We stand ready to work with other stakeholders and with the Department to achieve this important goal.

⁵⁶ Id.