



The latest on California politics and government

February 6, 2012

[Obama administration rejects California's Medi-Cal copays](#)

Federal health officials rejected [California's](#) bid to charge Medi-Cal copayments for everything from drugs to [hospital visits](#), dealing a new blow to the state budget but relief to low-income patients and their providers.

Gov. [Jerry Brown](#) and lawmakers relied on mandatory Medi-Cal copayments to save \$511 million in last year's state budget and presumed that the state would continue saving in future years.

The governor's latest budget, which estimates a \$9.2 billion deficit, acknowledges the lost savings in 2011-12. But it is relying on \$296 million to help balance next year's budget, according to Department of Finance spokesman **H.D. Palmer**.

The plan to charge low-income Medi-Cal patients and allow doctors to refuse care for nonpayment was unprecedented for a state on such a wide scale. The charges ranged from \$3 for "preferred" drug prescriptions to \$5 for [doctor visits](#) and a maximum \$200 on [hospital visits](#). Medi-Cal serves about 8 million Californians, though patients also eligible for Medicare were exempt from the copays.

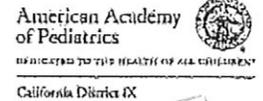
The state was required to obtain approval from the [Centers for Medicare & Medicaid Services \(CMS\)](#) to implement its plan. But [CMS](#) said in [a letter](#) today that it was "unable to identify the legal and policy support" for the change. Under the [Social Security Act](#), a state must meet several tests in order to charge copays, which include "providing benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients."

Providers, such as physicians and dentists, and advocates for low-income Californians warned that a copay plan would hurt low-income patients by cutting access to [health care](#). Providers felt it was a back-door cut in [reimbursement rates](#), on top of a 10 percent reduction that a federal judge recently blocked, because the state put the burden on them to collect the copays or make the decision to refuse patients for nonpayment.

Vanessa Cajina, legislative advocate for the [Western Center](#) on Law and Poverty, said Medi-Cal patients would have stopped using health care if faced with a payment



CHILDREN NOW



January 27, 2012

The Honorable Mark DeSaulnier
Chair, Senate Budget Subcommittee on
Health & Human Services
State Capitol, Room 5019
Sacramento, CA 95814



Re: Healthy Families to Medi-Cal Shift (Item 4260)

Dear Senator DeSaulnier:

Our children's health coalition is writing to express our opposition to the governor's budget proposal to transition children in the Healthy Families Program (HFP) into Medi-Cal.

We have serious concerns and thus do not support the proposed shift of all 875,000 HFP children into Medi-Cal. Instead, we recommend the state limit any such shift to "bright-line" children (those with family income below 133% of the federal poverty level), only *after assessing* access issues, implementing a transition and monitoring plan, as well as several other critical safeguards. We recommend keeping children above the "bright-line" in HFP until, at least, January 2015 when the state can evaluate the monitoring data on access and transition issues from this "bright-line" population.

Concerns with Shifting All Healthy Families Children

Our California children's health coverage coalition – comprised of the 100% Campaign (a collaborative of The Children's Partnership, Children Now and Children's Defense Fund-California), American Academy of Pediatrics California Chapter, California Coverage & Health Initiatives, United Ways of California and PICO California – believes that any decision about the future of children in the HFP must prioritize the needs of children and ensure that their access to care will not be disrupted. While there are advantages to transitioning the bright-line HFP children into Medi-Cal, there must be assurances that children will not be adversely impacted. Significant monitoring and access improvements would need to be assured for the existing Medi-Cal children, as well as for any transitioned children. The Department of Health Care Service's (DHCS) own access analysis, completed last year to assess the impact of the proposed provider rate reductions on Medi-Cal beneficiary access, identified some potential areas of concern for Medi-Cal access for children. For example, California's Medi-Cal children were well below the national average on measures such as percentage of children having at least one physician or clinic visit in the year. Only 56% of Medi-Cal children under age 20 received at least one physical or clinic visit during 2009, compared to the national average of 90%. As a result of this access analysis, DHCS did not move forward with the proposed 10% rate reduction to physician and clinic services for children in Medi-Cal. Therefore, we would request that DHCS provide a report on last year's analysis and any continuing access issues as they affect children, as well as their plan for addressing these access challenges. Additionally, before any consideration of the proposed full HFP transition, it is our view that a thorough evaluation of the impacts to children on the proposals to expand Medi-Cal managed care into the 23 counties that are currently Medi-Cal fee-for-service must also be undertaken. For example, the

transition to Medi-Cal managed care in rural counties should occur prior to any transition of HFP children to avoid multiple shifts in health plans.

Rationale for Shifting the "Bright-line" Children First

Following last year's similar budget proposal, the 100% Campaign commissioned a study by the Urban Institute in order to assess the implications of potentially moving HFP children into other coverage options. Consistent with Urban Institute's recommendations, at this time we would support a transition of children enrolled in HFP with family income up to 133% FPL. Transitioning only children with family income up to 133% FPL to Medi-Cal is in line with the Affordable Care Act (ACA), which requires the "bright-line" children between 100% and 133% FPL to be enrolled in Medi-Cal by 2014. These children are also the most likely to benefit from Medi-Cal's advantages, such as no co-pays or premiums. Carefully managing the shift of this population will also provide an important opportunity to build a path toward the coordinated, seamless enrollment system required by the ACA prior to the full scale roll out of enrollment in 2014. Additionally, transitioning these children in 2013 would provide an opportunity to leverage the full federal funding available for increases in Medi-Cal rates for primary care, which could increase access for these and other Medi-Cal children.

Critical Safeguards

Before "bright-line" children are transferred, the state should be required to implement various safeguards to ensure that Medi-Cal is able to provide quality coverage, with minimal disruption in access to care to both currently-eligible children and children who would be transitioned from Healthy Families. In particular, the state should address the following:

- **Access Issues.** The state should use this partial transition as an opportunity to improve access in Medi-Cal for both currently enrolled children and children who would be transitioning into Medi-Cal. The state must ensure that Medi-Cal health plans maintain a meaningful and sufficient provider network of primary and specialty care providers (including dental, mental health, and vision providers) capable of ensuring children get prompt access to needed care. The state must also implement a plan to further identify access problems and improve access to care for children in rural areas and underserved areas.
- **Maintain Investment.** At the very least, a large portion of any savings created by the transition must stay invested in the children's health care system, in order to ensure that existing and newly-transitioned Medi-Cal children have meaningful access to care. The funds could be used, for example, to increase reimbursement rates for specialty care providers serving Medi-Cal children, especially in fee-for-service and rural areas.
- **Monitoring System.** The state must work closely with stakeholders to develop and implement a monitoring and reporting system, as well as a regular mechanism through which DHCS can communicate important information about the transition to the Legislature, children's health advocates, certified application assistants, and other stakeholders. While DHCS implemented an access monitoring plan last year related to provider reimbursement rate reductions, this plan does not address children's access to physician and clinic services in Medi-Cal. Accompanying any transition, a monitoring system should include the ability to track:
 1. The progress of transitions, such as the number of children successfully transitioned into Medi-Cal within the month, the number of children who experienced a difficulty in transitioning, and any barriers that were encountered.
 2. Wait times for children in accessing services, including primary care and specialty services (including dental, mental health, and vision services).

3. Provider participation rates in order to track whether the provider network is sufficient to meet the needs of enrollees.
 4. Utilization of services among transitioned children, including frequency of primary care visits and well-child visits.
 5. The number of children who changed plans and/or providers.
 6. County by county data, where possible, on many of these elements to ensure vulnerable access areas are not missed.
- **Transitional Issues.** For this proposal to best serve HFP children, the state needs to carefully and deliberately transition children in a manner that informs their families appropriately and does not disrupt coverage. We recommend that the state undertake the following strategies:
 - Provide clear notification, public education and consumer assistance to help families navigate through the transition successfully;
 - Educate and inform the helping agencies, both public and non-profit, and providers, who will serve those families;
 - Provide counties authorization to accept the data from HFP cases in order to provide as seamless an enrollment transition as possible to Medi-Cal; and
 - Regardless of when the transition occurs – at annual renewal or on a fixed date – the transition should happen gradually over an extended period so that no child loses access to care. For example, the state of New York recently transitioned their CHIP children into Medicaid over a two month period during which at a child's renewal they continued to be served under CHIP as their Medicaid application was being processed. An extended time period will ensure that transitioning children can retain access to current plans and providers to the greatest extent possible, assuring a continuity of care for children in treatment.
 - **Special Focus and Oversight on Children's Issues at DHCS.** The state should create a child-focused unit at the DHCS to act and report on the transition of HFP children into Medi-Cal, as well as other children's enrollment, coverage and access issues. The unit should hold regular, substantive meetings with children's advocates and other stakeholders regarding the status of the transition, including meaningful updates on access data. If MRMIB is eliminated, it will be crucial not to sacrifice the focus MRMIB places on these critical children's issues.

Seek Further Information

Before moving forward with any transition, there are several areas where more information is needed. First, how does the state intend to access time-limited federal funding for a Medi-Cal primary care rate increase in 2013 and 2014? DHCS and other stakeholders should explore that potential funding to evaluate how California can take advantage of those federal dollars to enhance access to quality primary care for children. Second, additional data is needed from DHCS and MRMIB, including information about how many children would have to change plans and/or providers during the transition from HFP to Medi-Cal.

As noted above, we recommend that the remaining HFP children continue to be served in a HFP administered by MRMIB. Any future consideration of a transition of the remaining HFP children should be based on:

- The adequacy of access for children in Medi-Cal, and monitoring results of the transitioned children; and

- An assessment of whether HFP children could benefit from transitioning coverage to the California Health Benefit Exchange (HBEX), based on an evaluation of Exchange plans, costs and enrollment success after 2014.

As advocates for children, we cannot support the proposal to transfer all HFP children into Medi-Cal. Rather, we strongly recommend the state consider our recommendation to shift only the "bright-line" children (those with family income below 133% of the federal poverty level), *after* implementing the aforementioned critical safeguards. We further urge the state to keep children above the "bright-line" in HFP until, at least, January 2015 when the state can evaluate the monitoring data on access and transition issues from this "bright-line" population.

We look forward to working with the Administration, DHCS, and MRMIB staff to learn more about this proposal and to ensure that any impacts on children's health are positive. If we can provide you with any additional information, please feel free to contact us at nshort@childrennow.org or (916) 443-1680.

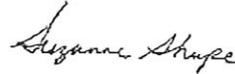
Sincerely,



Ted Lempert
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Children Now



Corey Timpson
Director
PICO California



Suzie Shupe
Executive Director
California Coverage & Health Initiatives



Wendy Lazarus
Founder and Co-President
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Kim Brettschneider
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