AGENDA

ASSEMBLY HEALTH COMMITTEE
Assemblymember Wilma Chan, Chair

AND

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assemblymember Hector De La Torre, Chair

Monday, March 14, 2005, 3:00 pm

State Capitol, Room 437

MEDI-CAL REDESIGN

I. DENTAL BENEFIT MODIFICATION

STAN ROSENSTEIN, DEPUTY DIRECTOR MEDICAL CARE SERVICES, DEPARTMENT OF HEALTH SERVICES
KIRK FEELY, LEGISLATIVE ANALYST, LEGISLATIVE ANALYST'S OFFICE

- MARTY MARTINEZ, POLICY DIRECTOR, CALIFORNIA PAN-ETHNIC HEALTH NETWORK ELIZABETH SNOW, VICE-PRESIDENT, PUBLIC POLICY AND IRVING LEBOVICS, DDS, CALIFORNIA DENTAL ASSOCIATION
- BILL POWERS, CALIFORNIA ALLIANCE FOR RETIRED PERSONS

II. SINGLE POINT OF ENTRY

STAN ROSENSTEIN, DEPUTY DIRECTOR MEDICAL CARE SERVICES, DEPARTMENT OF HEALTH SERVICES
KIRK FEELY, LEGISLATIVE ANALYST, LEGISLATIVE ANALYST'S OFFICE

- MARILYN HOLLE, SENIOR ATTORNEY, PROTECTION AND ADVOCACY
- Carol Brown, Chair, Healthy Families Subcommittee to the Children and Families, Task Force, Alameda County
- LYNN KERSEY, EXECUTIVE DIRECTOR, MATERNAL AND CHILD HEALTH ACCESS
- FRANK MECCA, EXECUTIVE DIRECTOR, COUNTY WELFARE DIRECTORS ASSOCIATION

- ANGELA GILLIARD, JD, LEGISLATIVE ADVOCATE, WESTERN CENTER ON LAW AND POVERTY

III. BENEFICIARY COST SHARING

STAN ROSENSTEIN, DEPUTY DIRECTOR MEDICAL CARE SERVICES, DEPARTMENT OF HEALTH SERVICES
KIRK FEELY, LEGISLATIVE ANALYST, LEGISLATIVE ANALYST'S OFFICE

- ANGELA GILLIARD, JD, LEGISLATIVE ADVOCATE, WESTERN CENTER ON LAW AND POVERTY
- DEENA LAHN, POLICY DIRECTOR, CHILDREN'S DEFENSE FUND – CALIFORNIA
- PATRICIA DIAZ, POLICY DIRECTOR, LATINO COALITION FOR A HEALTHY CALIFORNIA

IV. PUBLIC TESTIMONY

BACKGROUND ON ISSUES: MEDI-CAL REDESIGN

ADULT DENTAL SERVICES

Current Program
Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered optional. Generally, covered dental benefits for children and adults include: diagnostic and preventive services such as examinations and cleanings; restorative services such as fillings; and oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

Proposal of the Administration: The Administration is proposing to limit Adult Dental Services at $1,000 per 12-month period.

Detail: This proposal restricting the amount of dental services any individual adult Medi-Cal beneficiary can receive to $1,000 in any twelve-month period. An implementation date of August 1, 2005 is assumed. This proposal requires trailer legislation to enact. There are nearly 3 million adults in the Medi-Cal program. Approximately 95,000 Medi-Cal beneficiaries would be subject to the cap.

State Savings: The budget proposes savings of $48.2 million ($24.6 million General Fund) in 2005-06 in local assistance

Exceptions: The $1,000 limit would not apply to:
(1) Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient

severity such that the absence of immediate medical attention could result in serious impairment to bodily functions;
(2) Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and
(3) Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

Concerns

It is not clear what specific procedures are exempt from the cap, as well as what dental services would fall above a $1,000 cap. For example, dentures cost $900 but other related dental work associated with this procedure would likely fall above the cap, such as related gum work or necessary medications, or root canal work related to the denture. The Department has provided a list of 13 Medi-Cal dental services with fees that exceed $1000 and four services with an exact fee of $1000. In addition they have provided a number of other dental treatment sequences that would probably exceed $1000 annually.

The Administration is proposing to implement a $1,000 cap in Denti-Cal to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market and has eliminated or restricted services to enrollees due to budgetary constraints over the years. An example is dental cleanings, Denti-Cal enrollees only may receive one dental cleaning annually whereas the commercial market provides for two cleanings annually.

Expenditures for each of the nearly 3 million beneficiaries will have to be tracked. It is unclear how the Department of Health Services will track the dental expenditures to discern when an enrollee is about to exceed the cap. The Administration proposes to develop a tracking system and expend $4 million ($1 million General Fund) for a tracking system, the details are lacking.

Also many of the affected Medi-Cal beneficiaries may be enrolled in California's Regional Center system which provides services to eligible individuals with developmental disabilities. It is likely the Regional Center system would incur additional General Fund expenditures to provide dental services which fall above the $1,000 cap.

If a cap is to be implemented, consideration of a sunset date, rate adjustment factors, and the need for more preventive dental services, need to be discussed. Medi-Cal dental reimbursement rates are extremely low and placing a cap in statute without consideration for out-year implications is not constructive policy. Adequate access to dental services needs to be a part of the discussion.

Finally, it should be noted that DHS intends to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, DHS may adopt regulations. Additionally, DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using "all county" letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature

SINGLE POINT OF ENTRY

The Current Enrollment Process for the Single Point of Entry (SPE)

Currently, joint applications for the Medi-Cal Program and the Healthy Families Program are submitted to a "Single Point of Entry" where they are initially processed by the Healthy Families Program vendor. If a child appears to be eligible for Healthy Families, the vendor determines eligibility and processes the application. However, if the child appears to be eligible for no-cost Medi-Cal, then the application is forwarded to the county welfare office where the child resides for a Medi-Cal determination by an eligibility worker. Pursuant to Federal law, Medi-Cal eligibility must be determined by either a county or the state. The county is currently responsible for Medi-Cal eligibility determinations, sending out notices to applicants or beneficiaries regarding that determination, as well as handling questions concerning the determination or appeals regarding eligibility denials.

The Proposal of the Administration

The Administration proposes to change the processing for children's applications by authorizing a vendor to process Medi-Cal application for children received through SPE. Once processed, the vendor would send the application to the state for "certification". The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management. The Department of Health Services assumes that about 85,000 applications would be processed in this manner.

The net costs to the state for this proposal in 2005-06 are projected to be $6.8 million ($2.1 million General Fund). This includes the cost for 19.5 new state positions, as well as vendor contract expenditures and information system changes. The Administration projects savings of $9 million ($7 million General Fund) will be generated annually from the proposal when fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal .

The details of the proposal are not available yet. Issues such as information systems processing changes, coordination between the HFP vendor, state, and counties, and related matters.

Problems Encountered with current SPE vendor

Some problems with the vendor have been encountered in the processing of the 120,000 applications per year. Among them are the following:

- Application processing is slow sometimes;
- Applicants are repeatedly asked for information that had been previously submitted;
- Inability to access staff person through the Single Point of Entry member services line, including staff for non-English speaking callers.
- Children being disenrolled from Healthy Families even though their Annual Eligibility Review forms were submitted before the due date; and
- Lack of a clear and timely process for resolving problems and handling appeals.

COST SHARING

Current Program

The Department is currently authorized to collect co-payments. If a Medi-Cal beneficiary refuses to make the co-payment the provider must provide the service.

Proposed Cost Sharing

The Administration proposes to establish monthly premiums for certain families, children, elderly individuals, and persons with disabilities. Premium payments, with certain exceptions, would be $4 per month for each person under age 21 and $10 per month for other adults, with a monthly cap of $27 per month per family. Counties would determine premium level, if any, and DHS would contract with a vendor to conduct premium collections month.

The Administration estimates General Fund savings of $15-23 million annually, resulting from the amount of premiums collected and the number of beneficiaries losing coverage due to missed premium payments. Nearly 100,000 children, families, elderly individuals, and persons with disabilities could lose Medi-Cal coverage under the Governor's proposal.

Details

Effective January 1, 2007, Medi-Cal enrollees with incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage. The 100 percent of poverty threshold represents $1,306 per month for a family of three, $812 a month for a senior, or disabled individual, and $1,437 a month for a couple receiving SSI/SSP. For example, a family of three with a monthly earned income of $1,306 per month would pay $24 per month for coverage or $288 annually, representing almost 2% of total family income. Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If a dropped individual wanted to re-enroll, he or she would be required to pay back premiums owed from the previous six months in which they were enrolled.

Exempted from the premium requirement are share-of-cost beneficiaries, 1931 (b) families enrolled in CalWORKS, infants under one year of age, American Indians, and Alaskan Natives.

Adverse Effect on 1931 (b) Families

The Administration's proposal will have additional adverse impacts on 1931 (b) families. First, the Administration proposes to change how the existing earned income deduction will be applied for the purpose of determining premiums. This, in effect, will make more 1931 (b) families subject to premiums because, for the purposes of premiums, it will raise the family income level. Second, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These "recipients" are usually individuals who have left CalWORKS. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Cal services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and remain eligible for Medi-Cal, if they met the 100% FPL income limitation at the time of enrollment. However if a 1931 (b) family looses its eligibility for failure to pay premiums, the family would not be eligible to reenroll in Medi-Cal, even if it paid back premiums, unless it was at 100 percent of poverty or below.

Consequences of the Premium Proposal

Approximately 550,000 people would be required to pay a premium, including 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level. In the first year alone, DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled, and thereby add to the increasing ranks of the uninsured living in California. The Administration assumes that all dual eligibles (Medicare and Medi-Cal eligible) will not drop off because Medi-Cal pays Medicare premiums for dual eligibles. If the assumptions of the Administration are inaccurate the number of beneficiaries who lose coverage will be significantly higher.

State Savings

The Administration estimates that premiums will produce state GF savings of from $15 million to $23 million annually (0.1 to 0.2% of total GF expenditures for Medi-Cal). Approximately 50% of the savings would come from premium collections (net of costs) and the other 50% from savings from not having to provide services to individuals who failed to pay premiums but were otherwise eligible for continued Medi-Cal coverage. Of note, the Administration assumes that although 20% of individuals subject to premiums would drop off the Medi-Cal rolls, the projected savings would only be 2-5% of the cost of covering individuals subject to premiums, because the vast majority of care needed by those who drop off the rolls will ultimately be delivered by Medi-Cal.

The Administration projects Local Assistanc3 and State Operations expenditures of $6.85 million in 2005-2006. That would increase to $10.0 million in 2006-2007. The Administration expenditure projections do not include the following unknown costs: County Re-determinations; County Re-enrollments; County Premium Re-calculation; County MEDS Linkage to the Vendor; and Health Plans Options Processing.

Issues of Concern

- Adverse Effect on Medi-Cal Eligibility and Enrollment Process: .The proposal, as the Administration's figures suggest, will result in a churning of enrollees and increase administrative processing costs. This is not consistent with Administration goals of decreasing the number of uninsured in the state and increasing program efficiency. Individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. Existing law requires county redeterminations when individuals are dropped from Medi-Cal. Medi-Cal re-determinations increase county costs which have *not* been addressed by the Administration's proposal. Other county costs not included in the Administration's proposal are those that will be incurred in adjusting premium levels of families as income, family size, etc. change.
- Proposal is at odds with the Administration's goal of expanding Medi-Cal managed care and ensuring a regular source of care.
- Effect on "Medi-Cal Eligibility Determination System" (MEDS) and county systems.
- The proposal is at odds with Administration's goal of covering all kids. This proposal conflicts with current Medi-Cal policy of annual reenrollment of children aims to provide continuous coverage.