County Thoughts on the Next Section 1115 Medicaid Waiver
California State Association of Counties
January 2009

California's current Section 1115 Medicaid Demonstration Waiver – which funds hospitals and indigent care – expires on August 31, 2010. The California Department of Health Care Services (DHCS) and the Legislature have already begun work on the next Medicaid demonstration waiver. The DHCS drafted a concept paper in October and a subsequent revision to the concept paper in December 2009. Both houses of the Legislature have held informational hearings.

This document summarizes the initial thinking and recommendations of counties on a number of topics addressed in the concept paper and raised in the hearings. As additional ideas are brought forth for consideration by stakeholders, counties look forward to being involved in the discussion and may develop further recommendations.

COUNTIES ARE INTEGRAL PARTNERS IN SHAPING THE NEXT 1115 DEMONSTRATION WAIVER.

Counties have multiple roles in the existing Medicaid system and safety net health systems –

- Counties own and operate hospitals and clinics that serve Medi-Cal recipients and indigent adults. Counties provide services in their hospitals that benefit all Californians, including trauma care, burn units, and physician training.
- Under state law, counties provide health services to indigent adults.
- Counties provide mental health services to low-income Californians and are the mental health managed care plans for Medi-Cal beneficiaries who need specialty mental health services.
- Counties run Medi-Cal eligibility operations on the state's behalf, determining initial and ongoing eligibility for a complex array of programs for children and adults.
- Counties perform eligibility determinations, case management and authorization of service for children in the California Children's Services (CCS) program. Counties also directly provide medical therapy to children enrolled in CCS.
- Counties provide alcohol and drug treatment services to low-income Californians, to the extent resources are available.

Counties have expertise in the programs and populations that will be affected by this waiver. As such, counties should be integral partners in shaping the policy and programs piloted through the waiver. For example, under the existing 1115 Medicaid Waiver, 10 counties are already sponsoring Health Care Coverage Initiatives and are expanding access to health care for indigent residents, transforming service delivery, maximizing limited resources, and providing medical homes for residents with complex, chronic medical conditions.

Counties also serve as payers in the Medi-Cal system. In many cases, counties put up county funds as match for federal Medicaid funds. County hospitals use certified public expenditures (CPEs) and intergovernmental transfers (IGTs) to draw down more than $2 billion in federal Medicaid funds under the existing 1115 waiver. The mental health system also uses CPEs to draw down federal funds under a separate waiver.

Because of the state's chronic budget problems, California may look to rely on county expenditures to increase the amount of federal funds available for California's Medicaid program. **While counties have the fiscal expertise and, in some cases, could provide the non-federal share to capture new federal dollars through a new waiver, all federal resources obtained through a new waiver that rely upon county matching funds must be retained in the safety-net system and benefit the counties providing the match. In addition, in order for the State to negotiate a successful waiver with CMS that accomplishes the State's stated goals of supporting and strengthening the safety net, maximizing federal funds, and expanding coverage, the State must treat counties as true partners in the process.** The details of how to accomplish the next waiver must be carefully considered with counties involved every step of the way.

It is very difficult to separate the goals of the next Medicaid waiver from the state's budget crisis. Counties are mindful of the state's fiscal problems but are facing their own budget problems as well. Counties want to ensure the State of California continues to fund care for low-income Medi-Cal recipients.

Policy Positions

- If county expenditures are used as the match to draw down new federal funds, counties must retain the benefit of the new federal funds.
- Counties – including representatives of county hospitals, behavioral health, public health and indigent care – must be partners in state and federal discussions about financing a new waiver.
- Counties must continue to have the flexibility to manage health programs within the revenue base made available.

THE NEXT WAIVER MUST CONTINUE TO SUPPORT AND EXPAND FUNDING FOR PUBLIC HOSPITALS.

Counties urge that the next waiver build on and expand the support of public hospitals. Under the current waiver, financing for public hospitals relies on county funds to draw down the federal match via CPEs and IGTs. The federal government limits the amount of federal funds the state can draw down, and it is unknown at this time the total amount of federal funds that will be available in a new waiver. Due to the capped SNCP under the current Waiver, there are unreimbursed costs within the public hospitals that they could use to draw down increased reimbursement if the federal government approved an increase in the total amount of federal funds to be included in the waiver.

Policy Positions

- The waiver should increase the amount of federal dollars available for reimbursement to public hospitals.
- The waiver should increase the size of the Safety Net Care Pool to allow public hospitals an additional match source for unreimbursed costs and to enable them to continue ongoing delivery system improvements. Rather than being capped, as the SNCP is under the current waiver, the SNCP in the next waiver should grow to correspond with rising costs.

MANAGED CARE EXPANSIONS

EXPANSION TO SENIORS AND PERSONS WITH DISABILITIES

DHCS' concept paper appears to heavily favor a mandatory shift of Seniors and Persons with Disabilities (SPDs) into Medi-Cal managed care. Based on county experiences with health plans, there appear to be varying levels of readiness among the plans to serve seniors and persons with disabilities. Seniors and persons with disabilities are individuals who have different needs. Policy makers should take these varying needs into account while trying to craft care coordination strategies.

In addition to counties already providing services to persons with severe mental illness, public hospitals and clinics are currently serving seniors and persons with disabilities. Public hospitals have significant expertise and experience in treating seniors and persons with disabilities, and recognize the potential to improve care delivery for these individuals. As California transitions to more coordinated care, new networks and provider arrangements must continue to prioritize public hospitals as centers of care for these populations.

Policy Positions

- Counties are supportive of multiple models of care coordination, including traditional managed care plans, but also county-based structures, to provide services to seniors and persons with disabilities. It is critically important that counties be given the choice of how to best structure the care for the SPD patient population, given their complex care needs and varying health care structures and dynamics across counties.
- Regardless of which structure is chosen, public hospitals and clinics must be a central component of the provider network that offers high quality, coordinated care to seniors and persons with disabilities.
- County human services departments, which operate the In-Home Supportive Services (IHSS) program, the state's largest publicly funded in-home care program for seniors and persons with disabilities, must also be part of the care coordination of seniors and persons with disabilities.

EXPANSIONS TO RURAL COUNTIES

The state's concept paper includes a geographic expansion of care coordination for children and families to rural counties. Very little detailed information is provided in the concept paper. Managed care plans have historically had a very difficult time surviving

in rural California. Medi-Cal managed care plans have not attempted to expand into rural counties; however, numerous commercial plans serving non-Medi-Cal populations have withdrawn from these areas. The scarcity of providers makes it very difficult to build networks in rural counties.

In the early 1990's the California Department of Health Services initiated care coordination pilots for Medi-Cal beneficiaries in Placer and Sonoma counties. The Placer pilot, called Placer County Managed Care Network (PCMCN) resulted in improved access to primary and specialty care and reduced inappropriate use of emergency rooms. However, the state ended the project for a number of reasons, including issues over the "savings sharing" between the state and county and loss of the necessary federal "freedom of choice" waiver. The successes and challenges of this pilot project should again be reviewed in the context of this waiver.

Counties have been very active in recent geographic expansions of Medi-Cal managed care. County health departments have conducted quite a bit of outreach with providers, hospitals, medical societies and other interested stakeholders. Given the current limited fiscal resources in rural counties, affected counties may not be as prepared nor have the resources to assist in successful transition to Medi-Cal managed care.

Policy Positions

- Traditional managed care plans have not fared well in rural counties. Counties suggest limited pilots that utilize other models of care coordination, which should incorporate "lessons learned" from the rural Managed Care Fee-for-Service pilots of the early 1990's.
- The scope of the waiver proposal is quite ambitious. Expansions to rural counties may be one area to consider deferring or phasing in on a slower timeline.

CALIFORNIA CHILDREN'S SERVICES

Counties administer many pieces of the California Children's Services Program (CCS), including the following:

- Financial and residential eligibility determination for CCS Only Program.
- Medical eligibility determination for CCS Only, Medi-Cal/CCS and Healthy. Families/CCS, including diagnostic services.
- Case management and authorization of services for children in all three CCS populations.
- Administration of local Medical Therapy Programs.
- Direct provision of medical therapy services, primarily by county employed therapists, to children enrolled in the CCS program and those Special Education students who have had medically necessary occupational or physical therapy identified in their Individualized Education Program (IEP).

In addition, counties are legally responsible for 50 percent of the costs of Diagnosis, Treatment and Therapy for CCS Only and 17.5 percent for Healthy Families/CCS children, up to the cap set in Health and Safety Code 123940 (commonly called the

county “MOE”). Counties also share the cost of County Administration for the CCS Only Program (50 percent share) and Healthy Families/CCS (17.5 percent share).

The Administration proposes in its waiver concept paper to enhance care coordination for children enrolled in CCS. This has a number of implications for the program and counties that must be addressed. The current program is extremely complex in administration; counties are actually administering three separate programs. In addition, the current program is underfunded. Further, the state has capped the CCS allocation to counties, and the local revenues used by counties as match are also declining. The children served by CCS have very costly medical needs.

Policy Positions

- “Federalize” the state only CCS program (i.e. capture federal funds for the portion of the program that is funded with state and county dollars only).
- Realign the county share of cost for CCS back to the state, in order to give the state greater flexibility in restructuring and simplifying all three CCS programs.

BEHAVIORAL HEALTH

In California, counties have primary funding and programmatic responsibility for local mental health programs. Counties serve as the managed care plans for the Medi-Cal Specialty Mental Health program, serving both children and adults. Children and youth enrolled in Medi-Cal are served through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. In California, the specialty mental health managed care program operates under a federal Freedom of Choice 1915(b) waiver and accompanying State Plan Amendments that allow counties to offer targeted case management and rehabilitative services. Under the 1915(b) waiver, each county mental health plan contracts with the state Department of Mental Health to provide medically necessary specialty mental health services to the beneficiaries of the county.

Counties also provide public alcohol and drug treatment services and limited Drug Medi-Cal services for adults. Unlike mental health, counties do not provide matching funds for Drug Medi-Cal services. There are numerous issues with Drug Medi-Cal benefits. In the context of the waiver and promoting better integration and outcomes, it may be timely to review the program and restructure it.

County behavioral health systems are best situated to provide care for persons with severe mental illness. Counties have the fiscal and programmatic incentives to provide the most appropriate and cost-effective care to individuals with mental illness and addiction issues, with the primary goal of ensuring they have an opportunity to recover and lead healthy, productive lives. Counties are able to connect low-income individuals with housing, transportation, human services, employment, alcohol and drug treatment, and mental health treatment through existing county networks of services. When efforts to bolster behavioral health outcomes fail, counties directly bear the consequences, including incurring costs in other systems such as public safety. Because of the successes of county mental health plans, counties continue to support the specialty mental health managed care program.

Policy Positions

- CSAC supports the pursuit of pilots in a number of counties under the next 1115 waiver to improve health outcomes for persons with high behavioral health needs. In order to effectuate the pilots, counties support exploring alternative payment structures that would allow behavioral health and primary care to better collaborate and integrate services to this population.
- The waiver should not alter the ability of county mental health plans to be reimbursed for costs under the current State Plan Amendments.
- The waiver should preserve the existing specialty mental health managed care program.

COVERAGE INITIATIVES

The current waiver includes $180 million of federal funding a year for three years for Health Care Coverage Initiative pilot programs. The pilot programs, currently in 10 counties, serve low-income uninsured adults not otherwise eligible for Medi-Cal. As with other elements in the current waiver, counties provide the non-federal share for the $180 million in federal reimbursement. The DHCS concept paper includes a proposal to expand the Coverage Initiatives to more counties as well as development of more consistent standards for all counties.

Policy Positions

- Counties support expanding the coverage initiatives to additional counties provided that additional federal funds are available through the next waiver.
- Counties also support the development of more consistent minimum coverage standards for the Coverage Initiative program, including more standardized benefits.
- Counties urge the state and federal governments to re-examine the reimbursement structure, including an actuarially sound payment method.