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Informational Hearing of the Senate Health Committee and hearing on SB X1 1 (Hernandez and Steinberg)

Implementing the Affordable Care Act's Expansion of Medicaid in California

Wednesday, February 27, 2012, 1:30 p.m.

State Capitol, Room 4203
Sacramento, CA

On January 24, 2013, Governor Brown issued a proclamation calling for a special session to consider and act upon legislation necessary to implement the federal Patient Protection and Affordable Care Act (ACA). One of the areas addressed in Governor Brown's proclamation was changes to California's Medi-Cal program, described as changes that are necessary to implement federal law, including requirements for eligibility, enrollment, and retention.

The informational hearing portion of this Senate Health Committee hearing will focus on some of the major policy choices presented by the federal regulations implementing the Medicaid provisions of the ACA.

The hearing will begin with an overview of the Medicaid requirements in the ACA and the state policy options in these Medicaid provisions. The committee will then hear Medi-Cal the ACA's impact on Medi-Cal and California from the UC Berkeley Labor Institute, and how those enrollment estimates vary depending upon state policy choices. Next, the Administration will provide an overview of its proposed Medi-Cal expansion-related changes.

The hearing will then have four panels on selected major policy provisions of the ACA where the Legislature either has elected a policy option under federal law or where there is a policy difference between what the Legislature has proposed in SB X1 1 (Hernandez and Steinberg) and what the Administration has proposed in its draft amendments to this legislation. [Note: the Administration's amendments, which are included in the member's briefing materials, are drafted to SB 28 (Hernandez and Steinberg), which is similar to SB X1 1 but introduced in the regular session. Also, while this paper refers only to SB X1 1, it is important to note that an identical bill is pending in the Assembly in AB X1 1 by Assembly Speaker Perez.] The informational portion of the hearing will then conclude, and there will be a policy hearing and vote on SB X1 1 (Hernandez and Steinberg).

On February 21, 2013, the Senate Budget Committee held a hearing on the Governor's health care reform proposal that included an overview of the Administration's proposal, examined the ACA's impact on Medi-Cal and California, reviewed the state and county risks and responsibilities for the Medi-Cal expansion, and discussed the remaining uninsured following implementation of the ACA.

The focus of today's informational hearing is on several key state options under the ACA, policy differences between the Administration's draft proposal and SB X1 1, and to receive testimony from the Administration and stakeholders through stakeholder panels on selected issues. The attached side-by-side describes the policy differences and ACA options that are the subject of the panels. In addition to the panels listed below, there are other policy choices and policy differences between the legislative proposals and the Administration's proposals that will be discussed in the coming months as additional federal guidance is received and more is learned about the policy choices the state has under the ACA and its implementing regulations.

I. Panel 1 - Medi-Cal Benefits

Panel 1 will discuss the following:

- The Administration's proposed benefit package versus the benefit package in SB X1 1;
- The differences between the Medicaid benchmark and full-scope benefits;
- What benefits the Medi-Cal expansion population and the current Medi-Cal population should receive related to federal EHBs; and,
- Whether or not coverage for pregnant women should be increased from pregnancy-only coverage to full-scope coverage.

Discussion Questions

1. SBX 1 1 requires the Medi-Cal expansion population receive the existing Medi-Cal benefit package supplemented by the federal essential health benefits (EHB). The EHB are a list of 10 required services in the ACA, and includes mental health and substance use disorder services, including behavioral health treatment. Pursuant to federal guidance, last session the Legislature designated the benefits covered under the Kaiser Small Group plan as the state's EHB benchmark plan for the individual and small group insurance market. CMS indicates a state is not required to select the same EHB benchmark reference plan it selected for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medi-Cal. The Administration's language proposes to exclude long-term services and supports from the benefit package for the expansion population. What should the benefit package be for the Medi-Cal expansion population? Should the state designate the Kaiser Small Group plan as the state's EHB benchmark for Medi-Cal?
2. The expansion Medi-Cal population is required by the ACA to receive the federal EHB. Should the existing Medi-Cal population also receive the federal EHB as part of the existing Medi-Cal benefit package?

3. Draft regulations released in January 2013 revise Medicaid coverage for pregnancy-related services so that all services provided to pregnant women must be considered pregnancy-related unless specifically identified in the state's Medicaid State Plan as not pregnancy-related. Should women with incomes less than 200 percent of the federal poverty level (FPL) receive coverage for full-scope Medi-Cal benefits, or should pregnancy-only coverage continue?
4. When will the Administration have an estimate of the state cost difference between pregnancy-only and full-scope coverage of pregnant women in Medi-Cal?
5. Manatt, Phelps and Phillips LLC is providing policy guidance to DHCS on benchmark benefit plan options, and Mercer is assisting DHCS in estimating the cost and benefit differences between the current Medi-Cal state plan benefits and one benchmark plan option that could be provided to the Medi-Cal expansion population. When will the results of these analyses be released to the Legislature and the public?

II. Panel 2 – Enrollment and Redetermination Changes

Panel 2 will discuss the Administration's proposed changes and federal policy options regarding:

- Self-attestation of residency in California when applying for Medi-Cal coverage;
- Allowing beneficiaries to use annual versus monthly income in determining eligibility for Medi-Cal;
- Provisions making it easier for former foster youth who move to remain on Medi-Cal coverage; and,
- A provision in SB X1 1 to eliminate the deprivation requirement in Medi-Cal (the deprivation requirement requires a parent to have a child "deprived" of parental support as a condition of Medi-Cal eligibility).

Discussion Questions

1. SB X1 1 allows individuals to self-attest to their residency in California. If individuals applying for coverage via the phone or internet cannot self-attest to their residency and have to continue to submit paper documentation, can the state achieve real-time determinations of Medi-Cal eligibility?
2. The ACA expands coverage to former foster youth up to age 26. Former foster youth are categorically eligible for Medi-Cal and covered until age 21. Should former foster youth be allowed to remain on Medi-Cal and shifted to fee-for-service Medi-Cal if their redetermination form is returned as undeliverable?
3. A Medi-Cal application (known as the MC 210) instructs individuals to list how much income they receive. For individuals who know their family's income will go up or down in

the next few months, the MC 210 instructions direct applicants to explain this on a separate sheet of paper. Should the state allow individuals with fluctuating incomes to have the option of choosing between the use of monthly versus annual income to determine eligibility for Medi-Cal? Does federal law permit states to implement this option?

III. Panel 3 – Shift of Medi-Cal eligibility to Exchange Coverage

Panel 3 will hear the Administration’s proposal to:

- Shift individuals who are newly eligible for specified state health programs to coverage in California’s Health Benefit Exchange known as Covered California; and
- Reduce income eligibility for 1931(b) Medi-Cal to draw down additional federal funds.

Discussion Questions

1. Medi-Cal 1931(b) covers applicants with family incomes equal to or less than 100 percent of the FPL and recipients at higher income levels. The Administration’s draft language proposes to roll back 1931(b) coverage, contending they could draw down the higher enhanced federal matching rate for the expansion population.
 - a. Is this proposal allowable under federal law?
 - b. Should the director be required to reduce income eligibility for adults in 1931(b) coverage for purposes of drawing down enhanced federal matching funds?
 - c. What would be the new 1931(b) income eligibility level if this rollback were implemented?
 - d. How many individuals would be affected by this shift?
2. If the shift described in 1) is made, should these individuals receive a Medi-Cal benefit package that provides fewer benefits than the current Medi-Cal benefit package?
3. California currently offers specialty services under programs targeted at populations with specific medical conditions that are not currently eligible for full scope Medi-Cal coverage, such as the Genetically Handicapped Persons Program, the AIDS Drug Assistance Program, and the Breast and Cervical Cancer Treatment Program. The Administration is proposing to shift newly eligible individuals to Covered California.
 - a. How will the benefits and services in these state programs compare to the benefits and services in Covered California?
 - b. How will the premiums and cost-sharing in these state programs compare to the benefits and services in Covered California?
4. The state programs for which newly eligible individuals are proposed to be shifted to Covered California provide specialized services and have lower premiums and cost-sharing than coverage that will be available in Covered California. Should individuals be able to remain in these programs if they are unable to afford the premiums in Covered California?

IV. Panel 4 – Administration proposals to halt the Medi-Cal expansion, to reinstate prior eligibility rules, and establish authority to use All County Welfare Director Letters (ACWDLs) instead of regulations to implement ACA-related changes

Panel 4 will discuss DHCS’ proposed amendments to:

- Halt the Medi-Cal expansion if changes are made to the federal Medicaid provisions of the ACA;
- Reinstate mid-year status reports; and,
- Use ACWDLs instead of regulations.

Discussion Questions

1. Should the Legislature delegate to DHCS the authority to halt and roll back the Medicaid expansion if there is a change in the federal Medicaid provisions of the ACA?
2. Does providing DHCS the authority to halt the expansion effectively prevent the Legislature from addressing the health needs of low-income individuals and place individuals covered under the expansion of Medi-Cal at risk for a disruption in their care?
3. Should the director of DHCS be required to cease implementation of Medicaid health care reform provisions if any change is made to federal law?
4. Should the Legislature delegate to DHCS the authority to reinstate eligibility rules (such as mid-year status reports) if there is a change in federal law?
5. The Administration’s language and a provision of SB X1 1 allow DHCS to use ACWDLs, letters or similar instructions in lieu of regulations, and thereafter, to adopt regulations. However, there is not a date specified when regulations have to be adopted. The Administration instead proposes to provide a status report to the Legislature until regulations have been adopted. One of the proposals being discussed is to permit the use of ACWDLs on a time-limited basis, but to require the adoption of regulations by a date certain. Should regulations to implement the ACA-related Medicaid provisions be required to be done by a date certain?