



CWDA

January 24, 2008

To: Honorable Patty Berg, Chair
Assembly Budget Subcommittee No. 1

Honorable Members
Assembly Budget Subcommittee No. 1

From: Frank J. Mecca, Executive Director

**RE: Proposed Medi-Cal Cuts – CONCERNS
[Item 4260: BBR Pages 308, 310, 318, 320, and 322]**

The County Welfare Directors Association of California (CWDA) has serious concerns about the Administration's proposal to cut county Medi-Cal eligibility operations and to reinstate bureaucratic paperwork requirements that will cause children and adults to drop off the program and result in unrecognized workload for counties.

The Governor's Budget proposes three cuts to county Medi-Cal administrative budgets: eliminating the annual increases for caseload growth and the actual cost of operating programs, and cutting into the base funding by 2.5 percent. The budget also proposes to reinstate quarterly status reporting in the program and eliminate continuous eligibility for children.

As you consider these proposals, we wanted to provide some history on Medi-Cal eligibility funding decisions as well as information on the impacts to clients and increased program costs that have not been taken into account.

Proposal Again Attempts to Renege on Deal Negotiated in 2003

In 2001, the state budget crisis led to the elimination of annual cost-of-doing-business increases for all county-administered health and human services programs. In 2003-04, the Administration proposed to restore these annual funding increases for Medi-Cal only. The 2003-04 Budget Change Proposal submitted by the Administration highlighted the importance of fully funding the program, stating:

In order for counties to do the work that is expected of them, it is necessary that they be fully funded. ... Linking full funding with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state.

We agreed, and worked with the Administration and Legislature to create the initial performance standards for the processing of applications and annual renewals. Since then, new standards have been added for the program that "bridges" children found ineligible at annual renewals to Healthy Families and for the processing of alerts generated by the MEDS system.

Counties take these standards seriously and have now worked with state quality assurance staff through two rounds of reporting and corrective action, as needed, on the standards. We were therefore dismayed when the Administration proposed to eliminate the Cost of Doing Business increase in its proposed 2006-07 budget, without proposing any changes to the performance standards. The Legislature rejected this proposal and adopted statutory intent language that expresses the importance of coupling full funding with the performance standards in order to achieve the desired goals of timely, accurate program administration.

The concerns we had in 2006 when this proposal was last put before you are heightened with the increased amount of the cut, not only affecting the cost of doing business increase but also caseload growth and the base funding for eligibility operations. These deeper cuts only exacerbate the problems created by underfunding the system without making any changes to the performance standards that counties have supported in good faith based on the assumption of adequate funding for the program. If funding for Medi-Cal eligibility operations is cut, counties must be indemnified from the performance standards.

Cuts Will Greatly Impact Applicants and Recipients

The proposed \$142.2 million cut translates into a loss of 1,051 eligibility workers statewide. To give you an idea of the impacts of these lost staff, these staff would have been able to do all of the following:

- Handle intakes and ongoing services to the 216,062 individuals who the department estimates will enter Medi-Cal in 2008-09.
- Bridge the 70,000 children who become ineligible at annual renewal to the Healthy Families program so their benefits are not disrupted.
- Conduct federally required annual redeterminations for 771,000 cases.

Instead, these requirements will shift to other staff, increasing caseloads and lengthening the time it takes to determine initial and ongoing eligibility. Beneficiaries will have difficulty reaching their case workers, and providers will be unable to verify beneficiary information on demand, potentially delaying the provision of health care to thousands of adults and children across the state.

The proposals to move from mid-year status reporting to quarterly reporting and eliminate continuous eligibility for children are estimated to impact 157,395 children on average each month, plus thousands of additional adults. Some of the adult beneficiaries would lose eligibility three months earlier than they otherwise would, while the children would no longer be eligible for a 12-month period without reporting requirements.

Cuts Will Cost More Than They Save

If counties do as they have done before when cuts have occurred, they will focus on keeping “the front door” open and continue processing applications as timely as they can. This will lead to as many as 1.4 million annual redeterminations being delayed indefinitely, representing an estimated 3.5 million individuals.

The budget has assumed for several years that fully funding Medi-Cal eligibility operations, coupled with statutory performance standards that we discuss below, results in savings due to timely redeterminations. It is our understanding that the projected level of savings currently stands at about \$450 million annually (\$250 million General Fund). The proposed cuts – not just eliminating the annual cost of doing business increase, but also eliminating funding for caseload growth and cutting the base – are so deep that counties will no longer be able to meet these performance standards. As a result, annual redeterminations will be delayed and ineligible

individuals will remain on the rolls, increasing benefits costs and resulting in the elimination of these assumed savings.

Further, the quarterly status report and continuous eligibility proposals do not account for “churning” in the rolls. Experience with the mid-year status report indicates that more adults are discontinued from coverage because they fail to submit their reports on time than due to actual ineligibility. Counties also report that a substantial portion of these discontinued adults come back onto the program within a month or two of receiving notice that their eligibility has been terminated. If 60 percent of the discontinued children cycle back onto the program one time per year (based on data in an April 2005 California Endowment report), it will cost at least \$18 million to process their eligibility, plus another \$5 million to enroll them back into managed care.

Proposals are Incongruous with Health Care Reform

The pending ABX1 1 is based on the idea of ensuring health care coverage for all Californians, and providing special assistance to those with low incomes. This makes it difficult for us to reconcile the reduced levels of customer service that will result from the county operations cut; the addition of more paperwork for recipients to keep their benefits, rather than less; and the termination of an estimated 157,000 children from the rolls each year, plus their parents.

Trailer Bill Language is Unnecessary and Technically Flawed

The Administration has proposed the adoption of trailer bill language for all three of the proposed eligibility cuts – the cost of doing business, caseload, and 2.5 percent base cut. These statutory changes are completely unnecessary, as none of these increases is required by statute now. The Legislature and the Administration are free to make funding decisions for the program on an annual basis without any need for a law change.

In addition, the language for the 2.5 percent cut is drafted in such a manner that it could be interpreted as not only cutting the base by 2.5 percent in 2008-09, but instituting additional 2.5 percent cuts every year thereafter (i.e., a total of 5 percent in 2009-10, 7.5 percent in 2010-11). Given that these statutory changes are not needed and are poorly drafted, we urge their rejection.

Summary and Conclusion

The cuts proposed to Medi-Cal eligibility are deep, and will hurt new applicants and current beneficiaries alike. Further, the state will not achieve the level of anticipated savings due to the known costs of underfunding county operations (thus losing the \$450 million in annual savings achieved by the 2003-04 agreement) and the unaccounted-for costs of eligibility changes that will increase “churning” in the program.

Counties operate this program on behalf of the state and are proud of the job we do. Any cuts to the program not only go back on the deal made in 2003-04, but also make it impossible for counties to continue meeting the performance standards that were enacted as part of the deal. If county Medi-Cal operations funding is cut, counties must be indemnified from the performance standards.

Thank you for the opportunity to comment on these proposals. Please do not hesitate to contact CWDA if you have any questions.

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cc: Dan Rabovsky, Consultant, Assembly Budget Committee
Sumi Sousa, Office of The Honorable Fabian Nunez
Lisa Mangat, Consultant, Assembly Republican Fiscal Office
Jennifer Kent, Health and Human Services Agency
Pete Cervinka, Health and Human Services Agency
Ana Matosantos, Office of Governor Arnold Schwarzenegger
Sandra Shewry, Director, Department of Health Care Services
Katie Trueworthy, Department of Health Care Services
Mike Wilkening, Department of Finance
Shawn Martin, Legislative Analyst's Office
Kelly Brooks, California State Association of Counties
County Caucus