Protect Medi-Cal Funding
Children's Health in California
Issue Brief #1 in a 12-Part Series

Medi-Cal provides a long-term investment in health care that helps Californians succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medi-Cal coverage is tailored to the unique needs of low-income Californians and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medi-Cal's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 13 million Californians—one third of our state residents—who benefit from Medi-Cal each year.[3] Medi-Cal's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet explains why Medi-Cal is so critical for children and how they would be harmed by Medicaid funding caps.

Why Medi-Cal is important for children:

- **Medi-Cal covers health services for 5.7 million children living in or near poverty.**[4] Federal law requires state Medicaid programs to provide coverage for all children in families with incomes up to 138% of the Federal Poverty Level (FPL).[5] California elects to cover all children up to 19 years old in families with incomes up to 266% FPL.[6] In 2016, California extended full scope Medi-Cal benefits to all eligible children under age 19 regardless of immigration status.[7] Medi-Cal serves as the health care lifeline for abused and neglected children placed in the foster care system, as well as for many children living with developmental and other disabilities. Today, California's child health insurance enrollment rate has reached a historic high of 97 percent. Medi-Cal is an effective investment that lasts through adulthood, improving health, educational, and economic outcomes for children.[8]

- **Medi-Cal provides children with comprehensive preventive health screenings and treatment to address health issues early on.** Federal and state law require Medi-Cal to offer Early and Periodic Screening, Diagnostic and Treatment benefits to enrolled children under age 21.[9] Commonly referred to as "EPSDT," these services are designed to foster strong childhood development despite the many complications of living in poverty. EPSDT ensures that children

receive appropriate preventive, dental, mental health, developmental, and specialty services.[10] EPSDT provides critical protections so that children do not needlessly suffer from preventable and treatable health conditions, so they can grow up to be healthy and productive adults.[11]

- **Medi-Cal pays for services for children with chronic conditions and complex health needs.** Federal law requires Medicaid programs to treat physical and mental illnesses and conditions that are detected in Medicaid-enrolled children.[12] In California, Medi-Cal covers 42% of children with disabilities or other special health care needs.[13] Covered services include care in homes and community-based settings that enable medically fragile children or children with emotional or psychiatric disabilities to live at home rather than in institutional settings, visits to pediatric specialists for children with chronic conditions, and Behavioral Health Therapy services for children with Autism Spectrum Disorder.[14] In California, county administered Mental Health Plans provide specialty mental health services and are required to provide Intensive Care Coordination and Intensive Home Based Services pursuant to EPSDT to all children and youth under age 21 who are eligible for full scope Medi-Cal services and meet medical necessity criteria.[15] California offers additional services to children under age 21 with complex conditions through California's Children's Services (CCS) and requires Medi-Cal to refer eligible children to CCS to ensure access to diagnostic and treatment services, medical case management, and physical and occupational therapy services for vulnerable children.[16]

- **Medi-Cal helps ensure children have real access to health care.** Medicaid generally prohibits all forms of cost sharing for children, a critical protection for low-income families.[17] Recognizing the challenges faced by low-income families, Medi-Cal offers assistance in scheduling children's doctor visits as well as transportation services to get children to and from appointments.[18] At the start of life, to prevent coverage delays and guarantee continuity, babies born to mothers enrolled in Medi-Cal are "deemed eligible" for Medi-Cal until their first birthday and stay on Medi-Cal without having to submit a separate application.[19] California also enrolls infants up to age 1 born to mothers in the Medi-Cal Access Program into Medi-Cal without regard to income and 1 to 2 year olds with income up to 322% FPL into Medi-Cal.[20]

How funding caps would harm children:

- **Funding caps would likely lead to cuts in services for children living in poverty.** 58% of total federal funds California receives is for Medi-Cal.[21] The per capita cap proposal under consideration in the American Health Care Act reduces the amount of federal Medicaid funding available to California to provide essential health care services for vulnerable, needy children. California would

have to raise taxes or cut other parts of its budget by $45 billion over ten years to maintain Medi-Cal.[22] Shifting the cost burden to California means the state will likely cut back on children's health care services. Strain on the state and local budget also results in less money for other priorities, like education. Nationally, Medicaid currently pays out $4 billion to $5 billion a year in school-based health services, including funding for special education, medical supplies and EPSDT services like vision and hearing exams.[23] California school districts may have to dip into general education funds to pay occupational and speech therapists and ensure the state meets federal mandates to provide special education.[24] Additionally, children covered by Medi-Cal are more likely to graduate from college, have higher wages, and pay more in taxes so Medicaid caps jeopardize the long-term success of children.[25]

- **Funding caps threaten core protections for children.** With less federal funding available, California may try to avoid full implementation of the long-standing federal standards for children. For example, California might cut EPSDT services that ensure in-home nursing services for children with medically complex conditions or turn attention away from the outreach that is needed to make sure that children and families know about and use the early and periodic screening and treatment services that are available to children.[26] Restructured Medicaid financing means that the comprehensive EPSDT services provided to children may be at risk, leaving children without critical, timely care.

- **California will likely limit access to health care for children.** Federal spending caps would lead states to adopt cost-saving measures that reduce access to children's health care, such as narrowing provider networks to exclude pediatric specialists and adding more hurdles for children to access services, such as prior authorization requirements. California will most likely be forced to place barriers on expensive specialty care for children with complex health needs, restricting access to care for children who need it most.

ENDNOTES

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes Among Medicaid Patients in 2015 Within Medicaid Expansion States Under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation in expansion states, including California) http://care.diabetesjournals.org/content/38/5/833 ; DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (National study finding that Medicaid improves long-term outcomes for children); MICAH WEINBERG & PATRICK KALLERMAN, BAY AREA COUNCIL ECON. INST., MAINSTREAMING MEDI-CAL 5-6 (2016) (Medi-Cal enrollment associated with increased participation in the workforce), http://www.bayareaeconomy.org/files/pdf/MainstreamingMedi-Cal.pdf; CAL. DEP'T HEALTH CARE SERVS., MEDI-CAL MONTHLY ENROLLMENT FAST FACTS 8 (2017) (At least 64% of Medi-Cal Expansion enrollees were people of color as of December, 2016), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_December_2016.pdf; Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage*, 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid reduced health care disparities in expansion states, including California) http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.303155.

[2] *See* TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Nationally, employer-based coverage would cost 28% more than covering the same individual with Medicaid).

[3] CAL. DEP'T HEALTH CARE SERVS., *supra* note 1 at 1 (enrollment as of December, 2016 at 13.5 Million).

[4] Cal. Dep't Health Care Servs., MEDI-CAL CHILDREN'S HEALTH DASHBOARD 1 (2017), http://www.dhcs.ca.gov/provgovpart/Documents/March2017PediatricDashboardADAVersion.pdf

[5] 42 U.S.C. §1396(a)(l)(2)(C).

[6] CAL. WELF. & INST. CODE § 14005.26(d)(1)(B) (California implemented the federal optional targeted low-income coverage group (TLICP) pursuant to Section 1902 (a)(10)(A)(ii)(XIV) of the Social Security Act. A State Plan Amendment to move TLICP into Medi-Cal permits the state to impose premiums on children in families with income 161% FPL to 266% FPL); Cal. Welf. & Inst. Code § 14005.26(b) (The state statute sets the upper limit at 261% FPL but income is determined according to MAGI methodology which provides a 5% income disregard so the upper income limit for children in TLICP is 266% FPL).

[7] CAL. WELF. & INST. CODE § 14007.8; CAL. DEP'T HEALTH CARE SERVS., SENATE BILL 75 FULL SCOPE MEDI-CAL FOR ALL CHILDREN: ELIGIBILITY AND ENROLLMENT PLAN (2016), http://www.sa-bhc.org/wp-content/uploads/2016/05/SB-75-Eligibility-and-Enrollment-Plan-FINAL.pdf.

[8] JOAN ALKER & ALISA CHESTER, GEORGETOWN CTR. FOR CHILDREN & FAMILIES, MEDICAID AT 50: A LOOK AT THE LONG-TERM BENEFITS OF CHILDHOOD MEDICAID, 2 (2015), http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

[9] 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396(a)(4)(B), 1396d(r); CAL. WELF. & INST. CODE § 14132(v); CAL. CODE REGS., tit. 22, § 51184; *Id.* §§ 51340, 51340.1

[10] Letter From Cal. Dep't of Health Care Servs., to All Medi-Cal Managed Care Health Plans (Dec. 12, 2014) (APL 14-017), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf.

[11] CTR. MEDICARE & MEDICAID SERVICES, EPSDT – A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS (2014), http://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

[12] 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396(a)(4)(B), 1396d(r).

[13] ALKER & CHESTER, *supra* note 8; MARYBETH MUSUMECI, KAISER FAMILY FOUND., MEDICAID AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS 1 (2017), http://files.kff.org/attachment/Issue-Brief-Medicaid-and-Children-with-Special-Health-Care-Needs.

[14] *See* CAL. CODE REGS., tit. 22, § 51340.1(e) (home-based services for medically fragile children); CAL. WELF. & INST. CODE § 14132.56 (behavioral health treatment for children with autism spectrum disorders).

[15] Cal. Dep't Health Care Servs., MHSUDS Information Notice No.: 16-004 (Feb. 5, 2016) (Provision of ICC and IHBS as Medically Necessary Through EPSDT), www.dhcs.ca.gov/services/MH/Documents/ICC_IHBS_Through_EPSDT.pdf.
[16] CAL. CODE REGS., tit. 22, § § 51013; CAL. HEALTH & SAFETY CODE § 123805. (The CCS program is a state program for children up to age 21 with certain diseases or health problems. 70% of CCS participants are enrolled in Medi-Cal).
[17] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)
[18] CAL. CODE REGS., tit. 22, § §§ 51151, 51151.7; *id.* § 51323.
[19] 42 U.S.C. § 1396a(e)(4); 22 CCR § 50262.3(b).
[20] CAL. WELF. & INST. CODE §§ 15832(a)(3)(A), 15832(a)(3)(B)(i).
[21] GEORGETOWN CTR. FOR CHILDREN & FAMILIES, SNAPSHOT OF CHILDREN'S COVERAGE: HOW MEDICAID, CHIP, AND THE ACA COVER CHILDREN (2017), http://ccf.georgetown.edu/wp-content/uploads/2017/02/CaliforniaMedicaidCHIP.pdf
[22] JOHN HOLAHAN, ET AL., URBAN INST., THE IMPACT OF PER CAPITA CAPS ON FEDERAL AND STATE MEDICAID FUNDING 10 (2017), www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_2.pdf.
[23] JESSICA SCHUBEL, CTR. ON BUDGET & POL'Y PRIORITIES, MEDICAID HELPS SCHOOLS HELP CHILDREN (2017), www.cbpp.org/sites/default/files/atoms/files/4-19-19health.pdf
[24] Phyllis Jordan, What's at Stake for Schools and Students in Health Care Debate? Georgetown Ctr. for Children & Families: "Say Ahhh!" (Mar. 22, 2017), http://ccf.georgetown.edu/2017/03/22/whats-at-stake-for-schools-and-students-in-health-care-debate/.
[25] SCHUBEL, *supra,* note 23, at 2.
[26] ELISABETH WRIGHT BURAK, GEORGETOWN CTR. FOR CHILDREN & FAMILIES , HOW RESTRUCTURING MEDICAID COULD AFFECT CHILDREN 3 (2017), http://ccf.georgetown.edu/wp-content/uploads/2017/02/Medicaid-funding-caps.pdf.