CenCal HEALTH®
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Medicaid FAQ:

Common Questions on Current Policy Considerations

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General Questions About Medicaid

1. What are Medicaid, Medi-Cal, and CenCal Health?

a. Medicaid is a public health insurance program that provides free or low-cost health coverage to certain groups of people with limited income and resources. It is jointly funded by the federal government and individual states. In California, Medicaid is called Medi-Cal. CenCal Health provides Medi-Cal coverage in San Luis Obispo and Santa Barbara counties.

2. How many Californians are insured through Medicaid (Medi-Cal) in California?

a. Nearly 15 million residents rely on Medi-Cal for access to essential health care. This includes 5.5 million kids, 2.3 million seniors and people with disabilities, and 45,000 veterans, active-duty military or relatives of veterans. Nearly half of California's rural residents get health coverage from Medicaid.

3. How many people does CenCal Health cover?

a. CenCal Health is a Medi-Cal health plan. We are the only Medi-Cal health plan in San Luis Obispo and Santa Barbara Counties.

b. CenCal Health provides Medi-Cal insurance to eligible residents of Santa Barbara and San Luis Obispo counties. We cover over 242,000 people, representing 1 of every 3 residents of Santa Barbara and 1 of every 4 residents of San Luis Obispo.

4. How is Medicaid funded?

a. Medicaid is funded through a combination of state and federal funds. All states rely on the federal and state partnership to jointly fund the Medicaid program.

5. Is Medicaid efficient and cost effective?

a. Yes. California has the 14th lowest per-enrollee Medicaid spending nationwide, when adjusted for cost of living. Medicaid coverage is far less expensive than private health insurance -- 83% less than private coverage.

6. What is the ACA population?

a. ACA refers to the Patient Protection and Affordable Care Act of 2010 (colloquially known as Obamacare). The "ACA Population" typically refers to the population that gained coverage under Medicaid in that bill, which is any American making less than 138% of the Federal Poverty Line. This contrasts against the traditional groups that were covered: pregnant women, children, and people with disabilities. In its simplest usage, "ACA population" or "ACA expansion

population" typically refers to healthy adults between the ages of 18 and 64 years of age.

b. While the ACA didn't explicitly expand coverage to undocumented individuals, many states have chosen to cover at least undocumented children, and several have chosen to cover undocumented adults. In the states that cover undocumented adults, "ACA population" is sometimes used to make a distinction between covered children and covered adults.

7. What is the Expansion Population?

a. The Medicaid expansion population refers to adults under age 65 who became eligible for Medicaid under the Affordable Care Act (ACA) by having household incomes up to 138% of the federal poverty level (FPL). This expansion aimed to provide health coverage to low-income individuals who were previously ineligible for Medicaid. Over 74,000 CenCal Health members are eligible under ACA Expansion.

8. What are the potential impacts to Medicaid currently being discussed in Congress?

a. Medicaid is under the purview of the Energy and Commerce Committee. The Energy and Commerce Committee has been given a cost reduction target of $880B over 10 years. It is believed that such a reduction cannot be achieved without changes to the Medicaid program. Those changes may include the imposition of new requirements, changes in how Medicaid eligibility is determined, or changes in how Medicaid is funded.

9. Is there national support for Medicaid?

a. Yes. Medicaid funding supports nearly 80 million people nationwide, spanning all political viewpoints. The vast majority of the population is in favor of Medicaid, for good reason—It provides health care security to veterans, children, working families, and seniors in nursing homes.

10. Is CenCal Health contracted with the Federal Government?

a. No. CenCal Health operates through a contract with the California Department of Health Care Services.

11. Is CenCal Health changing provider reimbursement in anticipation of any changes being debated?

a. No. CenCal Health is contracted directly with providers and supports local access to care.

Medicaid Policy Issue #1: Provider Taxes

1. What are provider taxes?

a. Provider taxes are taxes that states impose on healthcare providers, such as hospitals, nursing homes, or managed care organizations, as a way to help fund the state's share of Medicaid costs. Federal Medicaid law allows provider taxes as a mechanism to support financing for State Medicaid programs.

b. Provider taxes are in use by 49 states, and each must meet CMS approval before they are implemented. The majority of states have multiple provider taxes, all of which are constructed with the rules prescribed in federal statute and regulations.

2. Why are provider taxes important?

a. Provider tax mechanisms serve as a critical component of the larger Medicaid funding mix that ensures access to care – they support supplemental financing to help bridge the gap so that Medicaid rates can be sustainable and allow investments that promote access to care.

b. Provider taxes allow for increased provider reimbursement, and they keep general taxes on the public low. Without provider taxes, states may be forced to raise taxes on their residents to close financial gaps.

3. How are provider taxes used in California?

a. In California, provider taxes allow for increased Medi-Cal payments via supplemental payments that keep essential providers like hospitals and nursing homes open. In CA, provider taxes represent over $20B in support to the Medi-Cal program.

b. California has multiple approved provider taxes that have been approved by CMS. In some cases, these taxes have been approved for decades and, similar to other states, they have become a core part of how the State finances its Medicaid program.

c. Across all reimbursement, Medi-Cal pays about 80 cents for every dollar it costs for care. Without provider taxes, payments would drop to 70 cents for every dollar.

4. What is the MCO tax?

a. The Managed Care Organization (MCO) tax is levied on health plans that provide services to Medi-Cal beneficiaries. The MCO tax draws down matching federal funds which are then invested by California into the Medi-Cal program.

5. What is Proposition 35?

a. Last November, California voters overwhelmingly voted to approve Prop 35 which invests California's MCO tax funding into the Medi-Cal program to improve access to care.

b. Proposition 35 supports new investments into critical Medi-Cal services delivered by providers, including primary care, specialty care, ER services, inpatient and outpatient hospital services, and other core health care services.

Medicaid Policy Issue #2: Program Integrity

1. What is Program Integrity in Medicaid?

a. Program integrity refers to ensuring that the Medicaid program is efficient and sustainable for the beneficiaries who depend on it. It means ensuring that only eligible members are enrolled, and that instances of fraud, waste, or abuse (FWA) are monitored, reported, and remediated.

2. What is a health plan's role in Program Integrity?

a. Plans have a significant role in guarding against FWA in Medicaid through provider monitoring. Health plans like CenCal Health are subject to audit and other oversight mechanisms to ensure program integrity.

b. Plans monitor that appropriate provider payments are made for medically necessary and coverable services rendered.

3. How does Medicaid eligibility relate to Program Integrity?

a. In some cases, people enrolled in Medicaid may not be eligible for the program. This could be due to issues with income or address verification, for example. Sometimes, a member may also be erroneously enrolled in two Medicaid plans, due to address issues.

4. Does CenCal Health determine Medi-Cal eligibility?

a. No. Medicaid eligibility is determined by the state. Health plans like CenCal Health receive lists of enrolled members each month. Ensuring that only those members eligible for Medicaid are enrolled and that there is not duplication of enrollment is important.

Medicaid Policy Issue #3: Work Requirements

1. What is the concept of work requirements for Medicaid?

a. The imposition of work requirements for Medicaid would mean that proof of work or the active pursuit of work would be required for certain people to be eligible for Medicaid. We don't know specifically what those requirements or specific populations are yet.

2. What impact could work requirements have in California?

a. In California, the majority of Medi-Cal enrollees are already employed, often in seasonal or hourly jobs with fluctuating income and without job-based health coverage. Many of these workers are likely a part of the Medicaid expansion population who would be subject to work requirements and would need to complete regular verification of employment in order to remain eligible for Medi-Cal.

3. Could work requirements cause an entire family to lose benefits?

a. No, work requirements for individuals ages 19 to 64 would not impact coverage for pregnant women, children, and people with disabilities. Furthermore, adults living in the same household will be evaluated for Medicaid eligibility on an individual basis. There are also several proposed exceptions to these requirements, which consider factors like childcare, volunteer work, and school attendance.

4. What ages would be impacted by work requirements?

a. The proposed work requirements would apply to individuals ages 19 to 64 unless they are medically certified as physically or mentally unfit for employment. Exceptions also include individuals who are parents or responsible caregivers for a dependent child under 7 years of age (and in some cases, over 7 years old), pregnant women, students enrolled in school at least half-time, currently homeless individuals, veterans, and those who are 24 years old or younger who have previously been in foster care.

5. Who would implement work requirements?

a. The state and county would have a responsibility to assess and determine eligibility for Medi-Cal, should work requirements take effect.

Medicaid Policy Issue #4: Reproductive Care

1. **What are the potential changes to reproductive care from the House bill and Executive Orders?**
    a. The language in the House bill prohibits federal funding of "prohibited entities." This is defined as entities which primarily provide family planning services, reproductive health, and related medical care; provide for abortions other than those needed in specific cases; and for which the total amount of Medicaid expenditures is over $1M annually. If this provision remains unchanged, it will pose an existential threat to Planned Parenthood – which is often the sole provider of reproductive care in many communities. This could dramatically impact access to care even in states where abortion is legal.
    b. The previous administration issued two Executive Orders to mitigate the impact of the overturn of Roe v. Wade. However, the current administration revoked both of those EOs and froze Title X funding to health clinics nationwide. Title X is an important funding source that supports affordable family planning and preventive health services for low-income individuals.

Where can providers learn more? CenCal Health maintains a Policy Pulse website where you can access fact sheets, articles, and general information. ***https://www.cencalhealth.org/policypulse/***