CALIFORNIA'S UNINSURED: PROGRAMS, FUNDING AND POLICY OPTIONS

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INTRODUCTION

This is a background paper for the California Health Foundation on California's efforts to cover the uninsured and fund safety net providers. The first section of the background paper will cover those efforts which passed the legislature and have been implemented in California and their impacts in covering the uninsured and/or funding safety net providers.

SECTION 1. PROGRAMS PASSED AND IMPLEMENTED.

Between 1982 and 1997, a series of incremental program changes made major shifts in the financing and delivery of care for the uninsured in California.

- Federal financing replaced much state and local funding;
- State funding changed its emphasis from covering individuals to financing safety net providers; and
- Financing of care to the uninsured was tightly tied to hospitals and emergency rooms at the same time that the insured population, increasingly covered by managed care plans, received more of its care in outpatient settings.

Over the past 15 years, Californians' health coverage moved away from private insurance towards expansion of Medi-Cal eligibles and growth in the uninsured. At least in terms of legislation passed and programs implemented, state health policy did relatively little to shore up the deteriorating private employer based health market. By contrast on the public side, there has been a significant and underappreciated growth in
programs, coverage and funding for MediCal and the uninsured. Safety net providers and hospitals have been the prime beneficiaries of these changes.

In this section, we will discuss California's programs for the uninsured in the following order:

- County health including the Medically Indigent Adults (MIAs), realignment, and Disproportionate Share Hospital (DSH) funding;
- Financing for private providers including DSH, Federally Qualified Health Centers and other funding programs;
- The roles of MediCal, Access for Infants and Mothers (AIM), Child Health and Disability Prevention (CHDP) and other state programs in paying for care to the uninsured; and

A. FUNDING FOR COUNTIES

The following are the primary sources of state and federal funding for county health:

1. MIA transfer and realignment
2. DSH and SB 1255
4. Prop. 99
5. SB 910 (MAC)
6. §1115 waiver for Los Angeles County
7. Mental health devolution

COUNTY OVERVIEW

Counties are the historic and legally mandated level of government in California responsible for delivering health services to the poor who have no other coverage. Counties spend at least $1.4 billion on care to the uninsured. Essentially counties are responsible under state law for the uninsured poor with incomes below poverty; this is about one third of the uninsured.

Overview of County Programs for the Indigent Uninsured
<table>
<thead>
<tr>
<th>County Type</th>
<th>Counties</th>
<th>Role/Organization</th>
<th>Eligibility</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small, rural counties; &quot;County Medical Services Program&quot; (CMSP)</td>
<td>34 counties with populations of less than 300,000</td>
<td>State purchaser: DHS operates &quot;mini-MediCal&quot; fee-for-service (FFS) program</td>
<td>Income and asset requirements same as MediCal</td>
<td>Funding from tobacco tax, realignment, and Emergency Medical Services (EMS/SB 12) funds; and in some counties, discretionary &quot;county overmatch&quot; funds. Rural Health Services (RHS) counties may contract back with DHS to administer their programs.</td>
</tr>
<tr>
<td>Large, &quot;private provider&quot; counties; no public hospital; Medically Indigent Services Program (MISP)</td>
<td>Orange Sacramento San Diego Fresno</td>
<td>Purchasers only: contract with private providers -- either FFS, contracts or managed care</td>
<td>MediCal-style eligibility and enrollment; limited to indigent with no categorical link</td>
<td>In addition to the above funding, most large counties receive SB 910 funds. Tobacco tax funds have declined, and realignment has grown slowly. Realignment is from a base that was set 20</td>
</tr>
</tbody>
</table>
California counties fall into three categories: the small rural counties, the large counties without a county hospital and the public hospital counties. Each type of county operates very different programs.
a. The small rural counties

34 small (populations below 300,000) rural counties' health programs are operated by the state as a traditional Medicaid fee for service program with limited benefits. These counties are referred to as CMSP (County Medical Services Program) or "contract back" counties. The state is at financial risk for any cost over runs.

b. The large counties without a county hospital

"Private provider counties", such as Orange, Sacramento, San Diego and now Fresno, have closed their county hospitals. They contract with and reimburse private hospitals, community clinics and private physicians who deliver services. Their indigent care programs are financed with funds from Proposition 99 and realignment (the transfer to the counties of a portion of the state sales tax and the vehicle license fees). Most such counties limit their county financial contributions to what is required by state matching and/or maintenance of effort rules.

The "private provider" counties are hamstrung financially by "funding equity" and by the decline in tobacco tax and slow growth in realignment revenues. The equity issue occurs because the base of state funding for county health services was set in the late 70s and early 80s with no or minimal adjustments for population growth and demographic changes since then.

Some county programs, such as Orange, have historically passed through the state revenues as they receive to local providers to support their care to the uninsured in emergency rooms. Others, such as San Diego, have tested managed care models for the uninsured and contracting with local community clinics as the focal points of an organized delivery system for the uninsured. "Private provider" counties typically limit those eligible for care to uninsured indigent county residents, not otherwise categorically eligible for MediCal. The ex-public, now University of California, hospitals still deliver most care to the uninsured in those counties.

c. The public hospital counties

The large "public hospital" counties (such as Alameda, Santa Clara, San Francisco, Los Angeles, San Bernadino and Riverside) have access to a broader funding base and maintain dual roles as providers and purchasers of care. As providers of care, they deliver care in county owned hospitals and clinics. As purchasers of care, they contract with private providers, including private physicians, hospitals and clinics for care to the uninsured. Alameda County, at one extreme of this spectrum, contracts quite extensively with community clinics. Santa Clara, San Francisco and Los Angeles have historically contracted with only a few private providers and deliver most services through their own facilities. Contra Costa County developed an organized HMO delivery system for its Medically Indigent Adults. Most of the larger "public hospital" counties do not have MediCal style eligibility systems and do not issue eligibility cards, but rather determine eligibility and any financial responsibility episodically when care is sought.
The overall demand for county health services is fueled by the growing numbers of uninsured. County hospital counties have access to and very heavy reliance on a far broader revenue base -- MediCal and DSH revenues -- to support their role in caring for the uninsured than do the private provider counties. Private hospitals rely on and compete for the same DSH and MediCal revenues. The public hospital counties are financially troubled by a losing competition with the private hospitals for Medi-Cal patients and DSH revenues and by excessive reliance on a costly hospital based approach to caring for the uninsured.

Financing Shifts

The passage of Proposition 13 sharply limited counties' ability to raise revenue from the property tax, and left them increasingly dependent on state and federal government revenues. In Los Angeles County, for example, 20% of the county health departments' revenue base was from county taxes in 1980. By 1995, this percentage was 6%; the total dollar allocation from county tax revenues had not increased over the ensuing next 15 years. Correspondingly, federal Medicaid (MediCal) revenues were 20% of the county's health budget in 1980 and had increased to over 50% by 1995; DSH is a large component of the counties' MediCal revenues.

### Legislation Relevant to the Uninsured: Counties and Private Providers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 8</td>
<td>1979</td>
<td>State allocations to counties for indigent health care and public health services, based on 1977-78 funding levels with annual cost of living increase, county matching requirements.</td>
</tr>
<tr>
<td>AB 799</td>
<td>1982</td>
<td>Transfer of Medically Indigent Adult (MIA) responsibility from the states to the counties, at 70% of state funding level.</td>
</tr>
<tr>
<td>SB 1732</td>
<td>1986</td>
<td>Construction and Reimbursement Program; provides additional payments to DSH hospitals related to capital construction costs.</td>
</tr>
<tr>
<td>SB 12</td>
<td>1987</td>
<td>Emergency Medical Services (EMS) funded by a $1 penalty assessment (increased to $2 in 1988) on moving vehicle violations. Most counties have adopted discretionary assessment. Distribution 58% to physicians, 25% to hospitals, 17% to counties; model for Proposition 99 Physician Service Account funding structure.</td>
</tr>
<tr>
<td>Prop 99</td>
<td>1988</td>
<td>Voter initiative for a 25-cent increase in the tobacco tax for funding care for the uninsured.</td>
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<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AB 75</td>
<td>1989</td>
<td>Established distribution formula for Proposition 99 funds. Funds AIM, MRMIP, and part of CHDP; also pays counties, private hospitals, community clinics and physicians for care to the uninsured.</td>
</tr>
<tr>
<td>SB 855</td>
<td>1989</td>
<td>Disproportionate Share Hospital funds from Medicaid. DSH funds provide significant subsidies to cover the costs of hospitals' uncompensated care for the uninsured. The CA legislation provides that county health dollars are used as match for federal DSH dollars.</td>
</tr>
<tr>
<td>SB 1255</td>
<td>1991</td>
<td>Disproportionate Share Hospital funds from Medicaid. DSH funds provide significant subsidies to cover the costs of hospitals' uncompensated care for the uninsured. The CA legislation provides that county health dollars are used as match for federal DSH dollars.</td>
</tr>
<tr>
<td>AB 948</td>
<td>1991</td>
<td>Realignment: Transferred state funding source for care for the uninsured to counties -- state sales tax and vehicle license fee. Requires county partial match (&quot;county overmatch&quot; , beyond the match required under AB 8) for indigent health.</td>
</tr>
<tr>
<td>SB 2098</td>
<td>1991</td>
<td>Conforms EMS fund provisions to those of Prop. 99; establishes more favorable reimbursement provisions for private physicians.</td>
</tr>
<tr>
<td>SB 910</td>
<td>1991</td>
<td>Medicaid Administrative Claiming and Targeted Case Management; federal reimbursement for administration and case management provided by county staff and contractors for MediCal recipients or applicants. County pays the match and is at risk for federal disallowance.</td>
</tr>
<tr>
<td>1115 waiver</td>
<td>1996</td>
<td>LA County receives a federal §1115 waiver to pay for outpatient services for the indigent uninsured. 1115 waivers must be budget-neutral for the federal government; savings to pay for increased match to come from reducing county hospital care. The county (not the state) must pay the match.</td>
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</tbody>
</table>

Throughout the 1980s and again during the 90's long recession, "state only" revenues for health care (such as the MIA and AB 8 funding streams) were steadily whittled down by state government and lost ground to health care inflation as well. Public hospital counties and private providers became heavily dependent on MediCal funding to care for the uninsured. Since 1990, the state has expected the counties to come up with the requisite Medicaid match (e.g. MediCal DSH, SB 910 and mental health devolution) -- a function which previously resided with the state.
A fierce competition now exists between public and private hospitals for MediCal patients and DSH revenues. In general, the "public hospital" counties have feared expansion of managed care because of the potential impacts on the distribution of the DSH dollars. They believe counties must control the design and implementation of MediCal managed care in order to preserve the financial viability of their own institutions.

Counties have piled up a string of successes in Sacramento, the overall impact of which has been to concentrate more federal and state dollars within county control. For the most part counties have been able to avoid any new responsibilities associated with the new revenue flows. State oversight over county health programs has generally diminished.

County Health also suffers funding cuts and shortfalls nearly every fiscal year. State government typically allocates new federal revenues with one hand while taking away existing "state only" funding with the other. County Boards of Supervisors balance their budgets and budget priorities in the same fashion. An increase in federal or state tax revenues for care to the uninsured may end up with a diversion of existing county health funding to state prisons, social services, or the local Sheriff's Department.

**COUNTIES: REALIGNMENT, THE MIAs AND THE UNINSURED**

*a. MIAs*

Prior to 1982-3, the state operated a "state only" financed program within MediCal for the Medically Indigent Adults (MIAs), those working poor and unemployed and homeless adults who due to federal law are ineligible for federal matching under Medicaid. In 1982-3, California, in response to a fiscal crisis brought on by severe recession, transferred responsibility for the MIAs to the counties at 70% of the state's funding base. Counties such as Los Angeles supported and funded this transfer in order to receive the state funds without complying with state strictures on eligibility, benefits, provider participation and reimbursement rates.

At the time of the transfer, uninsured single adults (who had no categorical linkage to federal Medicaid) with incomes below the poverty line were eligible for MediCal. Adults above the poverty line (who had medical expenses which reduced their incomes below poverty) were also MediCal eligible under the "spend down" or share of cost category. In 1982, there were 250,000 persons eligible for MediCal as MIAs. For the most part the state was paying for hospital care, 80% of spending, at a cost of roughly $750 million.

Counties initially received funding at an annual level of $523 million. The public hospital counties for the most part kept the new funds and the MIA patients within their own county hospital systems-- roughly 90% was spent on hospital based care. The private provider counties paid private hospitals, doctors and clinics on a capitated basis (San Diego), on a fee for service basis (Orange) or through a combination of contracts and
fee for service payments (Sacramento). In the small, rural (CMSP) counties, providers continued to be paid on a fee for service basis by the state.

By 1989, the counties' annual MISP (Medically Indigent Services Program) allocations had been pared back by a series of gubernatorial budget vetoes to $233 million. County health departments had a second state source of funding--the AB 8 program, established at the state level in 1979 after the passage of Prop 13. This program gave counties state funds for both indigent and public health based on their historic funding levels in 1977-8. The program was protected from the annual budget battles by a statutorily established COLA and funding base. By 1989, AB 8 funding had grown to over $400 million.

b. Realignment

AB 8 and the residual MIA allocation were combined as part of "realignment" -- the state tax subvention of one half cent on the sales tax and a portion of vehicle license fees. Realignment was divided among county health, mental health, and social services. The projected approximate value of the realignment subvention for county health services was $940 million. However, due to the downturn in the economy, the amounts actually received by the counties in 1991-2 were $833 million. By 1997-8, realignment revenue had grown to $1.15 billion.

Realignment removed the county health budget from the vagaries of Sacramento's annual budget wars and eliminated the minimal state oversight of counties' health spending. One of the quid pro quos for realignment was that counties were required to maintain a certain amount of match, a requirement which originated with the AB 8 subvention. Counties were required to report comparable data on the use of their county health systems through the MICRS data system.

County health systems today rely on a reshuffled mix of federal, state and county funding to provide health care and treatment in their systems. The principal revenues available to the counties to care for the uninsured include: $1.15 billion in "realignment," $333 million in state tobacco tax appropriations (Proposition 99), $480 million in county General Funds and $1.1 billion in federal MediCal disproportionate provider funds (SB 855 and SB 1255). Some of these state and federal funds go directly to counties for care to the uninsured, while others go directly to private providers bypassing county government, as is discussed later in subsection B.

A portion of the county health revenues are used for public health, a portion for county indigent health to the uninsured and a portion for care and treatment of MediCal, Medicare and other insured patients. At least $1.4 billion is devoted by counties to health care for the uninsured, as opposed to public health or care to MediCal patients.

Counties spend local tax dollars (county General Fund) to support county indigent health. Some are "mandatory" (about $341 million) in order to receive the state subventions; some are discretionary with the county, often referred to as "county overmatch." About $143 million of county health spending is "discretionary" -- i.e. county overmatch appropriated by county Boards of Supervisors.

The impact of the MIA transfer and realignment has been to revitalize moribund and decaying county health departments who had lost a sense of mission. The MIA transfer also significantly increased occupancy rates in county hospitals.
### Revenue Sources for County Uninsured

<table>
<thead>
<tr>
<th>Description</th>
<th>Funding Source</th>
<th>Funding Recipient</th>
<th>Beneficiaries</th>
<th>Intent</th>
<th>Amount (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB 855 DSH supplement to Medicaid payments; and SB 1255 supplements for emergency services</td>
<td>Federal dollars, matched by public hospital dollars</td>
<td>Hospitals serving a high percentage of MediCal and uninsured</td>
<td>Hospitals</td>
<td>Fund uncompensated care to uninsured</td>
<td>Federal $ to 123 DSH Hospitals: $363 M to private, $327 M to county, $35 M to districts (1997) +$342 M from SB 1255 to 67 hospitals</td>
</tr>
<tr>
<td>Prop 99 Tobacco Tax</td>
<td>State taxes on sale of tobacco products</td>
<td>MRMIB, CHDP, Hospitals, PhysiciansCounties</td>
<td>Providers of care to uninsured; Health education</td>
<td>&quot;Sin tax&quot; funds for health education, research, care to the uninsured</td>
<td>$494 million (1997-98 proposed)</td>
</tr>
<tr>
<td>Realignment</td>
<td>State vehicle license fees and sales tax; replaced state funds</td>
<td>Counties, for health and social services</td>
<td>Providers of care to indigent uninsured</td>
<td>Establish dedicated revenue source for indigent health care</td>
<td>$1.15 billion (1997-98 estimate)</td>
</tr>
<tr>
<td>County General Funds</td>
<td>Counties</td>
<td>County health departments or private providers</td>
<td>Providers of care to indigent uninsured</td>
<td>Augment federal and state funding</td>
<td>$480 million (1996-7)</td>
</tr>
</tbody>
</table>
**SB 855, DISPROPORTIONATE SHARE HOSPITALS (DSH)**

Disproportionate share hospitals are those which serve a high percentage of MediCal and uninsured patients. Those hospitals with a heavy share of uncompensated care (care to the uninsured and below cost reimbursement from MediCal) were felt to be burdened by their inadequately funded mission to serve the poor and thus unable to compete in the emerging competitive health market. The federal and state government's response was a program of funding for disproportionate share hospitals (DSH).

The initial California DSH allocations were approved as modest $25 and $50 million augmentations; the state matched federal contributions. Other states used provider's donated funds as the match and vastly inflated their federal funding streams. California followed the leaders, using public hospital dollars (county, district and University of California hospitals) to provide the match in order to avoid subsequently enacted federal restraints on using the donated funds of private hospitals. County, UC and District hospitals finance the DSH program through local certified public expenditures of $1.2 billion.

SB 855 (Robbins) in 1990 provided nearly $1.1 billion in increased annual federal MediCal funding for disproportionate providers, those hospitals with an unduly large share of low income (MediCal and indigent uninsured) patients. California now pays heavy subsidies to qualifying hospitals on top of the basic daily rates already negotiated with the California Medical Assistance Commission.

The DSH subsidies reimburse hospitals well in excess of costs of treating a MediCal patient in order to assist the hospital with the heavy financial burdens of caring for the uninsured. Under DSH, 123 California hospitals now qualify to receive payments for the costs of caring for the uninsured. The 1997 California Medical Assistance Commission Annual Report to the Legislature reports that private hospitals receive $363 million under DSH, county hospitals receive $327 million and University of California and District Hospitals receive $35 million.
The incentives created by DSH subsidies, however, have become frightful. They encourage the delivery system: 1) to treat patients on an inpatient rather than outpatient basis, 2) to further concentrate MediCal patients in public and private disproportionate share hospitals, 3) to crowd out uninsured patients from private facilities, and 4) to lock the distribution of patients and revenues into the most costly delivery settings. Ironically, the DSH incentive to centralize treatment of the indigent in hospital settings occurs at the same time as the state seeks to transition MediCal patients in its largest counties into managed care -- where the incentives are to move patient care out of hospitals and into outpatient settings.

The distribution of SB 855 funds is based on a state legislative formula. A facility's DSH payment is based on the percentage of MediCal and uninsured inpatient care to all inpatient care in that facility, and on the facility's amount of uncompensated care for MediCal and the uninsured to the statewide total. This appears fair and equitable, but over time it locks in perverse results. For example, the data indicate that the private hospitals are increasing their share of DSH funding, increasing their share of MediCal patients and decreasing their share of uninsured patients. Public hospitals' share of DSH is falling; their share of MediCal patients is declining, and their share of care to the uninsured is increasing.

Other problems with SB 855 are that it has built in disincentives to hospital downsizing. For example in the context of the Los Angeles County health care crisis, closing a public hospital would have meant a loss to the county of that facility's SB 855 funding. Under the DSH formula, federal DSH funds would then be redistributed to other facilities around the state. The county would still be obligated to pay its DSH match, but receive no benefit.

California's DSH program has the following flaws:

- In the distribution formula, a MediCal day for which a hospital receives a contracted payment rate is treated the same as an uninsured day for which the hospital often gets nothing;
- Hospitals are paid well over costs for MediCal days, and well under costs for uninsured indigents;
- DSH is limited to hospital based care (the most costly way to deliver services);
- Not enough of the DSH dollar goes to care for care to the uninsured; this is particularly true in private sector hospitals; and
- It has strong disincentives to downsizing public hospitals.

**SB 1255, RATE AUGMENTATIONS FOR EMERGENCY AND TRAUMA CARE HOSPITALS**

SB 1255 (Robbins) was also sponsored by Los Angeles County. It requires a county match and the funds go to public and private DSH hospitals. SB 1255 is limited to those DSH facilities which maintain emergency rooms and trauma centers -- 67 hospitals. SB 1255 rate augmentations are entirely discretionary with CMAC (the California Medical Assistance Commission), the state entity which negotiates MediCal reimbursement rates with each individual hospital. It is impossible to assess what is being achieved by SB 1255 because CMAC rate negotiations are not public. County facilities prefer the SB 1255 mechanism to SB 855 because they are not required to fund the match for their private competitors. The overall federal funding level for SB 1255 is about $684 hundred million in 1996-7, of which half are federal funds and half are the public match. County hospitals receive about 80% of SB 1255 funds. The federal bailout ($364 million) of Los Angeles County was distributed through the SB 1255 mechanism.

**PROPOSITION 99, THE TOBACCO TAX**
Proposition 99 was passed in 1988 by California voters as a twenty-five cent increase in the tobacco tax to serve both as a disincentive for smoking as well as to provide a new source of funds to improve delivery of care to the uninsured. Proposition 99 was implemented at the state level by AB 75 (Isenberg). This was to be a temporary funding allocation as the legislature wrestled with a longer term reform strategy. The initial allocation has persisted with few changes to date.

The initial $500 million in new health care funds went directly to counties, private hospitals and doctors, primarily for emergency and trauma care to the uninsured. This has diminished over time to $338 million in proposed health spending in 1997-8 due in part to the reduction in smoking. Due to the growth in Prop 99 funding for Access for Infants and Mothers (AIM) and the Major Risk Medical Insurance Program (MRMIP) for the medically uninsurable ($84 million), the direct county health component has declined to only $179 million. $13 million, is devoted to primary and preventive care in community clinics, and $51 million is allocated for preventive CHDP exams for children with incomes up to 200% of poverty.

Prop 99 required that the new initiative funds be used to supplement rather than supplant existing funding for the uninsured. Due to compromises in the authorizing legislation, the funds were primarily used by the state, county governments, private doctors and hospitals to replace existing state, county, and private levels of financial commitment.

Prop 99 failed to fund a balanced delivery system for the uninsured by requiring the counties and private providers receiving the new funding to collaborate in developing integrated public/private systems of care for the uninsured. At the time each side was unwilling to do so; that may change.

**SB 910, TARGETED CASE MANAGEMENT (TCM) AND MEDICAID ADMINISTRATIVE CLAIMING (MAC)**

Realignment, DSH and Prop 99 pay providers primarily for care to the uninsured. SB 910 pays for administration and case management.

SB 910 (Medicaid Administrative Claiming and Targeted Case Management) allows a local government agency to claim MediCal FFP for:

- helping individuals access the MediCal program or its services,
- monitoring the delivery of TCM services
- case finding, assessments, case planning and case coordination
- guidance with complex medical needs and medical consultation
- provider relations, resource development and quality management
- interagency coordination, program planning and development
- staff training and general administration. W&I §14132.47
SB 910 funds can be used for both MediCal recipients and the uninsured applying for MediCal. The caveats are: 1) the local agency must pay the match and a state administrative fee and be at risk for any federal audit disallowance; 2) the "administration" must be a necessary part of the administration of the Medicaid program; and 3) the local agency must keep records and/or time studies to identify the costs being claimed and assure there is no double billing.

The Los Angeles County health crisis of 1995 was in large part precipitated by an overly optimistic assumption of SB 910 revenues -- $655 million. The federal government disallowed much of Los Angeles County's claim because it failed to comply with federal MAC standards, finding the claim was double billed or for covered medical services rather than for administration. More recently, California's counties have been less aggressive and more successful in claiming under SB 910. The 1996-97 DHS budget estimates included $20 million for MAC and $40 million for Targeted Case Management.

**LOS ANGELES COUNTY §1115 WAIVER**

The Los Angeles County waiver is the first time that federal Medicaid matching funds have been made available for outpatient care to the uninsured in California. A number of other counties are seeking similar waivers from HCFA (the federal Health Care Financing Administration) without much success.

At the time of the crisis, Los Angeles County Department of Health Services free standing (outside of the hospital) outpatient services to the uninsured comprised only about 5% ($100 million) of the total costs of the county health system. Two thirds of the patients at these clinics are uninsured; by way of contrast about one third of LA County's inpatient care is for the uninsured. As explained above, DSH pays for care to the uninsured in hospitals, but the net effect of the state and federal DSH rules is such that the county cannot use DSH dollars or shift care into the free standing outpatient clinics without losing the federal match. The county can however use DSH for hospital outpatient and emergency room visits which is where the bulk of the county's outpatient services were delivered.

The Los Angeles Waiver contains the following key provisions:

- Federal Medicaid matching payments will be available for outpatient services to the indigent at county clinics, contract clinics and county hospital outpatient departments.

Nearly two thirds of the patients are uninsured and unable to pay at Los Angeles County outpatient clinics. The projected federal revenues from this aspect of the waiver were estimated at $40 million, but they could be much larger depending on how the county chooses to transform its system. Los Angeles County has chosen to limit financial eligibility for free care in its clinics to persons with incomes below 133% of poverty. Federal matching is not available for the undocumented.

- An interagency agreement between the State and the County regarding funding of indigent care in hospital settings.

This relates to the calculations of a hospital's cap under the DSH program. While obscure, this is significant in California; it means that the county hospital can claim credit under the federal DSH cap
for the match paid by the county for private hospitals' DSH payments under SB 855. The estimated value of this aspect of the waiver is $100 million. The 1997-8 federal Balanced Budget Act gives all public hospitals in California additional room under the federal DSH cap.

- Los Angeles County may transfer the federal and its own county contributions for DSH in its own hospitals from inpatient to outpatient care (delinkage from MediCal inpatient days).

In California, DSH is calculated based on an individual facility's share of the total statewide inpatient days of care to the MediCal and uninsured. If a facility reduces its inpatient days, it loses the DSH revenues to a competitor. This aspect of the waiver would have allowed the county to reduce its own inpatient days and transfer the DSH savings to expanding outpatient care. This would require a change in state statute as well as the §1115 waiver. As yet the federal government has not approved this aspect of the waiver. It is critical to Los Angeles and other counties who are seeking to restructure the imbalance between inpatient and outpatient care.

- The growth in federal Medicaid spending over 5 years for the Los Angeles County Department of Health Services will be limited to its federal base spending in 1994-5 plus an agreed upon inflation factor (10%).

A §1115 waiver must be budget neutral to the federal government. Over the past five years, the growth in federal Medicaid spending in the Los Angeles facilities had been nearly 20%, in contrast to a statewide growth rate of about 10% of which half is due to case load growth.

- In order to receive federal matching payments, county must 1) deliver services to MediCal and indigent patients and 2) meet the 50/50 match requirements (state will not finance the waiver).

LA's §1115 waiver will not set up a capitated, county organized delivery system under which a county system would be able to redirect any savings it realizes from eliminating unnecessary care. The Los Angeles County system, but for implementation of the strategic plan as will discussed later, will continue to be largely fee for service. To earn the new federal MediCal revenues, the county must deliver services to the county's indigent.

Under the waiver, LA DHS will now have federal matching payments available for care to the low income uninsured in its outpatient clinics as well as its hospitals, but the county itself (not the state) must pay the match. The lack of county matching revenues to exploit this opportunity is the Achilles heel of the waiver.

Los Angeles County: Before and After

The following describes Los Angeles County Department of Health Services prior to the waiver:

- Budget of $2.2 billion; ‘95-6 Budget shortfall of $655 million
- 6 hospitals, about 2,500 beds and 900,000 patient days annually,
- 6 comprehensive health centers, 39 health centers and 6 hospital outpatient departments,
- about 3 million visits,
- Recent studies indicate an unmet need for an additional 5 million visits for the uninsured,
and that, as compared to a HMO style of delivering services, the county is excessively reliant on inpatient care.

Since ‘82, county outpatient visits doubled, while inpatient hospital use was up 2.6%.

To date the County has contracted with 160 private providers to deliver outpatient and preventive services and reduced its own public free standing clinics from 39 to 26. The County plans to increase its ambulatory care visits by 50% and reduce its hospital beds from 2,500 to 1,500. The bed reductions will be achieved by privatizing Rancho Los Amigos and High Desert Hospitals and by rebuilding County USC at 600 beds or less.

The opportunities for further transformation of the Los Angeles County system under the §1115 waiver are as follows:

- expansion of outpatient and preventive care through cost effective public private partnerships,
- reductions in inappropriate use of county hospital emergency rooms, preventable hospital utilization and ultimately hospital beds, and
- restructuring from a centralized hospital-based system to a decentralized, integrated system with an emphasis on ambulatory, primary and preventive services.

**COUNTY SHORT DOYLE, REALIGNMENT, EPSDT, THE REHAB OPTION and MEDI-CAL MATCHING**

**Overview**

California counties now have the obligation to provide mental health services for both uninsured and MediCal patients. Over the past 15 years funding and programmatic responsibility for mental health has entirely devolved from the state to the counties. Prior to 1982, the state had primary responsibility to fund and provide for institutional based care (which was shrinking) while counties had responsibility for community based services to the uninsured indigent through the state funded Short Doyle program. The state also paid for county treatment of MediCal eligibles (MediCal Short Doyle) and paid private hospitals, psychologists and psychiatrists as a part of MediCal fee for service. During the 1980s, state and federal funding for mental health grew while county funding declined in importance.

Initially, the responsibility for organizing mental health care for the uninsured was shifted to the counties; ultimately the fiscal flexibility to reconfigure care for the MediCal population has been transferred as well. As part of "realignment", counties received funding and responsibility for institutional care to the uninsured. Next the funding and responsibility for MediCal fee for service institutional care was shifted to the counties. During 1997-8, counties are proposed to receive the funding and responsibility for MediCal fee for service outpatient care. The net result is that counties are able to consolidate care and treatment for the uninsured and MediCal populations in a single system. They are able to integrate both institutional and community based care and to create coordinated delivery systems using both public and private providers.

Consolidation and devolution has come at a price -- the state funding level is capped. Each county's MediCal and realignment allocations are capped at the program's growth rate. There is no new state money available, thus counties are for the most part responsible to develop their own resources to match federal Medicaid funds.
MediCal mental health coverage had been split between a standard fee for service program (for private hospitals, psychologists, psychiatrists and other private practitioners) and the MediCal Short Doyle program which paid for county mental health services. A provider with a Short Doyle contract could only bill Short Doyle; it could not also bill MediCal fee for service.

Reimbursement for outpatient care was grossly disproportionate between the two systems. Short Doyle MediCal rates are negotiated as a contract between the provider and the county Department of Mental Health for a specific volume of services. The advantage to billing through Short Doyle is generally a higher fee. For example, a mental health assessment can be contracted with a county DMH at up to state's maximum rate of $166 per assessment. The negotiated rates would not be hourly rates, but rather a global fee for each assessment up to the contract maximum. By contrast, the MediCal fee for service reimbursement is about $29 an hour for testing, case conferences, assessments and individual treatments and $39 an hour for family therapy. Counties face the challenge of integrating private practitioners into the county delivery system, and developing a payment structure and methodology for reimbursement of outpatient services which does not bankrupt their systems.

Alternative Delivery Structures and the Medicaid Rehabilitation Option

California is one of a number of states which authorize billing for mental health treatment services under the Medicaid rehabilitation option. The rehab option has no significant restrictions under the federal statute and regulations. Services can be provided off site; there is very little definition to the covered service; there are no limitations as to who may provide a rehabilitation service, and there are no requirements that it be delivered by or under the supervision of a physician or even that the physician have prescribed or approved the course of treatment.

Under California statute, the rehabilitation option is similarly undefined. The mental health statute and regulations offer a wide open application of the rehab option; counties pay the match for MediCal Short Doyle services with a combination of realignment and other state and county funding.

An entity seeking reimbursement for mental health rehabilitation services would need to negotiate the requisite local match with county DMH, the reimbursement rate and methodology of payment for treatment services, the criteria for utilization, the authority to deliver services, the standards for services, who is responsible for auditing to see that services are actually delivered, and who is financially responsible for any federal audit disallowance.

The state (rather than county) pays the MediCal match on EPSDT supplemental mental health services for children

The only exception to the basic premise that the county pays the match for mental health is for
EPSDT "supplemental services" (i.e. uncovered mental health services for children) recommended pursuant to an EPSDT examination. DHS regulations specify that financing EPSDT supplemental services, unlike the rest of the MediCal Short Doyle program, is a state responsibility. This shifts the financing burden to the state for a very limited set of supplemental mental health services.

Under California's regulations, "EPSDT supplemental services" are in the first instance stated in an open ended fashion defined by mirroring the language of federal law. However "EPSDT supplemental services" are then limited as follows: 1) they are subject to prior authorization with eight separate documentation requirements, and 2) they are subject to ten different criteria for establishing medical necessity. At present, county mental health services after an EPSDT screen are not subject to these restrictions.

B. FUNDING FOR PRIVATE PROVIDERS

In this subsection we discuss the following programs and financing:

1. Uncompensated care
2. DSH -- SB 855 and SB 1255
3. PROP 99
4. SB 12 (Maddy)
5. FQHC

OVERVIEW

Private providers are not obligated to deliver services, other than emergency care, to the uninsured. In the aggregate, they provide a large volume of free or low cost care to the uninsured, though as individual providers, the uninsured are a small percentage of their total patient load. Typically, the uninsured account for less than 3% of private hospital patients, in contrast to 20% of public hospital patients. A few private providers (particularly, certain private hospitals and some community clinics) provide a large volume of care to the uninsured.

Federal and state laws require hospitals which operate emergency rooms and trauma centers to treat patients in an emergency regardless of their ability to pay. Physicians in hospital emergency rooms or on call to the hospital are also obligated to provide emergency care. For the most part the recent changes in federal and state law were designed to pay hospitals and doctors for the services which they are obliged to provide. These changes were a response to the furor over patient dumping (the practice of turning away the uninsured in emergency situations) and the closure of hospital emergency rooms and trauma centers (particularly in Los Angeles County). With the exceptions for
emergency care, which will be discussed, little state, federal or county funding is earmarked to pay for care to the uninsured in private provider settings.

**HOSPITAL BASED UNCOMPENSATED CARE FOR CHARITY CARE AND BAD DEBTS**

When a hospital or other provider provides care and treatment to a patient with no health coverage and no ability to pay for care, this is referred to as "charity care". When the treatment is provided to a person with some ability to pay or with coverage, but no payment is made, this is referred to as "bad debt". As a practical matter, hospitals do not consistently label nonpayment as bad debt or charity care, but rather label all nonpayment as "uncompensated care."

In California, the amount of uncompensated care for bad debt and charity care in hospitals is about $762 million or 2.7% of hospital expenses. Physicians and other providers also provide uncompensated care but there are no routine state wide records for such costs other than in hospital settings. Many physicians will provide below cost care or accept partial payments from existing patients who are temporarily uninsured, but only a very few would accept a new patient with low income and no coverage.

Uncompensated care is not evenly distributed among hospitals. Much of it occurs in public hospitals; which make up less than 14% of California's hospital costs. California has a far lower rate of hospital uncompensated care (2.7%) than the national average (5%). Among private hospitals, uncompensated care is unevenly distributed. Its distribution is a function of a hospital's location and the hospital's voluntary choice to maintain a trauma center or an emergency room.

Since 1982, California law has allowed private carriers to selectively contract and negotiate rates with hospitals and other health providers. During this time frame, the burden of paying for uncompensated care in California's private hospitals quietly shifted from private sources (cost shifting to employer based health insurance) to public resources, such as DSH, Prop 99 and SB 12, discussed later in this subsection.

**Trauma centers and emergency rooms**

Uncompensated care primarily occurs in emergency settings such as hospital emergency rooms (ERs) and trauma centers. Trauma centers are distinguished from other ERs because they have surgical areas dedicated to trauma care and a full complement of specialists such as neurosurgeons and orthopedic surgeons promptly available 24 hours a day to treat the most serious emergencies, usually injured victims of crime, auto accident, stroke or natural disaster.

In some private hospitals as many as 50% of the patients entering the emergency room or trauma center are uninsured, thus creating a severe financial burden on the hospital and doctors involved. Under state and federal law, all patients facing a medical emergency are guaranteed access to any hospital's emergency services, but a hospital is not required to operate a trauma center or emergency room. Therefore, when a facility or its doctors decide that the fiscal stress is too severe, they simply close the trauma center or emergency room.

Over the last decade in Los Angeles County, 12 of 23 trauma centers closed -- leaving vast areas of the
without timely access to trauma care. Problems with access to trauma care were not unique to Los Angeles; other counties, such as Sacramento and Alameda, had difficulties finding private hospitals willing to accept trauma center designation. The combination of DSH, Prop 99, SB 12 and OBRA/IRCA coverage of emergency care for immigrants now gives private hospitals and doctors a range of potential funding streams for emergency care to the uninsured.

**THE IMPACTS of PROP 99, SB 855, SB 1255 AND SB 12 on PRIVATE PROVIDERS**

These measures were implemented in light of the patient dumping scandals and trauma center and emergency room closures. Under each measure, the funds flow directly to the private hospitals. The county Board of Supervisors or the county Department of Health Services cannot divert these funds to the public hospitals. The background for this decision is that a number of the "public hospital" counties were not paying private hospitals for their emergency and trauma care to the uninsured indigent. Private providers and many legislators did not expect that this would change if the new funds went through the counties. The unfortunate side effect of this decision is that counties have little influence with private hospitals to develop and organize public/private systems of care for the uninsured.

**a. SB 12**

SB 12 (Maddy) and its companion measure AB 214 (Margolin) established financial penalties for hospitals and doctors engaged in patient dumping. SB 12 increased the fines and assessment for driving violations of the state's motor vehicle code and established a fund to pay emergency room doctors and "on call" specialists for uncompensated care. Physicians are compensated pro rata from the fund based on their uncompensated billings for indigent uninsured patients submitted to the fund. Initially, few doctors billed the fund for their services. In 1995, the Emergency Medical Services funds exceeded $40 million.

**b. Prop 99**

In the implementation of Prop 99, separate programs were established for counties, private hospitals and private physicians. The private physicians component of Prop 99 was based on the SB 12 model; however billing and payment procedures were radically simplified so that more doctors would be paid. The current allocation of Prop 99 funds is $24 million. Physicians are paid about 50% of their charges.

Prop 99's private hospital program pays for uncompensated care in private hospitals. Those with emergency rooms and trauma centers must maintain them as a condition of receipt of the funds. Children's hospitals receive their funds from a special statewide allotment in light of their regional specialization. Hospitals' OSHPD reported data for uncompensated care (charity care) was used as the basis to distribute the funds. The hospital account is divided: half into a mandatory and half into a discretionary account. Each private hospital receives a check for its pro rata share of the statewide total uncompensated care reported to OSHPD from the mandatory account. The county Board of
Supervisors has leeway to direct the discretionary account to private hospitals to maintain "safety net" emergency and trauma services. There is no uniform statewide auditing of hospitals' data and practices in providing and reporting uncompensated care; each hospital uses its own reporting and auditing system within OSHPD's guidelines. Private hospitals received about $31 million from this revenue stream in 1996-7.

c. SB 1255

SB 1255 is limited to DSH hospitals with emergency rooms or trauma centers. It is a discretionary fund, subject to negotiations between individual hospitals and CMAC. There is no published report of what hospitals do with their SB 1255 funding. Over 60 hospitals meet the criteria for SB 1255 eligibility -- Medi-Cal contractor, DSH provider, and have an ER or be a children's hospital. Hospitals present proposals for use of the funds, and CMAC reviews and negotiates the requests annually. SB 1255 funds have been used for disparate purposes, such as installing bullet-proof glass in an emergency room, in lieu of rate increases and to save county general funds. Over time, hospitals have become more creative in their requests. This has been a steadily increasing funding stream, reaching $342 million in federal funds in 1996-7. As of 1995, private hospitals received 20% of SB 1255 funding.

SB 855 is the state's DSH program for public and private hospitals. The distribution formula is statutorily specified, based on each hospital's percentage of Medi-Cal and uninsured patients in its own facility and its pro rata share of the statewide uncompensated care for Medi-Cal and uninsured patients. As mentioned already, public hospitals pay the match for the privates. Private hospitals increased their receipts of SB 855 funding, by increasing the numbers of Medi-Cal patients they treat while decreasing the amount of care to the uninsured. 1996-97 projected net annual payments to private hospitals' (community and children's) under SB 855 total $364 million, an increase of $146 million from the prior year. The distribution of funds to individual hospitals varies each year because (1) to qualify, a hospital must have a Medi-Cal utilization rate at least one standard deviation above the statewide mean; and (2) Federal OBRA regulations limit DSH payments to a facility's uncompensated care costs. In 1997, the public and private hospitals negotiated a temporary DSH truce in essence dividing the SB 855 funds in half between the types of facilities.

FQHCs AND COMMUNITY CLINICS

There are over 500 community clinics in California. Community clinics provide most of their care to MediCal patients and the uninsured. There is enormous variability. For example at certain clinics, 90% of the patients are uninsured. While at those clinics specializing in maternity or pediatrics, 90% or more of the patients may have MediCal or CHDP eligibility. Most clinics ask their uninsured patients to part pay for care.

Federal law requires the Medi-Cal program to reimburse certain clinics (Federally Qualified Health Centers or FQHCs and "look alikes") at their reasonable and necessary costs for care to MediCal patients. FQHC does not reimburse clinics for the costs of care to the uninsured as the LA County waiver does. There are a number of requirements that must be met to be certified as a qualified FQHC, but the rewards of being reimbursed for reasonable and necessary costs are substantial -- ordinarily rates are about double what MediCal would otherwise pay for outpatient services.
Initially FQHC status was reserved for a limited number of federally funded comprehensive health clinics; then it was expanded to the "look alikes". Many community clinics and a number of California counties have already set up their outpatient clinics under FQHC to receive the higher fees. Some of these have ranged over $200 a visit, though commonly they are much less -- between $80 and $110.

In 1994, the primary care community clinics across California had operating revenue of $320 million and provided over 6 million visits. MediCal was the principal payor; however clinics provided roughly three million visits for the uninsured. 148 Rural Health Clinics were designated under FQHC in California in 1993-4, receiving $37 million from MediCal. 173 FQHCs, Indian Health Centers and "look alikes" were designated in 1993-4, receiving $125 million from MediCal. Only a comparatively few are in Los Angeles County.

It is possible to secure FQHC status either as a county clinic or as a community clinic. The clinic must have a community governing board (but this can and has been done within a county government structure) and a broad range of medical care services to qualify for FQHC status. The advantage to a county is that it need not pay for MediCal uncompensated care (the difference between cost and MediCal payments) with county indigent care funds. FQHC status and payments will be gradually phased out by the year 2003 under the Medicaid provisions of the 1997 Balanced Budget Act. In the interim, the 1997 Balanced Budget Act requires states to supplement FQHC clinics' MediCal managed care reimbursement.

It takes significant lead time to develop the necessary approvals for FQHC status. State and federal approvals of hospital based FQHCs have slowed and stalled since the $200 plus fees for Santa Clara County outpatient clinics were approved. The advantage to the provider of a hospital based site are that many of the hospital's relatively high administrative, space and equipment costs can be paid for under FQHC. State and federal regulators see this as a clear disadvantage.

In addition to FQHC and MediCal payments, clinics also receive funding from a variety of other state and federal programs to care for the uninsured: CHDP for preventive care to children, Family Planning and Teenage Pregnancy Prevention, Prop 99, federal Homeless, AIDS, Community and Rural Health Clinic funding. MediCal makes up 51% of clinic funding, other state and local programs comprise 22% and patients sliding fee payments are 14% of clinics revenue. It is critical to develop a better and more appropriately targeted clinic funding stream for care to the uninsured than the MediCal FQHC program, which is both ill designed to accommodate the move to MediCal managed care and at odds with the incentives of most other reimbursement methodologies.

C. MEDI-CAL AND THE UNINSURED: OVERLAPS, EXPANSIONS AND CONTRACTIONS

In this subsection we discuss the following programs and financing streams:

1. Pregnant women and infants (200% of poverty)
2. Children (133% of poverty)
3. DSH
4. OBRA and IRCA expansion for undocumented and amnesty eligibles
5. CHDP (200% of poverty)
6. AIM (300% of poverty)
OVERVIEW

a. MediCal

The state spends over $18 billion in both state and federal funds on 5.4 million beneficiaries under the MediCal program. Most MediCal eligibles are eligible because they receive cash assistance -- SSI (aged, blind or disabled) or AFDC (now TANF) for single parents and minor children. In general, one must be both poor (although income maximums are slightly higher than for AFDC) and categorically linked (i.e. meet eligibility qualification criteria for SSI or AFDC) in order to be Medicaid eligible. Most MediCal eligibles are children and mothers; most of the spending is for the aged and disabled.

<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Impact/Results</th>
<th>Amount (Year) and Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>MediCal</td>
<td>Pregnant women and infants up to 200% FPL, Children age 1-6 up to 133% FPL, Children 6-13 up to 100% FPL, Adults with categorical linkage to AFDC/TANF, SSI</td>
<td>Insures 5.4 million California residents at an average annual cost of $2564 per eligible ($1,082 for AFDC); covers almost 50% of all births. Covers over 50% of poor and 20% of near poor</td>
<td>$18.3 billion (1996-97); 50/50 federal/state funds</td>
</tr>
<tr>
<td>Program</td>
<td>Eligibility</td>
<td>Services Provided</td>
<td>Funding Source</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Child Health and Disability Prevention (CHDP)</td>
<td>Children &lt;21 up to 200% FPL</td>
<td>Provides 500,000 screening exams annually and follow up treatment for uninsured children</td>
<td>$70 million (1997-98 estimate) from state funds</td>
</tr>
<tr>
<td>California Children's Services (CCS)</td>
<td>Children with qualifying conditions in families up to $40,000/yr.</td>
<td>Covers full services and case management for MediCal, uninsured and privately insured children with qualifying conditions</td>
<td>$85 million from state funds in addition to MediCal program costs</td>
</tr>
<tr>
<td>AIM (Access for Infants and Mothers)</td>
<td>Pregnant women and their children &lt;2 up to 300% FPL</td>
<td>Served cumulative total of 27,000 pregnant women and 23,500 infants since 1992</td>
<td>$45 million from Proposition 99 funds and $2.5 million from beneficiary share of premiums</td>
</tr>
<tr>
<td>California Kids</td>
<td>Uninsured children 2-18 not eligible for MediCal or CCS; family income 100-200% FPL; nominal copays</td>
<td>10,000 children covered at an average overall cost of $28 pmpm</td>
<td>$4 million from corporate and charitable foundation contributions</td>
</tr>
<tr>
<td>Major Risk Medical Insurance Program (MRMIP)</td>
<td>Medically uninsurable individuals rejected by commercial carriers</td>
<td>Served 18,000 cumulative total of otherwise uninsurable persons since 1991</td>
<td>$40 million from Proposition 99 funds (1996-7) to subsidize subscriber premiums ($44 million)</td>
</tr>
</tbody>
</table>
Genetically Handicapped Persons Program (GHPP)

| Adults, otherwise uninsured/uninsurable, with certain qualifying congenital conditions | Serves approximately 800 persons with unusual and high cost medical care needs | $11 million (1996-97) from state funds |

Healthy Families (MRMIB)

| Uninsured children 2-18 not eligible for MediCal or employer coverage; family income 100-200% FPL | Projected to serve 580,000 uninsured children | Projected to cost $485 million at a 2:1 federal state match in 1998/9 |

Single adults under 65 are ineligible for MediCal, unless disabled. Moreover, most "traditional" two parent working households are not eligible for coverage of the parents, though the children may be eligible. Furthermore, the family or individual must be poor -- i.e. have income below the federal poverty line, have high medical expenses which reduce one's income and have few assets. Many low wage, working, uninsured families simply have a bit too much income or assets to qualify for MediCal.

There are certain eligibility categories under MediCal and other state programs where there is substantial overlap with the uninsured: the medically needy families category, the children's coverage categories (medically indigent and medically needy children, CHDP children and CCS children), the pregnancy only category, coverage of emergency care for new immigrants and the undocumented and the back to work eligibility categories under the new TANF program. These eligibility categories have the most relevance to efforts to cover the uninsured.

About half of MediCal program eligibles (women and children, but not the aged and disabled) are moving into MediCal managed care in the state's most populous counties. For the most part the contingent, intermittent and limited benefit eligibles will not be moved into managed care.

A portion of MediCal pays for care to individuals who are otherwise uninsured. MediCal funding for the uninsured is important in that half of it comes from federal matching payments. The uninsured are "individuals with no public or private coverage". How can the uninsured also be paid for by MediCal since they by definition have no public coverage?

- First, MediCal spends $1.1 billion in federal dollars on DSH to public and private hospitals to pay for care to patients who are uninsured discussed in subsections A and B.
- Second, portions of the MediCal population, such as the undocumented and new immigrants, are eligible only for a "limited benefit" package (emergency care) and receive MediCal only during the emergency and are otherwise ineligible and uninsured. Women with incomes up to
200% of poverty are eligible for maternity benefits, but only when they are pregnant.

- Third, there is a group of "intermittent" eligibles who are on and off the program -- using health care when they are on MediCal and being uninsured and foregoing all but emergency care when they are off. The welfare to work provisions of welfare reform are likely to increase the numbers of intermittent eligibles as families cycle on and off the program and into low wage jobs with no health coverage.
- Finally, extensive segments of the MediCal population qualify for the program on a "contingent" basis for a month at a time for costly hospital care or other catastrophic medical expenses but, during the rest of the year, are uninsured and ineligible for MediCal.

The limited benefit only, pregnancy only, contingently and intermittently eligible categories all have high per capita costs because they are eligible for MediCal only when they have very high cost care, typically in hospital settings.

The groups of uninsured and their relationship to MediCal include:

1. The categorically ineligible (mostly, adults without children),
2. The red tape ineligible (deterred by the welfare stigma or the complex and demeaning application and recertification process),
3. The outpatient ineligible (typically, those with incomes over poverty who are eligible for MediCal only if they have high medical expenses, emergencies or become pregnant),
4. The immigrant ineligible (the undocumented are eligible only for emergency care and most new immigrants are disqualified for a period of time and subject to deeming of sponsor's income), and
5. The work ineligible (while it is permissible to work and qualify for MediCal; the program is not employment friendly, i.e. it does not reward work).

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**THE POTENTIAL OVERLAP OF MEDI-CAL AND OTHER STATE PROGRAMS WITH THE UNINSURED IS OVER $4 BILLION**

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
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<tbody>
<tr>
<td>SB 855 (DSH)</td>
<td>$1.1 billion</td>
</tr>
<tr>
<td>SB 1255</td>
<td>$342 million</td>
</tr>
<tr>
<td>Children only (MediCal)</td>
<td>$68 million</td>
</tr>
<tr>
<td>CCS</td>
<td>$84 million</td>
</tr>
<tr>
<td>CHDP</td>
<td>$70 million</td>
</tr>
<tr>
<td>Emergency only (undocumented)</td>
<td>$630 million</td>
</tr>
<tr>
<td>AIM (up to 300% of poverty)</td>
<td>$50 million</td>
</tr>
<tr>
<td>Program</td>
<td>Funding</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Pregnancy only (up to 200% of poverty)</td>
<td>$335 million</td>
</tr>
<tr>
<td>Medically Indigent Children</td>
<td>$390 million</td>
</tr>
<tr>
<td>Medically Needy Families</td>
<td>$756 million</td>
</tr>
<tr>
<td>MRMIP</td>
<td>$40 million</td>
</tr>
<tr>
<td>Healthy Families</td>
<td>$485 million</td>
</tr>
</tbody>
</table>

**EXPANSION OF GOVERNMENT PROGRAMS**

As the number of uninsured have increased, the government programs designed to cover their ever increasing numbers have proliferated. The decline of private employer coverage has been accompanied both by the expansion of eligibles in government programs, and growing numbers of uninsured. The two principal California public programs affected by the growth in uninsured have been MediCal and the county health system. The number of Californians on MediCal doubled in the last decade from under 2.7 million in 1983 to 5.4 million. There are no reliable numbers on the growth in the numbers of uninsured persons using county health systems because counties have not kept this data in a uniform and comparable manner over the same time frame, and the coverage of patients between MediCal and county health has not remained constant. Independent researchers have documented the increasing demand on county health departments and their static budgets.

The uninsured are predominantly employees and family members with incomes above poverty (80% connected to the workforce and two thirds with incomes over poverty), and therefore many are not eligible for existing public programs except when costly hospitalization is required. New programs or statutory expansions of existing programs have been instituted to allow the working population with incomes below 200% of the federal poverty level to receive publicly funded help with the costs of health care. In these efforts, California has lagged behind states such as Hawaii, Minnesota, Washington, Massachusetts and Oregon who have smaller percentages of their populations uninsured.

California's eligibility expansions have focused on low income children and pregnant women, and have primarily occurred in the context of the newly available federal matching funds under MediCal and the Prop 99 cigarette tax revenues dedicated to the uninsured.

**Pregnant women and infants**

California expanded its eligibility levels for prenatal care and delivery and coverage of newborns up to age two from poverty level ($12,000 for a family of three) to 300% of poverty, under MediCal and the AIM program. It has included maternity care coverage for low income individuals going through legalization of immigration status under the amnesty program and for undocumented women. MediCal now pays for 47% of California's annual births, and less than 3% of California's births are to uninsured women. California also doubled physician reimbursement rates for prenatal care and
delivery and instituted the Comprehensive Perinatal Services program to pay for health education, nutritional and psychosocial counseling. There is strong competition between public and private providers to deliver care to pregnant women in the MediCal program.

Children

California has expanded MediCal income eligibility for young children from the federal poverty level to 133% of poverty. It used Prop 99 cigarette tax funding to expand preventive health care and require follow up medical treatment under Child Health Disability Prevention (CHDP) for children in families with incomes up to 200% of poverty and for new borns up to 300% of poverty under AIM. During the recent years of state budget crisis, the Wilson Administration proposed programs to further expand eligibility and programs for children's outpatient services. In 1997, California enacted the Healthy Families program to cover the 580,000 uninsured children between 100% and 200% of poverty and to improve MediCal enrollment for the 500,000 uninsured children with incomes below poverty.

The medically uninsurable

$30 million in new Proposition 99 funds were used to establish insurance premium subsidies for carriers covering individuals rejected as medically uninsurable. California also has programs (California Children's Services, CCS and Genetically Handicapped Persons Programs, GHPP) for children and adults with designated costly and serious medical conditions whose income and assets exceed MediCal limits. Furthermore MediCal permits a buy in of the premiums to maintain private insurance coverage for those with high medical costs to prevent impoverishment.

Emergency care

Emergency rooms and trauma centers received financial assistance for care to uninsured immigrants under California's implementation of the Omnibus Reconciliation Act of 1986 and the Immigration Reform Control Act (OBRA and IRCA) at a cost of over $1.1 billion. California also directed nearly $1.1 billion in new federal DSH funding to public and private hospitals with the largest shares of care to the uninsured and MediCal populations.

MediCal buy ins and transitional coverage

The most far reaching expansion of publicly financed systems to reach the uninsured was contained in an early version of AB 4196 (Baker and Hansen) of 1990, which proposed: 1) to restore MediCal eligibility for the wholly state funded category of the Medically Indigent Adults (poor families and individuals with no categorical linkage to Medi-Cal), thus transferring that obligation back to the state from counties where it had been shifted in 1982; 2) to allow a Medi-Cal "buy in" (voluntary purchase of Medi-Cal coverage) by either the employer or employee for all uninsured persons with incomes under 200% of federal poverty level; and 3) to establish a MediCal outpatient benefit for
individuals with incomes between 100 and 150% of poverty. The estimated General Fund costs of this approach exceeded $2 billion annually. Without a proposed funding source in a very tight budget year, this component of AB 4196 was dropped. The approach of trying to fund the costs of caring for the uninsured out of state and federal taxes is an interesting and useful counterpoint to the proposals which seek to build coverage for the uninsured through employment based coverage.

California has limited transitional coverage for some AFDC families going back to work. This is proposed to increase up to two years of transitional coverage in the implementation of the welfare to work program if a federal waiver can be secured. The new Federal State Children's Health Insurance Program and federal Medicaid expansions gives states the option to extend 6 months of guaranteed Medicaid eligibility to managed care enrollees and 12 months of guaranteed Medicaid eligibility to children.

**MANAGED CARE AND THE STRATEGIC PLAN**

California has begun a process of mandatory enrollment into managed care for most family program eligibles. This is often referred to as the Strategic Plan. The stated rationales include better systems of care for patients, limited cost savings to the state, better incentives for providers and emulation of the private market's move to managed care.

There are really three separate models in operation in California's counties: County Organized Health Systems, Geographic Managed Care and the Two Plan model. In County Organized Health Systems (COHS) counties, there is a single managed care system for all MediCal beneficiaries. COHS programs include the aged and disabled, the CCS and foster care children and other categories which are carved out (exempt) from mandatory participation in the other models. There are a limited number of COHS counties (Santa Barbara, San Mateo, Orange, Santa Cruz and Solano). While COHS has been reasonably successful and other counties such as Los Angeles and San Bernadino would have preferred this option, there are two reasons why this option is not likely to expand: 1) federal law restricts the number of pilot projects and 2) DHS believes that there is lack of beneficiary choice and insufficient inter plan competition in this model, resulting in potential stagnation over time and an undue concentration in bargaining power. A change in federal law to permit expansion of COHS to those counties with inadequate numbers of MediCal eligibles (San Francisco, Contra Costa and Napa) under the Two Plan model is likely to occur in 1998.

*a. Geographic managed care*

Geographic Managed Care is operational in Sacramento County and in the planning and development stage for San Diego County. Under this model, patients choose among a number of HMOs which have been selected by CMAC after a long bargaining and negotiating process. This is close to the model used by large employers and by the purchasing pools such as PERS, PBGH and HIPC. Geographic managed care is not favored by the "public hospital" counties because they believe it has insufficient protections for their hospitals and other safety net providers. Typically county hospitals, community clinics and many minority physicians do not have established relationships with commercial plans, are not part of commercial plan's networks of care, and do not have the data systems in place to assume financial risk and manage patient care in the commercial HMO model.
b. The Two Plan model

Most of the large "county hospital" counties have chosen the Two Plan model, though many would prefer COHS. In this model, they are given the option to operate one of the two health plans as the "Local Initiative". Under the "Two Plan" model, counties and safety net providers have extensive protections: guarantees of a large share of the patients to the Local Initiative, guaranteed participation by safety net providers and protections of the DSH allocations during a transitional period. However, safety net providers are also at substantial risk because: 1) their rates are not guaranteed; 2) their share of patients is not guaranteed; 3) their ability to manage patient care in an HMO model is underdeveloped and untested; and 4) most of the Local Initiatives themselves are brand new and inexperienced in managed care. Furthermore, some clinics and some traditional MediCal providers lack the managed care credentials to which the plans are accustomed and some of the private physicians entering these networks are inexperienced in treating a MediCal population. This is all played out in the context of major enrollment snafus which are characteristic of nearly every mandatory managed care Medicaid effort in this country.

c. Carved out populations

It is important to bear in mind that most of the more costly and vulnerable populations such as the elderly and disabled, the CCS and foster children are "carved out", exempt from participation in managed care except on a voluntary basis. Furthermore, the bulk of county hospital patients are the "contingent and emergency only" eligibles discussed earlier who are also exempt from managed care.

Despite their many fears, managed care presents two important opportunities for safety net providers and community clinics. The first is to develop truly integrated systems of care for patients, and the second is to develop a better balanced system of care which can improve the hospital and emergency room dominated delivery systems for care for the uninsured indigent. Local Initiatives and COHS models are the more likely vehicles to achieve a synthesis of MediCal and county health systems although some of the commercial plans may become creative in their efforts to cover the uninsured as well.

IMPACTS AND PROSPECTS FOR THE FUTURE

Increased funding and new programs expand funding for the state's safety net providers, but it is less than clear how much of the safety net funding trickles down to better care for the uninsured. State and county governments, providers, health care workers and employers operate a "zero sum" game in which expanded funding is used to offset an "unexpected shortfall" from some other source. Why should an economically sophisticated employer offer maternity coverage to its low wage workforce when the state is stepping in with public tax dollars? County and state budget officials operate within a set of financial incentives to concentrate available funding where it can be federally matched and to substitute federal matching funds for county or state only spending. Why spend a county tax dollar on health care when a state or federal dollar is so much less costly to the county tax base? Why spend a
state tax dollar on health care when the federal government will pay 50% or even 100% of certain costs?

The enormous advantage of covering the uninsured incrementally through MediCal expansions is that this is the path of least political and fiscal resistance. The most politically appealing portions of the uninsured population, such as young children, can be covered first with a 50% federal match. Coverage can be phased in as revenues are available. There is no need for messy votes to raise taxes, impose an employer mandate on small employers, rein in insurer practices, or embark upon untested or experimental programs with uncertain results. However, massive growth in the numbers of eligibles for public programs like MediCal too often prompts attacks on entitlements. This is now in process as the federal and state governments seek to roll back MediCal coverage for new immigrants and the undocumented, the disabled and welfare families as part of the implementation of the recent federal welfare reforms and Proposition 187. The recent federal and state enactment of financing and coverage for uninsured children provides an unparalleled opportunity to cover California's low income children and their low wage working parents as will be discussed in Section 3.

### Summary of Existing Funding Streams and Approaches to Expanding Coverage of the Uninsured

<table>
<thead>
<tr>
<th>Population</th>
<th>Number Uninsured</th>
<th>Available Funds</th>
<th>Issues</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids at &lt;100% FPL</td>
<td>585,000</td>
<td>MediCal</td>
<td>MediCal: Excess assets; &quot;red-tape eligibility&quot; Undocumented</td>
<td>Simplified MediCal eligibility; outreach; outstationed staff; elimination of assets tests.</td>
</tr>
<tr>
<td>Adults at &lt;100% FPL, MediCal linked</td>
<td>Part of 1.5 million</td>
<td>MediCal</td>
<td>Same as for children</td>
<td>Same as for children</td>
</tr>
<tr>
<td>Adults at 1.5 million</td>
<td>1.5 million</td>
<td>Counties</td>
<td>Fluctuating</td>
<td>Statewide 1115</td>
</tr>
<tr>
<td>Income Level</td>
<td>Budget Allocation</td>
<td>Health Programs and Funding Streams</td>
<td>Coverage and Services</td>
<td>Policy Initiatives</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>&lt;100% FPL, no MediCal link</td>
<td>responsible for coverage, using: realignment, tobacco tax; DSH funds</td>
<td>eligibility. Access to services in county health waiver; county-level waivers to consolidate Medicaid and indigent funding; assist county reform efforts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kids at 100-200% FPL</td>
<td>625,000 Public: MediCal, DSH, CHDP, tobacco tax, CCS; Private: California Kids, BC MediFam</td>
<td>Fragmented funding streams provide coverage for all but routine outpatient</td>
<td>1902(r)(2) MediCal expansion; CalReach; Limited benefit plans with MediCal &quot;wrap around&quot;; Targeted tax credits or vouchers</td>
<td></td>
</tr>
<tr>
<td>Adults at 100-200% FPL</td>
<td>1.4 million MediCal and county health programs for high cost services</td>
<td>Intermittent and shifting coverage between employer, county health and MediCal Waiver and consolidation of public funds; MediCal transitional coverage, buy-in; Extension of purchasing pools, underwriting; Targeted tax credits or vouchers; Purchasing arrangements for flex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kids at 200-300% FPL</td>
<td>250,000 AIM (&lt;2); MediCal with share of cost; CCS for some high cost care</td>
<td>Limited public funding now available for high cost care; Affordability, availability of private coverage</td>
<td>1902(r)(2) MediCal expansion and consolidation of existing funding sources; Limited benefit plans with public fund wraparound; School based coverage; Targeted tax credits or vouchers; Transitional coverage; Flex workforce incentives</td>
<td></td>
</tr>
<tr>
<td>Adults at 200-300%</td>
<td>703,000 MediCal and county</td>
<td>Affordability, availability of private</td>
<td>Limited benefit/provider network plans; Extension of purchasing pools,</td>
<td></td>
</tr>
<tr>
<td>FPL</td>
<td>health programs for highest cost services</td>
<td>coverage</td>
<td>underwriting reforms; Targeted tax credits, vouchers; Purchasing arrangements for flex workers;</td>
<td></td>
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<td>-----</td>
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<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Children at 300%+ FPL</td>
<td>200,000</td>
<td>MediCal, CCS only for most costly conditions</td>
<td>Same as for adults</td>
<td>Extension of underwriting reforms; Purchasing arrangements for flex workers Tax deductions for self-employed, individuals; Transitional coverage</td>
</tr>
<tr>
<td>Adults 300+ FPL</td>
<td>1.3 million</td>
<td>MediCal, GHPP only for most costly conditions</td>
<td>Affordability and accessibility of private coverage (self employed, transitional, flex workforce)</td>
<td>Same as for children</td>
</tr>
</tbody>
</table>

Cost to Cover Uninsured Population By Extending MediCal

<table>
<thead>
<tr>
<th>Family income by % of federal poverty level</th>
<th>Uninsured Population</th>
<th>MediCal Cost</th>
<th>Federal Cost (50%)</th>
<th>State Cost (50%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 100%</td>
<td>2,032,000</td>
<td>$2.2 billion</td>
<td>$1.1 billion</td>
<td>$1.1 billion</td>
</tr>
<tr>
<td>Family Income</td>
<td>Number of uninsured Children</td>
<td>Cost children</td>
<td>Number of uninsured adults</td>
<td>Cost adults</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------</td>
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<td>---------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Below 100%</td>
<td>585,000</td>
<td>$477 million</td>
<td>1,500,000</td>
<td>$1.6 billion</td>
</tr>
<tr>
<td>100-199%</td>
<td>625,000</td>
<td>$510 million</td>
<td>1,400,000</td>
<td>$1.5 billion</td>
</tr>
<tr>
<td>200-300%</td>
<td>250,000</td>
<td>$204 million</td>
<td>703,000</td>
<td>$763 million</td>
</tr>
<tr>
<td>300% +</td>
<td>200,000</td>
<td>$163 million</td>
<td>1,370,000</td>
<td>$1.5 billion</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,660,000</td>
<td>$1.4 billion</td>
<td>4,950,000</td>
<td>$5.3 billion</td>
</tr>
</tbody>
</table>

**Cost to Insure Uninsured Children and Adults Through HIPC**