

To: ITUP Conference and Workgroup Participants

From: Lucien Wulsin, Executive Director

A Working Draft

We started to compile some thoughts on health care issues for California in the new federal Administration. We would very much appreciate your suggestions and thoughts on top priorities, additions, deletions and modifications.

1. **Stimulus package:** A temporary increase in the Federal Medicaid and S-CHIP matches is essential. States such as California struggling with declining state revenues and burgeoning state deficits due to the recession and an increased demand for Medicaid services as our unemployment rates rise. Federal assistance should come with reasonable conditions so that states do not cut eligibility for medical assistance at this time of high unemployment and economic crisis.¹
2. **Federal health reform:** The time is ripe for a bi-partisan and balanced resolution of the three critical failures of our nation's health care system: the large and growing numbers of uninsured, the high and spiraling rise in the costs of health care for employers, employees, governments and individuals, and the poor performance of the over-all system in producing quality health outcomes equivalent to other nations. This will help the bottom lines and payrolls for businesses and working families and improve the nation's health.
3. **Coverage for adults:** Medicaid (Medi-Cal) should provide coverage for all categories of low-income adults.² States (such as Oregon, Massachusetts and Arizona) cover the MIAs (Medically Indigent Adults) with federal 1115 waiver Medicaid funding while other states (such as Washington, Michigan, Pennsylvania and Indiana) cover MIAs with only state or local funds. In California coverage for the MIAs is a county responsibility, largely financed by state "realignment" funds. California counties spend about \$1.8 billion on care to 1.2 million low-income uninsured adults. The federal government should allow states to cover this population as a part of Medicaid with federal matching funds – a long time priority of the National Governor's Association. California could use

¹ California faces a budget deficit of at least \$24 billion from October 2008 through the end of June 2010 due to declining revenues and has recently proposed to reduce eligibility levels for working families by a third to 70% of the federal poverty level, to eliminate coverage for two parent full time working families, to re-institute paperwork barriers for young children in the form of semi-annual status reporting, to strip all covered benefits other than emergency services for new legal immigrants, to cut provider rates by 10% and to eliminate optional services such as adult dental.

² Medicaid at its inception was an adjunct to the federal welfare programs for the aged and disabled and poor single parent families who were out of a job. It has evolved over the past 40 years to cover working families, but does not yet offer coverage for low wage working adults without minor children living at home (MIAs or medically indigent adults).

county³ matching funds to match federal Medicaid funds for low-income adults without minor children living at home. Alternatively, California should request a large 1115 waiver from the Obama administration to finance state coverage of MIAs with federal Medicaid funds. An 1115 waive will require budget neutrality.⁴

4. **S-CHIP re-authorization:** S-CHIP is a program with 2:1 federal state match that pays for coverage of more than a million otherwise uninsured children in California's Healthy Families, Medi-Cal and AIM programs. It expires in March 2009. Congress needs to immediately re-authorize the program with a substantial increase in federal funds⁵ and no additional restrictions on states' abilities to cover uninsured children⁶.
 - a. *Withdraw August 17, 2007 directive* restricting state eligibility expansions for children and parents under S-CHIP and Medicaid. This memo initially sought to discourage states such as New York and New Jersey from expanding their S-CHIP programs to children of families up to 400% and 350% respectively. It was then expanded to seek to restrict expansions of Medicaid programs for parents as well. GAO (United State General Accounting Office) found there was no legal basis for the directive. It should be withdrawn.
5. **Extend California's Family PACT waiver:** Family PACT pays for family planning services (these services qualify for a 9:1 federal match). The federal Center for Medicaid and Medicare Services (CMS) sought to force California to abandon its simplified and time-tested enrollment process and use the more costly Medicaid application, eligibility determination and enrollment process – a process that costs more to determine eligibility than the covered family planning services. CMS should permit California to keep its simpler enrollment and eligibility determination process that saves money for both the state and federal governments.
6. **Augment and renew 1115 waiver for hospital contracting, DSH and Safety Net Care Pool:** This waiver governs Medi-Cal's selective contracting program, the federal DSH (Disproportionate Share Hospitals) and DSH look-alike

³ Exclusivity – Some counties with public hospitals are concerned that covering the uninsured would shift their patients and their financing to private hospitals and lead to closure of some public hospitals. They have suggested a period of safety net plan and provider exclusivity as they transition their systems into a competitive managed care model.

⁴ Budget neutrality -- In order to secure a federal match, California needs to be willing to offer federal Medicaid budget concessions. These could include moving the disabled into managed care and/or shifting DSH and/or safety net pool funds into coverage as and if uncompensated care to the uninsured is reduced.

⁵ Congress' bi-partisan re-authorization bills with a \$35 billion increase in federal funds over the next five years were repeatedly vetoed by President Bush in 2008. California's expenditures on Healthy Families exceeded its allocations and federal allotments; however the extension of Healthy Families from October 2008 until March 2009 held harmless California and other states whose program costs exceeded the capped allotments.

⁶ The Bush Administration sought to restrict states from covering uninsured children with family incomes in excess of 200% of the Federal Poverty Level. This would curtail federal funds for coverage of uninsured children of working families in the Healthy Families and AIM programs.

supplemental payments for uncompensated care to the uninsured in public and private hospitals and the safety net care pool for uncompensated care to the uninsured in inpatient and outpatient settings.

- a. 2010 renewal – this waiver is scheduled to end in two years and will need to be renegotiated in light of the increasing burdens of care due to the growing numbers of uninsured.⁷
- b. The issues are largely financial, with hospitals needing higher state and federal payments to offset the growth in their uncompensated care burdens.
- c. The federal government needs to assure that the non-federal match is tangible and real, but also give state and county governments greater flexibility in meeting their match requirements.
- d. Other issues include a need for greater hospital transparency and accountability to assure that public funds are being used for their prescribed purposes, such as care for the uninsured.⁸
- e. California should switch from per diem to a form of DRG (Diagnosis Related Grouping) reimbursement so that the Medi-Cal program's financial incentives for hospitals are coordinated with Medicare.

7. **Mix and match for local public private partnerships – clarification:** Local public-private partnerships in California expand care to the uninsured; they need flexibility from federal regulators to integrate federal program funding with other financing. The issue is clarification of the opportunity for these initiatives to patch together local funding, federal and state Medicaid funds and employer and uninsured employee funds.⁹

⁷ The federal allocations for DSH and the safety net care pool are frozen and do not adjust to the growth in numbers of uninsured in this recession or the growth in the costs of medical care.

⁸ We would suggest transparency of payments and their uses so that it is assured that the dedicated funds are supporting care to the uninsured as opposed to other hospital and/county priorities.

⁹ Examples from California:

- 1) San Francisco, San Mateo, Santa Clara and Contra Costa counties are developing managed care systems for their uninsured, integrating non-profit safety net clinics with the county delivery system. To avoid the potential “Catch 22” loss of federal funds for the safety net, these programs are titled “access not coverage”. Federal regulators should specify the ability of local safety net plans to create Medi-Cal supp policies for the uninsured who have/could have Medi-Cal for limited partial benefits as a subset of a more comprehensive local benefits package.
- 2) Clarify that Emergency Medi-Cal can be integrated coordinated with local Healthy Kids programs. Emergency Medi-Cal pays for emergency services. Healthy Kids programs in over 20 large counties cover basic health services for the same children. Federal regulators should specify the ability of local safety net plans to create Medi-Cal supp policies for the uninsured who have/could have Medi-Cal for limited emergency benefits.
- 3) Clarify that Medi-Cal perinatal coverage can be integrated into child care worker's coverage. A high percentage of child care workers are uninsured; their low pay is too high to qualify for Medi-Cal, too low to afford private insurance. They are likely to qualify for Medi-Cal perinatal coverage or AIM, should they become pregnant. Los Angeles, San Francisco and Santa Clara have all sought to cover uninsured child care workers. Federal regulators should specify the ability of local safety net plans to create Medi-Cal supp policies for the uninsured who have/could have Medi-Cal for perinatal benefits.

8. **ERISA – clarification:** Clarify that a state or local government’s “pay or play” financing based on a percentage of wages is permissible under federal law (ERISA, the Employee Retirement Income Security Act¹⁰). Pay or play is a term of art for a funding approach that taxes employers to pay for part of the costs of coverage of the uninsured and gives them a credit against the tax for their current health spending.
9. **Federal match – flexibility:** States must provide a match for federal Medicaid and S-CHIP funds; it must be real, not illusory, and federal funds cannot be used to match federal funds. The federal government should give states latitude on the form of the match, provided it is real and transparent, stays in the system and pays for the services to which it is being matched.¹¹
10. **Support for local coverage expansion initiatives:** California received \$180 million annually for three years to develop model pilot programs to cover the uninsured. After a competitive grants process, ten counties received discrete shares of the funds for their pilot programs. CMS then restricted local flexibility by imposing an income cap at 200% of FPL and requiring the counties to use

¹⁰ ERISA was adopted to protect the security of employees’ retirement pensions and included a provision allowing self-insured employers who might otherwise be subject to the jurisdictions of 50 states to adopt a single national benefits plan subject to the jurisdiction of the US Department of Labor. The US Supreme Court found that a Hawaii law mandating the scope of employee health benefits for all employers was invalid as applied to a self-insured ERISA plan. Some argue that ERISA bars state efforts to finance coverage using employer financing while others point out that state’s traditional insurance and taxation authorities are not pre-empted by ERISA. Recent efforts to cover the uninsured in the state of California (percent of payroll that varies by employer size) and the County of San Francisco (flat hourly fee equal to the average cost of public employer health benefits) relied in part on employer financing using quite different variations on pay or play. In a recent decision the Ninth Circuit Court of Appeals upheld San Francisco’s local “pay or play” ordinance.

¹¹ In California, a two-thirds vote is required to increase taxes, but a simple majority vote is required for fees, premiums, local matches and assessments. See the following examples of potential matches in California.

- 1) *Clarify that employer and employee contributions into state pool for coverage of the uninsured can be used as match.* One promising approach to cover the uninsured combines contributions from state or local governments with funds from uninsured employers and uninsured employees. The funds could be collected as taxes, fees, premiums or assessments. Whatever the form, they should be eligible as match.
- 2) *Clarify that charitable contributions can be used as match for federal Medicaid and S-CHIP funds.* Philanthropy has helped pay the premiums for local programs for the uninsured. If philanthropies are so motivated, their contributions should be permitted to qualify as match where available.
- 3) *Clarify that state/local match must be real and transparent – not recycled federal funds -- but can come in multiple guises.* California counties are the bulwark and local pioneers in developing care and coverage for the state’s uninsured; they have substantial unmatched spending on care to the uninsured – portions of these funds are state funds transferred to the counties for local health and mental health programs. County contributions could come as a match as New York counties do, as certified public expenditures (CPEs) as some California counties now do, or as intergovernmental transfers (IGTs) as California did for over 15 years before facing federal disapproval in 2005 due to the illusory matches occurring in other states.

federal DRA (Deficit Reduction Act) procedures for determining citizenship rather than the counties own well-established and far less costly mechanisms.

- a. *Clarify that counties can use their own procedures to verify eligibility of US citizens.*¹²
- b. *Clarify that the August 17, 2007 directive restricting income eligibility does not apply to these local pilots.*¹³
- c. *Extend and expand successful local models and give year-to-year spending flexibility for the three year pilots.*¹⁴

11. Revise federal regulations governing DRA implementation of citizenship verification requirements to allow for state/local administrative flexibility.¹⁵

12. Federal match for new legal immigrants:¹⁶ Under federal law, the federal match for new legal immigrants is only available for emergency care and deliveries during their first five years as legal permanent residents. This makes little sense as immigrants' hard work, drive and creativity are critical to the nation's economic recovery and progress.

¹² While the federal waiver funds can be restricted to assure they do not cover the undocumented (except as permitted under federal law for emergencies and deliveries), the federal government should not be micro-managing county eligibility procedures to the extent of complying with CMS' rigid rules on DRA compliance

¹³ The August 17, 2007 directive initially sought to restrict state's capacity to cover middle income uninsured children under S-CHIP, then it was expanded to restrict covering the uninsured in excess of 200% of FPL through Medicaid as well. GAO determined that this action was unlawful; it should be disavowed and abandoned. Several California counties including San Francisco, San Mateo, Santa Clara and Contra Costa sought waiver funding and had been approved to include coverage for uninsured adults over 200% of FPL as part of their pilots, but for CMS' restrictions.

¹⁴ A number of the local pilots appear very promising and should be extended and expanded; others that are unable to achieve their goals need to be revised or abandoned. The federal waiver conditions prevent carry-over of unspent funds; requiring that the full allotment be spent in each year and only in that year. Local governments should be given additional budgeting flexibility as CMS' changes in the terms and conditions of the waiver were responsible for delaying the start of local programs during the first two years of the pilot. California was approved for an additional \$360 million in federal funding that was never received because the state legislature declined to implement managed care for the disabled. These funds should be redirected to support additional coverage expansion initiatives in California.

¹⁵ DRA's citizenship verification requirements were enacted to assure that those applying for Medicaid as US citizens are in fact US citizens. However it was implemented in an excessively bureaucratic and prescriptive fashion, posing red tape headaches to many low-income US citizens who do not have ready access to a certified copy of their birth certificate – a fairly common occurrence. The federal rules should be amended to allow flexibility for state and local officials who are on the ground and more able to implement this in a common sense fashion in their communities.

¹⁶ California is disproportionately impacted by this policy. The federal statute enacted in 1996 needs to be changed.

13. **Expand safety net health plans:**¹⁷ These are health plans operated by California's local governments that use a network of community clinics, doctors and hospitals whose primary missions are care for low-income populations.
- a. *Authorize more COHS (County Organized Health Systems in California's counties).*¹⁸
 - b. *Allow and encourage greater collaboration among LI's (Local Initiatives).*¹⁹
 - c. *Enhance safety net health plans ability to cover disabled through managed care.*²⁰

¹⁷ Safety net health plans organize the safety net delivery system in a beneficial fashion; first they allow the disconnected elements of the safety net to collaborate in providing better and more coordinated care to the Medi-Cal and Healthy Families populations. Second, they provide the foundation and infrastructure for local efforts to cover the uninsured ranging from Healthy Kids programs, to programs for home care workers to Healthy San Francisco and Access to Better Care (ABC) in Contra Costa and WELL in San Mateo.

¹⁸ COHS is a single plan model of managed care organized by local governments that has worked well in Santa Cruz, Santa Barbara, San Mateo, Orange and Solano. It is and should be the preferred model in communities too small to support the competitive managed care models (Two Plan and Geographic Managed Care). Federal law precludes its spread with a 10% cap on COHS in California. The cap should be lifted to allow COHS wherever the community is too small for meaningful competition -- most of the Northern Regional, Central Valley, Central Coast and North Central regions of California.

¹⁹ LI's (Local Initiatives) are county developed safety net plans, typically defined by county boundaries. California has nine large county operated LIs within its 58 counties. As they develop new coverage models for the uninsured, they need to collaborate across county lines. For example Bay Area plans could collaborate regionally to cover uninsured child care workers, where the actuarial risks and premiums can be reduced by regional collaboration.

²⁰ Medi-Cal managed care has proven superior to Medi-Cal fee for service in delivering care to families. Safety Net plans afford the opportunity to improve care for other aspects of Medi-Cal such as the SSI disabled population and other chronically ill populations where service coordination would improve patients' outcomes. This should be authorized in those California counties where local managed care plans are doing a superior job.