



**Thoughts on Next Steps for California Health Reform:
Seek a Waiver or Wait and See?**
Insure the Uninsured Project
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To: ITUP Conference Participants and Workgroup Attendees
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We hope that President Elect Obama and Congress will be able to come together on a major health reform this year. There are many ideas afloat, ranging from Single Payor to Shared Responsibility to Individual Mandate. The final package may meld good ideas from each camp.

California stands to benefit from a reform effort in several ways. One, we are unable to reach final consensus on the shape of reform here in CA. Two, we face a huge budget deficit that is going to consume the Governor and legislative leaders' attention. Three, the federal government can definitively solve the ERISA obstacle and has greater flexibility with financing options than we do here in CA because the bulk of the \$200 billion tax subsidy undergirding employment based coverage is federal funding. Four, we in California benefit greatly from reform as we have one of the nation's highest percentages of uninsured persons, and more specifically uninsured adults.

In the meantime, state government is facing a \$40 billion shortfall over the next 18 months as tax revenues have plummeted, unemployment has increased, and the need for government services has escalated. Included in the falling revenues are sales taxes and vehicle license fees that support realignment (health, mental health and social services) which alone face a decline of over half a billion dollars.

Economic stimulus, an FMAP (Federal Medical Assistance Percentage) increase and S-CHIP (State Children's Health Insurance) reauthorization are going to help California's budget and need to be as robust as possible to avert a depression, but those funds are not going to trickle down to care and coverage of uninsured adults, whose numbers are increasing as unemployment rises.¹ It is possible that economic stimulus may include some limited funds to help with the costs of covering recently laid off workers; how this would work and be administered is unclear.

In California we have no General Fund money to enact/implement a reform, yet we are for the most part reasonably close to agreement on viable next steps, and the California efforts are compatible with the approaches laid out by President-elect Obama during the presidential campaign.² It is time for providers, plans, county governments and all of us to step forward, contribute matching funds and make progress where possible. There are federal funds available if we can commit to make the match.

We could/should seek a federal waiver to help us get started. We would be ahead of the curve if and when federal reform passes and have our own momentum if federal reform initially consists of interim federal support and flexibility for state efforts. We can help our safety net providers, clinics and local emergency rooms survive the recession/depression and build the framework and infrastructure for the future if they too are willing to help and make the necessary changes. We can build on the good ideas from the California Performance Review Commission,³ the Medi-Cal reform meetings, the health care reform efforts and the Medi-Cal waiver dialogue⁴.

Option 1: Great big waiver (global waiver, e.g. Vermont)

This would encompass the entire Medi-Cal and Healthy Families programs. It would include all current federal financial participation (FFP) and include the FFP for the expansion proposals of AB X 1 1 (Nunez), specifically covering parents up to 200% of the federal poverty level (a bit over \$40,000 for a family of four and other non-categorically eligible adults (medically indigent adults or MIAs) up to 200% of FPL as well as increasing provider reimbursement rates to Medicare levels.

This will help community clinics, public and private safety net hospitals and doctors by paying for most of the uninsured adults who cannot afford to either pay for their own services or buy their own coverage. It helps those employers offering coverage by somewhat reducing the cost shift or hidden tax that helps pay for private sector uncompensated care.

Federal funds under the waiver would grow by 10% a year to account for caseload growth and the rising costs of medical services.

Of course the challenge for California is meeting the match. We think and would urge that the waiver request give California flexibility in how to meet the match as long as the matching funds are readily transparent, linked to the health coverage, and not recycled federal matching funds. The match could be county match (match, certified public expenditures or intergovernmental transfers), provider match (fees or taxes), plan match (fees or taxes), philanthropy match, and or participating employer and employee fees as the match.⁵

The waiver would need to assure adequate flexibility to cover MIAs and parents and increase provider rates and to shift federal DSH (Disproportionate Share Hospitals) and/or safety net care pool (SNCP) into coverage as hospital uncompensated care is reduced so we do not then lose these funds back to the federal government.⁶

Managed care appears to be doing a better job of providing appropriate access to services than fee for service Medi-Cal does.⁷ The waiver should seek to use managed care for MIAs and for the disabled who are not Medi-Medis (aged and disabled receiving both Medicare and Medi-Cal). There is a concern among some safety net hospitals that they could lose existing patients and revenues to other facilities. We would suggest that the state seek authority to use the County Organized Hospital System (COHS) model to cover MIAs in counties with county hospitals during a transitional period.⁸

SHMOs (Social HMOs like On Lok and SCAN) are a better model of care for long term care populations because they have the incentives and ability to work with patients and their families to avoid more costly institutional care. They fund and support home and community alternatives to nursing home care as well as nursing home care. It allows the frail elderly the option to stay out of institutional long-term care. SHMOs should combine in home support services (IHSS) and home care services funding with institutional care funds.

Medi-Medis have both Medicare and Medicaid; significant numbers of seniors with Medicare voluntarily join an HMO to get better care and coverage.⁹ There should be a program of clear and voluntary incentives to join managed care for persons with Medi-Medi coverage.

Medicaid started as a simple program for families, seniors and the disabled on welfare. Its initial complexities were due to the then rules governing AFDC (Aid to Families with Dependent Children), OAA (Old Age Assistance) and DA (Disability Assistance). It has over the last 40 years evolved to its status today with hundreds of different subcomponents and programs -- one program for mental health, another for developmental services, one program for the Medi-Medis, one program for those in nursing homes, another for those receiving long term care in the home or community, one program for families, a different one for pregnant women, one program for those with kidney disease, one program for those with breast cancer, one program for those entitled through one law suit and another program for those entitled by another law suit. Medically indigent adults were off coverage, then on coverage, then off and then back on for some conditions and services and off for others.¹⁰ It is time to modernize the eligibility rules and processes and make the sub-programs compatible and move from a paper chase application process to using modern technology -- e-applications and e-verifications. It is time for consistent and uniform statewide administration of a program that beneficiaries and providers can understand and use in a straightforward fashion.

Electronic medical records are critical to tie together the information from diverse providers to better treat their patients and reduce unnecessary costs, such as repeat lab tests, and improve quality by identifying the treatments that work best for particular symptoms.¹¹ This may well be a part of the President-elect's economic stimulus package. California is already ahead of the curve as Kaiser hospitals and doctors have implemented this important advance as have other large private medical practices and they are seeing the large improvements in patient care and costs. But safety net providers are often well behind in implementing this high priority reform¹², so why not seek funding as part of a waiver and part of the economic stimulus package to rapidly introduce Electronic Medical records for the providers who participate in Medi-Cal and Healthy Families. It will have spin-off effects in terms of reducing over-all health costs and improving quality of care to insured and uninsured patients alike. Some part of these costs might be matched at the far higher Medicaid match for automated claims processing.¹³

And we should implement pay for performance (P4P) for providers and health plans under the waiver. P4P makes differential payments based on improved patient outcomes from better treatments and creates the necessary incentives to steadily improve the quality of services and to reverse poor quality outcomes.

The waiver could and should include a parental mandate to enroll their children in coverage subsidized by their employers or federal/state programs. This could start with a simple restatement of existing state family law responsibilities of parents to meet the basic needs of their children¹⁴ and could include a simple check-off form and reminder associated with school enrollment.

Option 2: Middle-sized waiver (MIA waiver, e.g. Arizona or Oregon)

At least ten states cover the MIAs (medically indigent adults) as part of their Medicaid programs with federal matching, including our near neighbors of Arizona and Oregon and our distant neighbors in New York and Massachusetts.¹⁵ Others cover them without a federal waiver and match as Minnesota and Washington State do.¹⁶

Counties already spend \$1.8 billion on care to 1.2 million uninsured adult patients as compared to an average premium of over \$4000 for insured adults.¹⁷ Many of the county uninsured would be eligible under a waiver,¹⁸ and we could double the funding available to pay for their care. Due to the recession, counties' realignment funds to pay for health and mental health will be falling while the numbers of uninsured and unemployed adults they must care for will be rising.¹⁹

The waiver could cover both physical and mental health services to MIAs now paid for by the counties since mental health is a Medicaid (Medi-Cal) service.²⁰

Counties should pay the match up to their current resources spent on county residents in these county health and mental programs who now enroll in Medi-Cal.²¹

Emergency care and services to uninsured undocumented could also qualify for Medicaid matching under the waiver.²²

As hospital uncompensated care is reduced, the state needs to request and receive the flexibility to shift DSH and/or safety net care pool program into coverage.²³

The waiver would use the existing local managed care arrangements in place for families to cover the MIAs. For counties with county hospitals the waiver would use a COHS (County Organized Health System) model²⁴ during a transitional period to cover the MIAs through local safety net community clinics and hospital networks.

Electronic medical records and P4P reimbursement would be rapidly implemented to allow for a quick improvement in the quality and efficiency of the care system.

Option 3: Hospital Selective Contracting waiver

California's Selective Contracting program for hospitals operates pursuant to a federal waiver first submitted in 1983 and subject to annual renewal.²⁵ The waiver expires in 2010 and will need to be renegotiated.

In the last waiver, hospitals were able to secure reimbursement at cost for inpatient care in public hospitals, to expand their DSH funding to \$1 billion annually and to secure \$580 million in Safety Net Care Pool (SNCP) funding.²⁶ Safety Net Care Pool funds must be spent on the uninsured but may be spent on either hospital based or community based services.²⁷ DSH funds are limited to hospital uncompensated care: either care to the uninsured or Medi-Cal payment shortfalls from hospitals' actual costs.²⁸

The waiver also included \$180 million in annual funds for three years to expand coverage for the MIAs and \$180 million in annual funding for two years to assist with the transition to managed care for the aged and disabled. The legislature declined to expand managed care and thus forfeited the \$360 million.

Under this waiver, the state's ability to increase its share of federal funds is constrained by the effectiveness of the selective contracting program in reducing hospital payment rates.²⁹

A very high priority in the negotiations should be an increase in the state's DSH allotment and SNCP funding to pay for the increased care to the uninsured due to the recession and soaring unemployment rates.

In our view, hospitals need more flexibility in their DSH funding to allow them to downsize beds and move funds to urgent care and other outpatient care services as needed. The failure of the LA 1115 waiver to give the county flexibility to re-orient its system priorities has been part of the ongoing obstacle to properly managing the county's public system.

The last round of federal-state negotiations restrained local match through a process known as IGTs (Inter Governmental Transfers) and shifted the primary mode of local match to CPEs (Certified Public Expenditures).³⁰ CPE's require county government to front the expenditure in question with the hope of payment later, often much later.³¹ With the fall in state and local revenues and the freeze in credit markets and the state's continuing budget crises, local governments may need greater flexibility in meeting the required match. We would urge local flexibility as to how to meet the match provided the match is real and transparent, devoted to the program expenditure in question, and not recycled federal funds.

There should be increased accountability and reporting to assure federal DSH funding is being used for its primary stated purpose uncompensated care to the uninsured.³²

In most counties the delivery of care system for the uninsured is top heavy – concentrated in hospitals and emergency rooms in particular³³; a portion of the increased federal funds should be reserved and set aside for community clinics, who have a large volume of uncompensated care as well, and can and should be expected to serve as the safety valve for the care to the uninsured that is being unnecessarily delivered in hospital emergency rooms because they are too often the only place the uninsured can turn for certain access to care.³⁴

Care for the uninsured works best when safety net providers collaborate,³⁵ yet the silo funding they receive discourages a collaborative approach to care. There should be incentives in the waiver for public and private sector safety nets receiving DSH funding to collaborate in care for the uninsured and accountability to assure they actually do so.

Counties without county hospitals have substantial expenditures for the uninsured that are not now not matched.³⁶ Some of these counties receive no DSH and SNCP funds to assist in their missions to care for the uninsured.³⁷ These small rural counties and payor counties should have the option to access FFP using their county match to cover MIAs in their counties.³⁸

There are now ten local coverage expansion initiatives with funds totaling \$180 million annually that are making important but uneven progress in expanding eligibility and services to the uninsured.³⁹ The next round of waiver negotiations should open this opportunity up to more counties, re-allocate funds to those who are making the most important strides and increase the pot of funds to allocate to counties who are most committed to pioneer improvements in their systems. The process should continue to be competitive grants in order to bring out the most creative and collaborative responses from local safety nets. In the waiver terms and conditions, the federal government should clarify that local programs, such as Healthy San Francisco, the WELL program in San Mateo and Healthy Kids programs throughout the state can wrap their local funding around Medi-Cal coverage.⁴⁰

¹ We estimated an increase of nearly 500,000 uninsured Californians due to a projected increase in the state's unemployment rates from 5% to 8.5%. See Impact of Unemployment Growth on Medicaid, Uninsured and State Revenues at <http://facts.kff.org/chart.aspx> from Dorn et al, Medicaid, S-CHIP and the Economic Downturn (Urban Institute, April 2008)

² Like California's AB X1 1 (Nunez), President-elect Obama proposed covering all children including a parental mandate, covering the MIAs through Medi-Cal (Medicaid), subsidizing premiums on a sliding fee basis, insurance reforms to assure availability and pay or play for employers. One key difference is the lack of an individual mandate for adults in President-elect Obama's plan.

In several of the federal reform proposals and in Senator McCain's proposal, there were changes proposed in the federal tax rules governing health benefits.

³ See California Performance Review Commission, Prescription for Change, Issues and Recommendations (January 2005) at <http://cpr.ca.gov>

⁴ See Peter Harbage, A Roadmap to Coverage: Implementing a Childless Adult Medi-Cal Waiver in California (Blue Shield of California Foundation, March 2008)

⁵ Implementation will depend on provider, plan and county willingness to make the match. If for example, counties are willing to make the match to cover the MIAs, but hospitals are not willing to make the match to increase their reimbursement to Medicare levels, the MIAs would be covered but hospital rates would not be increased. Currently, some plans make a match, know as a quality assessment fee and some providers and counties make matches for DSH, Safety Net Care Pool, Inpatient Rates, Medicaid Administrative Claiming and Targeted case Management. Under the reform package in AB X1 1, hospitals, counties, and employer fees/taxes would have been used to draw down federal match. While negotiations were arduous, agreements were reached with hospitals and counties, but not health plans.

⁶ Federal DSH funding for example is capped in several ways and cannot exceed a facilities uncompensated care cost of caring for the uninsured and the Medi-Cal underpayment. If rates are increased to Medicare levels and half the uninsured are covered, a facility's ability to claim and retain DSH would fall quite dramatically. Some hospitals and advocates share a belief that uncompensated care can be reduced and DSH funds retained; federal law does not permit this. Rather than return these funds to the federal government as a windfall, California should request to reinvest these funds in the coverage expansion.

⁷ Preventable hospitalization rates were 1/3rd lower for families in managed care and 1/4th lower for the disabled in managed care. See Primary Care Research Center, Preventable Hospitalizations Among Medi-Cal Beneficiaries and the Uninsured (December, 2007) at www.chcf.org

⁸ The COHS model is a single plan without other competitors, which gives the county greater control over the range and selection of providers in the plan. Because it is Knox-

Keene licensed, patients are assured they will be treated in a timely fashion, with a geographically convenient choice of primary care physicians or clinics and timely access to specialty services.

⁹ Nearly a third of Medicare recipients voluntarily enroll in HMO's as compared to just over 10% nationally. Rand Corporation, Medicare Facts and Figures: a California perspective (February 2006) at www.chcf.org.

¹⁰ MIAs were added to the Medi-Cal program under then Governor Ronald Reagan in the early '70s and terminated under then Governor Jerry Brown in 1982-83. Certain services, such as long term care for the MIAs were continued at the state level while the rest devolved to the counties. Over time, certain services and classes of beneficiaries returned to Medi-Cal, often due to federal matching opportunities: pregnancies and family planning, breast and prostate cancer, TB and HIV.

¹¹ Dougherty and Wulsin, Health Information Technology, Electronic Medical Records – A Primer, California Research Bureau (September 2008)

¹² Ibid.

¹³ MMIS systems can be reimbursed at a 75% matching rate under Medicaid. 42 CFR 433.116

¹⁴ See Family Code §§ 3750, 3900 and 3950.

¹⁵ See ITUP, §1115 Waiver Research and Demonstration Projects (November 2003) at www.itup.org/reports.html#wavier

¹⁶ See Ucello and Gallagher, General Assistance Programs: the State-Based Part of the Safety Net (Urban Institute, January 1997) at www.urban.org/publications Only a handful of states provide no medical assistance in any form to their MIA or GA (General Assistance) populations.

¹⁷ See Wulsin, Safety Nets and Coverage Expansion: ITUP Recommendations (July 2007) at www.itup.org/reports and Dam and Wulsin, Overview of Health Insurance coverage and Financing for Low Income Populations in California 1998-2008 (August 2008) at www.itup.org/reports

¹⁸ Under the Governor's proposal and AB X1 1 (Nunez), an estimated 650,000 uninsured adults (MIAs) with incomes below poverty and 860,000 uninsured indigent adults (MIAs) with incomes between 100% and 200% of FPL. Nearly half (44%) report they now have no usual source of care and just over three in ten (31%) report using a community clinic or county clinic. 2.5% report using an emergency room or urgent care clinic. See Safety Nets and Coverage Expansion: ITUP Recommendations at www.itup.org/reports.

The numbers of uninsured MIAs (1.5 million eligibles) are somewhat higher than the numbers of uninsured users of county health services (1.2 million). Assuming the cost of

managed care is \$200 pmpm or \$2400 annually, the cost of enrolling all 1.5 million in managed care is \$3.6 billion or roughly twice what counties now spend on the same population and exactly equal to the sum of the federal match and a county match.

¹⁹ In the recent Governor's Budget, it is projected that total realignment funds will fall by \$500 million or roughly 11%. In the Urban Institute study the numbers of uninsured would have increased by a somewhat less than 500,000, of whom roughly 30% would be MIAs (adults without children living at home and incomes of less than 200% of FPL.

²⁰ We do not have any data on the amount that county mental health departments are spending on the Medically Indigent Adults (MIAs). Counties receive in excess of \$1 billion through mental health realignment and over \$680 million through Proposition 63 that can be spent on mental health for MIAs and others. Legislative Analyst's Office, California's Mental Health System: Underfunded from the Start, Overview of the 2000-01 Budget Bill at www.lao.ca.gov and California Mental Health Directors Association, History and Funding of California's Public Mental Health System (March 2006) at www.mhac.org/mhservices/index.cfm

²¹ Counties have at least \$3.8 billion in funding for physical health services, of which a significant portion – realignment, county match, Prop 99, SB 12 and tobacco litigation settlement and other local funding streams could be used as match. See Wulsin, Safety Nets and Coverage Expansion: ITUP Recommendations and Overview of Health Insurance coverage and Financing for Low Income Populations in California at www.itup.org/reports.

²² OBRA of 1986 funds and requires states to cover undocumented persons eligible for Medicaid for emergency services.

²³ Federal law caps each individual facilities DSH payments at the costs of its uncompensated care to the uninsured, plus its uncompensated care to Medi-Cal patients. When facilities are paid at Medicare rates for Medi-Cal patients and MIAs, most of their uncompensated care eligible for DSH reimbursement disappears and unless re-allocated under the waiver would revert to the federal government.

²⁴ Counties in California have an 1115 waiver for mental health that makes the county organized mental health delivery system the exclusive source of care. From the perspective of counties with county hospitals, the COHS structure gives counties the organizational infrastructure to assure that the MIAs are treated by safety net providers and others in their communities. It does not allow for the long waits for specialty care and long travel times for primary care that plague some county health systems. It would transform the roles of primary care, which become the focal point for care to the MIAs and relieve financial and workload pressures on local emergency rooms.

²⁵ The selective contracting waiver releases the state from freedom of choice restrictions and allows the state to competitively bid its hospital services in those communities where there are sufficient providers to assure local competition. CMAC (California Medical Assistance Commission) also negotiates the reimbursement rates for geographic managed

care and until recently COHS counties as well. Its most recent report details \$572 million in program savings through its negotiations. The Commission reports that its rate negotiations have increased payments at 3.8% annually over the past 25 years as compared to an increase of 6.3% without hospital selective contracting for an accumulated savings of \$10 billion. California Medical Assistance Commission, 2008 Annual report to the Legislature at www.cmac.ca.gov/annual.asp

²⁶ See Harbage, Schneider and Ryan, California's Medicaid Hospital Financing Waiver (April 2006) at www.chcf.org/topics/medi-cal/index.cfm/

²⁷ Ibid.

²⁸ Ibid.

²⁹ See n. 25

³⁰ California's Medicaid Hospital Financing Waiver (April 2006)

³¹ California's Medicaid Hospital Financing Waiver (April 2006). For example, the local coverage initiatives waited nearly 14 months from their inception to be paid for their services. Pizzitola, California's Coverage Initiatives: Year One Challenges and Successes and a Forecast for Year Two (Insure the Uninsured Project, December 2008)

³² Hospitals are under financial pressure from a number of fronts including the need for seismic upgrades, the demands of medical educators and county executives with shortfalls in other funding and demands from local law enforcement. It is essential to carefully monitor the funds targeted for care to the uninsured to assure that they are spent for these purposes.

³³ Some counties in 2004 reported devoting over 70% of their MIA expenditures to inpatient services. See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care to the Uninsured (Insure the Uninsured Project, October 2008) at www.itup.org/reports.html

³⁴ For example, in 2004 clinics reported receiving only \$60 million from counties to compensate for their \$550 million in costs for over 5 million visits by the uninsured. Ibid. Counties such as Alameda and Los Angeles have excelled in developing excellent relations with their clinics. California's Safety Nets and the Need to Improve Local Collaboration in Care to the Uninsured

³⁵ Ibid.

³⁶ At least \$500 million in expenditures for the uninsured are reported by the counties without county hospitals. Safety Nets and Coverage Expansion: ITUP Recommendations at www.itup.org/reports.html

³⁷ Ibid.

³⁸ Ibid. There are at least three ways for counties to make a match – as IGTs, as CPEs or as a local match. We think the local match option is easiest for small counties while the CPE or IGT model would be easiest for the payor or hybrid counties. Public hospital counties have in the past indicated a preference for IGTs or CPEs.

³⁹ See Pizzitola, California's Coverage Initiatives: (Insure the Uninsured Project, December 2008) and Espejo, Overview and Update of California's Section 1115 Waiver Coverage Expansion Initiatives. (Insure the Uninsured Project, November 2008) at www.itup.org/reports.html

⁴⁰ See Wulsin, ITUP Thoughts on California Federal Health Care Issues (Insure the Uninsured Project, November 10, 2008) at www.itup.org/reports/html There is a need to clarify that the range of coverage expansion initiatives being developed by local governments for the uninsured are not subjected to the provisions of 42 USC 1396a(25)(g) and are thus able to wrap around or supplement Medicaid coverage.