The Safety Net and Transition to Coverage for California's Uninsured

September 28, 2009

The safety net includes community clinics, public hospitals, some private hospitals and doctors and local health plans. Most of their patients and subscribers are low income Medi-Cal, Healthy Families and uninsured patients.

When federal reform passes, most (we estimate 80%) of their uninsured patients will have the opportunity and obligation to enroll in health coverage. This is because, by all accounts, federal reform will exclude undocumented workers, which account for somewhat less than 20% of California's uninsured. The safety net's low-income uninsured patients (up to 133% of FPL) will enroll in Medi-Cal; most will likely enroll in the managed care version of Medi-Cal. Moderate-income uninsured patients will likely enroll in coverage through the Exchange.

The move to Medi-Cal managed care has already happened for children and their parents with few adverse and some beneficial consequences. For some populations, such as the MIAs (medically indigent adults), the programs used to deliver care are quite different, however. First, MIAs are not now on Medi-Cal, but rather receive their care in county programs that often differ substantially by county. Second, many of those county programs bear only a faint resemblance to Medi-Cal managed care coverage; in other words, their care to the uninsured is more likely to be episodic and unmanaged and their patients are far less likely to have a usual source of care.

Let's review some of the differences: eligibility processes, eligibility rules, provider networks, reimbursement rates, the use of managed care, and the roles of hospital emergency rooms and primary care doctors. County eligibility processes and eligibility rules are comparatively simpler than those for Medi-Cal and are often handled by the county health department rather than the social services office. Some county provider networks are much more limited than Medi-Cal; the most severely limited are Merced and Fresno, which each block grant their entire program to a single community hospital. Others, such as the small CMSP counties and Orange, are the same as the Medi-Cal provider network. In provider counties with public hospitals, few or no private doctors and hospitals are part of the networks. In some counties with county clinics, local non-profit community clinics are excluded as well. Reimbursement rates differ as well. In some counties, provider reimbursement rates are lower than Medi-Cal. In others, they are the same as Medi-Cal or at facility cost, while in others it is a local block grant to a public or private facility. Average spending per user is less than Medi-Cal (about half), so average utilization and access are far lower. Finally, only a few Bay Area counties (such as San Francisco, San Mateo and Contra Costa) are using a combination of a local health plan with local clinic networks to manage care for the county indigent. Thus, the model of care for the uninsured in local safety nets would likely shift from one that is episodic, emergency room centered and often uncoordinated to a coverage model

based on primary care, care management for the chronically ill, and continuity of care.

For many counties, the move to Medi-Cal managed care with federal reform will entail a broader choice of providers, better reimbursement for providers, financial benefits for local government, and a shift to a model of care with which most safety net providers are already familiar. For the previously uninsured population, there will be more timely access to care, a reliable usual source of care and a new emphasis on continuity of care and prevention.

Reform may improve care but also poses challenging questions to local safety nets. Will a broader choice of providers destabilize public hospitals? How quickly can they adapt to a more competitive managed care framework? What are the infrastructure needs in terms of primary care clinics? Will emergency rooms topple as they lose a steady stream of uninsured patients and attendant revenues? Will there be adequate capacity among local providers to meet the increased utilization by the newly insured? Can they handle the increased demand for care management for the chronically ill? Can and will they coordinate their services? Are adequate preventive services available? We think the safety net is in good shape to handle this type of transition and that plenty can be done to ameliorate these worries. The safety net already has the local Medi-Cal managed care infrastructure in place and has handled the transition of coverage for a large number of Medi-Cal families and children in the past.

What do you think? And what are the biggest local challenges in your community?

The far larger share of the higher income uninsured (moderate and middle at 133-400% of FPL) will likely get their coverage through the Exchange. The recent Council on Economic Advisors' analysis projects that nearly 2/3rds of California's uninsured will be covered through the Exchange and over 1/3rd through the Medicaid (Medi-Cal) expansion.[i]

The Exchange proposed is a hybrid, somewhat like the Healthy Families program for uninsured children, somewhat like the HIPC/PacAdvantage for small employers. Like Healthy Families or HPIC/PacAdvantage, it will offer a choice of plans. Like Healthy Families, it will have a premium subsidy in the form of a tax credit with rules for distributing the tax credits to the uninsured and small employers. The process will be simpler than in Healthy Families; essentially the credit will be based on an individual's federal tax forms without the complex income disregard rules and calculations of Medi-Cal and Healthy Families.

Like Healthy Families and the HIPC, the Exchange will emphasize a more commercial model of coverage with few, if any, of the Medi-Cal special protections (like DSH, FQHC and special status) for safety net providers and plans. Most safety net providers and plans participate minimally in the private insurance market for

small employers and individuals although they do participate in the Healthy Families program for uninsured children.

Within the Exchange, there will be sliding fee scale copays and premium contributions to make coverage affordable. Subscribers choosing the more costly plans will pay the full costs of the incremental price difference. In other words, the Exchange is a more competitive market price driven model within which safety net providers and plans will need to compete effectively on price.

Safety net plans and providers have inherent advantages of language, location and name familiarity. Public hospitals and clinics are able to hire doctors, while their competitors cannot. Unlike the commercial market where advertising, agents and brokers are key parts of the health plan and provider marketing process to small employers and individuals, the Exchange will likely offer a more level playing field for marketing and enrollment. Based on our research, some safety net plans have been highly successful competitors in the Healthy Families market, whereas others have not.[ii] Some community clinics see a strong share of Healthy Families children, but most do not.[iii] Some county hospitals and county clinics have not made a major effort to compete in Healthy Families for a variety of reasons. Local Healthy Kids programs have been a highly successful in improving care for uninsured children not otherwise eligible for Medi-Cal and Healthy Families and have also served as an excellent enrollment and marketing arm for safety net providers. Will the safety net maintain and build upon these vital programs? It appears that in many Bay Area counties, they will.

What do you think have been the most important determinants of safety net providers' successful participation in your local Healthy Families market and how do you think those would apply in the Exchange?

What other steps should safety net providers be taking to prepare for competition within the Exchange or Medi-Cal managed care?

- First, these providers should be taking full advantage of the opportunity and enhanced funding to build electronic medical records.
- Second, they should build the local safety net into a coherent, coordinated and integrated network of care that works the same for MIAs and Medi-Cal managed care subscribers; this means using local managed care, reorienting to a primary care centered delivery system and better coordinating and managing primary and specialty care for the chronically ill.
- Third, they could establish accountability and incentives for improving quality and patient outcomes; poor quality and poorly performing professionals need to be quickly retrained, carefully monitored and if the poor performance continues, let go—promptly.
- Fourth, they should make flexibility, the capacity to adapt to rapid change, innovation and the need to compete organizational imperatives. Safety nets need to look to Group Health Cooperative, Intermountain Health Systems, Health Partners, Kaiser, and Geisinger to understand what these systems are

doing successfully that can be applied to the very different context of their own safety net.

- Fifth and most immediately, California will seek a Section 1115 waiver to expand managed care and provide opportunities for increased federal matching of local expenditures for the medically indigent adults. Safety nets should embrace this opportunity to get a head start on federal reform.[iv]
- Sixth, safety net providers should connect to low wage small employers and the flex workforce, since their employees are the safety net's patients.
- Seventh, safety nets should work with Congressional leaders and the Obama Administration to assure participation opportunities for local safety net plans in the new legislation. They fit into neither the public plan articulated in the House bill nor the cooperatives envisaged in the Senate Finance Committee's deliberations, yet they are an important building block for our state's implementation of federal reform.

Prepared by Lucien Wulsin, Insure the Uninsured Project September 28, 2009

---

[i] California Healthline, New Data Underscore the Impact of Health Care Refrom for California (September 23, 2009) at www.californiahealthline.org; Council of Economic Advisors, The Impact of Health Insurance Reform on State and Local Governments (September 15, 2009) at www.whitehouse.gov

[ii] See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008 at www.itup.org/reports In some Bay Area counties, the local safety net plan has achieved more than a 50% market share, while in one Southern California county, the market share is less than 11%.

[iii] Crall and Wulsin, Counties, Clinics, Hospitals, Managed Care and the Uninsured in Eight California Counties: a Ten Year Trend Report 1996-2006, (Insure the Uninsured Project, October 2009) Among clinics in three Southern California counties, the percentage of Healthy Families patient visits ranged from a low of 1.1% to a high of 4.1% of total visits. Among clinics in five Bay Area counties, the percentage of Healthy Families patient visits ranged from a low of 0.5% to a high of 3.5% of total visits.

[iv] The Framework laid out by Senator Baucus affords states the opportunities to secure federal Medicaid matching for the MIAs in 2011 as well as pioneer the exchanges and tax credits for small low wage employers.