



Attendees

Margaret Beed, MD – Health Care Agency/Public Health Services
Greg Buchert, MD – CalOptima
Steve Delgadillo – Community Action Partnership of Orange County
Stacy Dyer, Orange County Health Care Agency
Janice Frates – Health Care Administration Program, CSULB
Olga Garcia – CalOptima
Jon Gilwee – UCI Medical Center
Russ English – Western Medical Center of Santa Ana
Troy Jacobs, MD/MPH – Orange County Health Care Agency
Ambrocia Lopez – Coalition of Orange County Community Clinics
Megan MacDonald – Orange County Health Care Agency
Diane Mendoza, Children's Hospital of Orange County
Adela Montanez – Latino Health Access
Liz Pejeau – Public Law Center
Susana Perez – UCI Medical Center
Debbie Phares – Orange County Congregation Community Organization
Mary Pinkerson – St. Joseph Health System, Center for Healthcare Reform
Cecilia Bustamante Pixa, MPH – St. Joseph Health System
Veronica Richardson – Insure the Uninsured Project
Nancy Rimsha – Health Consumer Action Center of the Legal Aid Society-Orange Co.
Gina Tang – UCI Medical Center
Kathryn Tarbell – Health Consumer Action Center of the Legal Aid Society-Orange Co.
Quyen Vuong – Healthy Smiles for Kids of Orange County
Susan Zepeda – The HealthCare Foundation for Orange County

Introduction

Veronica opened the meeting with a brief history of Insure the Uninsured Project, reminding attendees of the upcoming annual conference on February 16th in Sacramento. Introductions indicated participants represented many Orange County healthcare stakeholder organizations working with the uninsured.

Updates

Veronica provided a 2004 data summary of Orange County, highlighting key points and significant changes in the past year. A PowerPoint presentation summarizing these

points was distributed to workgroup attendees on February 3rd. Some highlights of the presentation are as followed:

- In 2003, Orange County became a “majority-minority” county.
- Although Orange County has the lowest percentage of low-income residents and lowest proportion of Medi-Cal enrollees in the Southern California region, it is important to keep in context the county’s large population (2nd largest in the state) in relation to the rest of the counties in California.
- Slight declines in Healthy Families enrollment may be attributed to the introduction of a new contractor, Maximus, which has had some start-up problems. Maximus is also expected to administer the new streamlined Single Point of Entry (SPE) proposed by Governor Schwarzenegger.
- A discussion of community clinic information revealed that five clinics are currently in the process of applying for federally qualified health clinic (FQHC) status.

Californians for Healthy Kids

Debbie Phares is the Financial Capacity Organizer for the Orange County Community Congregation Organization (OCCCO). Access to health care for all children is one of OCCCO’s top priorities. As an affiliate of the Pacific Institute for Community Organization (PICO), OCCCO also works on a statewide level to advocate for children’s health care using the Healthy Kids model pioneered by Santa Clara County stakeholders. PICO played a leading role in developing the Santa Clara County program. Debbie provided an update on the Californians for Healthy Kids effort.

Debbie noted that California Health and Human Services Secretary Kim Belshe has been quite receptive to the group’s proposal. The proposal is also an attractive “legacy” item for the Schwarzenegger administration.

Legislation has been introduced as a “placeholder” (spot bill) but is still being revised. Many legislators are willing and eager to be sponsors. Public action for the initiative is planned for April 13th in Sacramento. Debbie will notify participants when the legislation is introduced as a more specific bill. Major statewide partners include the California Teachers Association. For more information, please refer to the 100% Campaign website: www.100percentcampaign.org.

Proposed 2005-2006 State Budget

Veronica provided attendees with information on the health and human services changes within the proposed 2005-2006 state budget. Highlights from the presentation are as followed:

- Overall, state general fund revenues have increased 7.0%.
- All programs within the Department of Health & Human Services are proposed to increase with the exception of CalWORKs. This includes an 8.2% increase for Medi-Cal, which accounts for 72% of state general fund expenditures.

- The Administration is proposing a shift of the AIM program (funded currently by Prop. 99 funds) to other federal/state funding sources; children currently covered by AIM will be able to qualify for Healthy Families which garners a higher federal match.
- Other proposed programs include an obesity initiative (uses a public health approach that would include funding repositioning and requiring more physical activity in schools), the California Rx program, and expanded newborn genetic screening.

Participants discussed the challenges of obtaining more Medi-Cal funds for Orange County as a donor county and for California as a donor state, rather than attempting to redirect funds from recipient counties or states who will oppose any changes to the status quo. The Bush Administration has proposed Medicaid block grants, however the National Governor's Association has vigorously opposed this idea.

Medi-Cal Redesign

Veronica provided an overview of the six proposed reforms under Medi-Cal Redesign with discussion of each proposal element provided by the audience afterwards.

Managed Care Expansion

The administration proposes to expand managed care to 816,000 additional patients in the state. Families and children would be enrolled in 13 additional counties while seniors and disabled individuals who are not also Medicare eligible would be enrolled in managed care (in essence, the majority of impacted seniors and people with disabilities will consist of disabled individuals who have not yet met the 2-year eligibility requirement under Medicare). Implementation would begin in January 2007 with expected savings of \$177M to be realized beginning in FY 2008-2009.

Orange County already has experience with aged, blind, and disabled populations through its County Organized Health System (COHS), CalOptima. Participants noted that it is vital to make sure that beneficiaries have coordinated care through qualified providers. A lot of handholding is required to overcome beneficiaries' fears about potential loss of benefits, having to change doctors, etc. There are a lot of benefits to be gained from successfully implementing managed care, but more harm than good can come about if implementation is not done well.

Participants note that managed care does offer more services through case management and disease management programs. In addition, the health plan is more accountable for quality than a fee-for-service provider. CalOptima created a system of willing providers and health networks that take care of problems at an earlier stage of implementation.

Right now, dual eligible (Medi-Medi) beneficiaries and a small proportion of other beneficiaries (some disabled) receive care through CalOptima Direct, a less restrictive managed care program, rather than a tightly contracted private provider network. This program is similar to CCS for children, where "any willing provider" can participate.

There are challenges to managed care in Orange County. The intensity of care and case management that CalOptima's population requires makes continuing participation in the plan challenging for some providers. Most COHS' are now operating at a deficit. DSH payments have declined significantly because managed care days don't count. Several health plans have withdrawn from the market because the capitation doesn't cover the cost of care. Before considering managed care expansion, the DSH subsidy loss for managed care patients needs to be resolved, especially when considering large counties such as Los Angeles. It should also be discussed how managed care for the aged/disabled will be sustainable into the future.

Some plans do a much better job of treating the severely disabled than others. UCI, for example, has more specialists and is more accommodating, so it attracts more disabled beneficiaries. These providers should be paid more. As an example, Inland Empire Health Plan is actively recruiting disabled beneficiaries and making special efforts to help providers serve them well.

Beneficiary Cost-Sharing

The administration proposes monthly premiums for individuals with incomes above the federal poverty level and for those seniors and people with disabilities with incomes above the SSI/SSP payment level. Those who have Medi-Cal with a share-of-cost, infants under 12 months, and 1931(b) enrollees enrolled in CalWORKs would be exempt. Premium payments would be \$4/month for each child under 21 and \$10/month per adult with a \$27/month cap per family. Two months of missed premiums will be cause for disenrollment. Expected implementation would be January 2007.

Participants acknowledged that a premium may be preferable to a co-payment for providers (unless the patient is uninsured), but expressed concern that the proposal is likely to encourage healthy eligibles to leave the program, result in adverse selection for CalOptima due to fewer well individuals paying premiums, and cause more use of EDs. The theory that people may value their insurance more because they are now paying for it may not exactly hold water if they can't afford it. Logistical hassles and the cost of collecting the premiums are also considered a problem. Orange County United Way has set up limited sponsorship for Healthy Families children. Could something like this be established for Medi-Cal to make the premium more workable?

Dental Benefit Cap

The administration proposes to limit dental services to no more than \$1000 per 12-month period. This proposal would apply to most dental services, including dentures. Savings of \$50M are expected beginning FY 2005-2006 with expected implementation by August 2005.

Attendees noted that \$1000 may cover the cost of the dentures, but does not cover the full cost involved in obtaining dentures, such as any necessary extractions. Extractions and dentures are already currently overused as an alternative to restorative services.

Hospital Refinancing

The state currently uses a “Selective Provider Contracting Waiver” to negotiate for lower cost providers, ensure geographic access to services, and provide for the availability of all necessary services. The waiver is set to expire on June 30, 2005. California, as well as other states, has been scrutinized by the federal government for its usage of IGTs.

As of yet, it’s still unknown where negotiations are between the stakeholders. Not enough information has been given by the entities involved to evaluate the proposal nor have they clarified a methodology for Certified Public Expenditures (CPE, proposed to replace the IGT method). This proposal does mark a significant policy shift with Medicaid, a state/federal partnership, which is now being turned into a federal/local (county, UC hospitals) partnership.

California expects to lose significant DSH monies, which would particularly impact public and academic hospitals. There are eight or nine DSH hospitals in Orange County – loss of these funds would impact services to Medi-Cal and uninsured beneficiaries.

Children’s Application Processing

The Administration proposes to allow the Healthy Families processor, Maximus, to process applications for Medi-Cal. They currently forward these applications to the appropriate county for processing. After eligibility is established, DHS will confirm eligibility and forward the application to the county Department of Social Services for final approval. Expected savings of \$1.2M beginning in FY 2005-2006 with ongoing savings of \$15.9M would be expected. Implementation would begin March 2006.

Concern was expressed that Maximus has not demonstrated full competence to handle Healthy Families. Medi-Cal is a much more complex program and other states have also had problems with Maximus. A private contractor needs to have a stellar track record.

In theory, creating an effective computerized eligibility screening system could best be done by a private contractor if it had the right computer programming. Many “data silos” already exist; what is needed is better coordination. Some of the less common programs (e.g., the working disabled program) are not known in the county programs. We should look to the experience of New York post-9/11 who simplified the Medicaid application to just two pages.

State Monitoring

The administration proposes to contract with a vendor to monitor county performance to make sure eligibility determinations and redeterminations are performed within federal guidelines (within 45 days of application for initial determinations; annually for redeterminations). No fiscal savings are expected.

Next Steps and Priorities

Veronica thanked participants for their participation and advised the group that an e-mail of the PowerPoint presentation and notes from the meeting will be sent out in the coming weeks.

ITUP would like to thank Mary Pinkerson and Monica Mano for their assistance in securing a venue for this meeting and Janice Frates for providing ITUP with a written record of the day's discussion.