

Insure the Uninsured Project traveled to seven distinct regions of California in 2008 for our Regional Workgroups. As a component of each of these meetings, health reform and local needs assessment discussions were held in order to gauge local reform priorities in San Diego, Orange County, Los Angeles, the Central Coast, the Central Valley, Bay Area, and the North Rural areas.

Health reform is once again a national priority, and it would be a devastating blow to let this opportunity slip due to political or ideological differences. For health reform to work effectively for California, the reform components must work together. There isn't one singular thing wrong with healthcare, it is a combination of shortcomings: cost containment, access problems, administrative lag, infrastructure, lack of health information technology, the failure of the health system as a whole to adapt to different economic, social, and geographic areas (this is especially important in California). As such, it is not possible to design or implement a single approach to coverage and access for California's uninsured, yet health reform will not be successful as a piece-meal or balkanized amalgamation of policies and regulations.

These recommendations should be viewed as details within a comprehensive reform plan and not as stand-alone components. These recommendations originated from discussions with local health experts, local government officials, providers, labor union representatives, hospitals, businesses, advocates, academics, health providers, researchers, consultants, philanthropists, community organizers, health plans, insurers, and public health officials. Stakeholders involved in our discussions were encouraged to speak openly about what are perceived to be the highest priorities and biggest threats to health coverage. Below are ITUP's 2008 regional workgroup recommendations for health reform, summarized from these meetings.

### **Utilize and expand proven coverage models as a base for health care in California**

Expanding health coverage through existing programs was deemed desirable compared to creating new programs. The consensus was that new programs increase confusion and add to the already difficult-to-navigate health system. By expanding current programs, administrative work is not duplicated and current enrollment, utilization and reimbursement protocol remains mostly the same.

The coverage initiatives have proven most successful in the Bay Area, Ventura and Orange. These could serve as good models for other areas. These models would not, by any means, be generalized to California's rural areas.

### **Preserve Oral Health**

Oral health's importance in public or clinical health has been absent. Because of this, dental health funding is especially susceptible to budgetary cuts. Utilizing an integrated managed care model for oral health may be a way to solve this, but ultimately, the health field must recognize oral health as a necessary component to patients' overall health.

**Coordinate more effectively with Public Health**

Basic public health promotion is absent throughout much of California's rural areas. Typical health outreach measures aren't easily applied in these low populated regions. This affects screening rates in these areas, and leads to decreased long-term health and poor health outcomes for chronic conditions.

**Shared Responsibility for Financing and Cost Containment must be included in any health reform**

Cost sharing is a must for effective health system transformation. Responsibility for the transformation must be shared among employees, employers, health plans, hospitals, providers, and insurers. This was a resounding theme that emerged through all regions of the state.

Subsidies for small business must be a part of health reform. Workgroup participants in Orange County and San Diego expressed these views the most frequently.

Health care will be unsustainable unless cost containment and affordability issues for small businesses and individuals are addressed.

**Respond appropriately to California's diverse economic and geographic landscape**

California is an economically, ethnically, and geographically diverse state. As such, health reform must take into consideration certain unique needs. For example, sharply contrasted against San Diego and Orange County's small private business is the dominant role of agriculture in the Central Coast/Valley and North Rural regions. Los Angeles and the Bay Area rely heavily on community clinics and public hospitals while rural areas have no public hospitals and no public health plans, and rely heavily on rural health clinics to offset their dearth of participating private physicians.

A large portion of the economy in California's Central Coast, Central Valley, and rural areas is agriculture based. Migrant farm workers, documented or otherwise, prove a difficult population to provide care for. Coverage for these populations should be administered through an employer association and provided by a network of linked clinics.

San Diego needs solutions to affordability for small private businesses. The aforementioned subsidy for small businesses to provide health coverage is one strategy. Without truly effective cost controls, a mandate on employers would adversely affect job growth and overall sustainability of small businesses.

Residents of the rural areas of California need a different coverage solution; one idea would be to establish a rural purchasing pool. California's purchasing pool for small employers has, in the past, not lived up to expectations as it was voluntary, played under a different set of underwriting rules and thus led to unfavorable risk pooling. Couple the large geographic spread of rural areas, the small provider base and the lack of provider

and plan competition, the problem is not an easy one to solve. Guaranteed issue with an individual and employer mandate would still not be enough without infrastructure improvements for purchasing and price competition in rural areas.

**Improve primary care infrastructure and performance**

In rural areas of California, having insurance does not mean access. Infrastructure limitations, smaller provider base, and wide geographic areas make it difficult to adapt a typical health care model to rural areas.

One way to expand infrastructure in rural areas is by expanding the roles of nurses and physician assistants. A broadened scope of work for these already well-trained professionals could be the keystone to health system improvements in rural areas. If coupled with improvements to the existing network of rural health clinics, this would be invaluable to the residents of rural areas of California (Central Valley, North Rural, and parts of the Central Coast).

Physician recruitment and retention is a priority in the north rural regions. Reimbursement rates remain low and providers in rural areas are too often inundated with the challenges of sustaining a business to effectively focus on providing healthcare. It is simply too difficult in rural settings for doctors to duplicate administrative work. One solution to solve this problem presented at the North Rural workgroup was to change the rule prohibiting hospitals from running clinics and doctor's offices for rural areas.

In the Bay Area, there is concern over maintaining the viability of the safety net during a reform process. The public and private safety net is an integral part of that region's success in caring for medically indigent adults and compromising this would be detrimental to health coverage for millions.

In Los Angeles, active public-private partnerships between the county and community clinics provide care to the uninsured. Los Angeles County relies on its network of community clinics and county hospitals to provide care to its medically indigent adults. Deepening this relationship in Los Angeles County is an important measure to care for millions of Los Angelenos under a health system overhaul.

General improvements to integration, infrastructure and capacity of community clinics would greatly improve and expand care to millions more Californians across the state.

To improve quality of care, a pay for performance model for physician reimbursement may be adopted. Although pay for performance is not able to capture and adjust for the unique needs of each patient, it is considered a viable method to improve quality.

**Improve and expand Medi-Cal**

With targeted changes, expanding Medi-Cal was considered by our regional workgroup participants one of the best ways to expand coverage to California's uninsured. But many

providers do not accept Medi-Cal patients for the reasons that the program is too complex, the paperwork too extensive and the reimbursement too low. Simplifying and streamlining the program's eligibility, enrollment, and reimbursement would undoubtedly help to solve this problem, especially if coupled with an effective health information technology overhaul.

### **Expand Health Information Technology**

Improving and expanding health information technology (HIT) and electronic medical records (EMRs) is a strategy that would improve nearly all facets of health care if done properly. It would improve the quality of care to patients, reimbursements could be easily streamlined, and administrative costs could be decreased. The main barrier to widespread adoption of HIT is the initial investment required but HIT could save the state billions in health spending over the next decade.

### **Simplify administrative processes and reimbursement in California's public health care programs**

Most areas voiced concern over the difficulty involved in navigating the pathways of state health funding. A simplification of the categorical method of funding healthcare was suggested. A hybrid somewhere between categorical and block grant funding with improved accountability for performance would accomplish this.

Workgroup participants identified excessive administrative costs as a key area for attention in overspending of the health dollar. Our workgroup participants strongly believed that a larger portion of each health dollar must be maximized on providing health care instead of provider profits. Tighter controls on excessive administrative costs were recommended.

### **Ensure California's Health Funding**

Education, corrections, and health care are the three main publicly funded services in California. Education is essentially guaranteed its share through Prop 98. The Corrections Department is protected by the courts. Health spending has no comparable protections during state and local budget shortfalls. This concern was voiced in every single region of California covered by our 2008 Regional Workgroups. Health care needs similar protections enjoyed by education and/or corrections. A health trust fund would be one way of accomplishing this.

### **At the very least, cover all children**

There was unanimous workgroup consensus throughout all regions of California on the need for comprehensive coverage of all kids. Kids are cheap to cover and access to healthcare in a child's early life has been shown to improve health outcomes through adulthood. Workgroup participants across California were bitterly disappointed that coverage for kids was not accomplished in California during 2007 and early 2008.

Twenty-eight counties in California run Children's Health Initiatives to expand coverage for California's low-income families. Many Children's Health Initiatives throughout California are experiencing difficulties with sustainable funding.

On the Central Coast, the CHIs are particularly strong, but as with the Central Valley, one of the biggest barriers to further successes is getting funding to enroll more kids into coverage. Alameda County's Healthy Kids program was forced to shut down as a result of the loss of funding. The Children's Health Initiative of Greater Los Angeles has experienced short term and long term funding challenges, but enjoys a strong coalition and the administrative and financial backing of LA Care Health Plan and the Los Angeles First Five Commission.

The Children's Partnership is looking toward health information technology as a means to increase and streamline enrollment and lower the number of uninsured kids, many of whom qualify for public programs.

Kids coverage recently had the boost of a speedy Children's Health Insurance Program (CHIP) reauthorization with funding for program expansion under the Obama administration. And the enhanced Federal Medical Assistance Percentages (FMAP) rate of the economic stimulus package means significant new federal resources for California. The effects of these great strides are just being felt, and the increase in federal funding provides an important opportunity to reduce significantly the numbers of uninsured children in California. A more solidified and reliable state funding base to increase coverage for uninsured children is a high priority for regional workgroup participants throughout California.

### **Top 3 Recommendation Priorities**

Ideally, comprehensive health reform would solve all of these complex issues. California is a vastly diverse place, making a cookie-cutter approach to healthcare impossible.

These are the top three recommendations from our regional workgroups:

- 1.) Cover all children. Children are inexpensive to cover and health outcomes into adulthood would be significantly better if all children were covered. Kids are California's future and new federal funding is available.
- 2.) Health Information Technology. HIT has the capacity to save billions in health spending, reduce administrative costs and improve quality. HIT is one generalized improvement that California could implement on a large scale. To name a few benefits, HIT would generate better health outcomes for typically hard-to-manage populations, it would streamline administrative procedures, allow for better population health monitoring, lead to more effective public health measures, and would easily monitor and compare physician effectiveness.
- 3.) A Health Care Trust Fund. Ensure health funding with a designated and protected funding stream.