

ITUP's EXECUTIVE SUMMARY of RECOMMENDATIONS FROM ORANGE AND SAN DIEGO COUNTY REGIONAL WORKGROUP

Recommendations were as follows:

- Healthy Family (HF) enrollment:
 1. Orange and San Diego counties are interested in increasing Healthy Family enrollment. Compared to the coordinated Orange County approach, San Diego County Healthy Families outreach effort is more diffuse and the community has failed to come together for outreach. San Diego has had much better success outreaching to the uninsured through employers. School based outreach has been very successful in Orange.
 2. Community health centers prefer not to move families into HF, because they do not want to lose these patients to another provider and are paid less than cost.
 3. EDS does not do a good job reimbursing CAAs for approved applications.
 4. The marketing theory of HF is faulty; the problem is not brand name identification; it is closing the sale.
 5. Recommendations:
 - **Cover parents through HF**
 - **State should spend more money on community based efforts, which are far more effective than the state's advertising campaign.**
 - **Use an umbrella organization to coordinate outreach efforts**
 - **Train more Spanish speaking CAAs**
 - **Change the incentive to include retention as well as enrollment**

- MediCal enrollment:
 1. San Diego County appears to be more successful at getting eligible people into MediCal than Orange County.
 - San Diego has adopted a new approach to MediCal enrollment, which promotes rather than deter enrollment in public programs.
 - There has been a big effort to change the appearance of MediCal because many people were associating MediCal with welfare.
 - Outreach is located in community-based organizations in San Diego, whereas outreach workers are placed in health centers in Orange County.
 2. Most applicants prefer HF to the MediCal model. MediCal asset test is a hassle, but excludes very few.
 3. Orange County has been successful in moving people from TANF to work through CalWorks. Many people have shifted onto 1931b MediCal, but many people do not receive benefits at work or through public programs.
 - **Change incentives so people keep their coverage**
 - **There should be a single application for all programs.**

- Community clinics and Orange and San Diego Counties:
 1. Orange County community clinics are much smaller than San Diego clinics. Patients who visit the Orange County clinics are more likely to be uninsured. MediCal visits are declining while the uninsured visits are substantially growing.

- The county program for the indigent is a far better payor and partner for San Diego clinics than in Orange County.
 - UCI-Santa Ana is the only federally qualified center (FQHC) in Orange County.
 - In Orange County, CalOptima expanded the number of private providers willing to see MediCal patients and county indigent patients.
2. Clinics in San Diego have embraced managed care.
 - Clinics work with health plans to develop marketing strategies.
 - Clinics' success in San Diego is a result of private practices that were willing to take limited numbers of MediCal patients.
 - San Diego clinics have commercial contracts and see themselves as serving a broader community.
 - MediCal is more important to clinics in San Diego because their clinics are MediCal/FQHC reimbursed.
 - San Diego County contracts with community health centers as the exclusive primary care provider for the county indigent population,
 - In San Diego, some of the larger hospitals that see many uninsured patients have contracts with its community clinics to divert non-urgent patients.
 3. County determines eligibility for county indigent programs through extensive verification; clinic patients would rather pay for their care than go through the verification hassles.
 4. Recommendations:
 - **Develop a stronger primary care component for MSI; improve access and referrals to specialty care; it is primarily an emergency care oriented system**
 - **Get more Orange clinics FQHC certified**
 - **Develop and contract with systems for care for the uninsured**

➤ Hospitals:

1. Office of Statewide Health Policy (OSHPD) -- hospitals report what they are paid by the county for the care to the county indigent uninsured. Medically Indigent Care Reporting System (MICRS) -- the county reports what it is paying the hospitals.
 - **OSHPD and MICRS reported figures** are very different for hospital outpatient and emergency services and **need to be reconciled.**
2. There are more community clinics and fewer hospital-based outpatient clinics in San Diego. There are more hospital based outpatient clinics in Orange who are being reimbursed by the county.
3. Orange County hospitals report receiving \$100 million through Disproportionate Share Hospitals (DSH) whereas San Diego County hospitals report that receiving only \$60 million through DSH. Why the difference?
 - Due to the competitive hospital market in San Diego, few hospitals meet the DSH thresholds. DSH thus does not help pay for as much care to the uninsured in SD.
4. Why are Orange county clinics less successful in billing MSI for their care to indigents than OC hospitals?
 - Hospitals are better able to identify the uninsured eligible for MSI, bill and get paid for their care.

- It is difficult to get people apply for county health programs because of welfare stigma.
- 1115 waiver to cover Medically Indigent Adults (MIAs):
- To get a federal 1115 waiver to cover the MIAs, difficult changes would need to be made to assure the federal government that there is cost neutrality -- such as putting the disabled into managed care, which Orange County had done quite successfully.
 - While care to the disabled works well in CalOptima; it is believed that the county indigent population is very different from the MediCal populations and that managed care would not work well for them.
- Private coverage:
1. Options to increase private coverage of the uninsured:
 - Small low wage employer tax credit
 - Healthy Families Purchasing Credit
 - Refundable tax credit for flex workers
 2. About a million of the uninsured are offered coverage but do not take it because they cannot afford it.
 - Use HF purchasing credit because there is a 2/1 federal match and the funds are targeted to those uninsured who have not taken up employer offered coverage.
 3. Most employers do not offer coverage to flex workers even though they offer coverage to full time full year workers.
 - Refundable tax credits would be workable if employers can self-certify, receive a quarterly voucher, and use it with a carrier in a reformed individual market, which guarantees issuance of coverage and has transparent and comparable pricing information.
 4. Private coverage recommendations include:
 - **HRSA Pilot Program Options for Uninsured Children and Small employers through CalOptima in Orange County**
 - **Coverage for Home Care workers**
 - **Employer/employee options to buy in to public programs**
 - **Strong barriers to Crowd Out**