
**Summary of the
Regional
Workgroups:
2004/2005**

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Insure the Uninsured Project (ITUP) is a private, non-profit organization that identifies, assists, and promotes new approaches to expanding health care and coverage for California's uninsured. ITUP was established in 1996 and is funded by the Blue Shield of California Foundation, The California Endowment, the California HealthCare Foundation, and The California Wellness Foundation. Brooke Fox prepared this report.

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Executive Summary

This year marks the fourth annual convening of Insure the Uninsured Project's (ITUP) eight regional workgroups throughout California. ITUP's regional workgroups bring together a wide variety of local participants to discuss and prioritize local and regional strategies, learn of each other's challenges and successes and make recommendations for state policy makers. The workgroups addressed the following items: new county, regional and state data, Medi-Cal redesign, hospital financing, coverage expansion opportunities, efforts to expand coverage of all children and legislation affecting the uninsured. Each workgroup was adapted to fit the particular needs of the regions in addressing the most relevant issues.

Workgroup members made recommendations on proposals, policies and programs based on their experiences and needs. From the broad to the specific, workgroup members offered their suggestions on components of the Medi-Cal redesign, the hospital financing waiver and coverage expansion opportunities. There was consensus across workgroups that the proposed managed care expansion for aged, blind and disabled Medi-Cal beneficiaries can be beneficial so long as the implementation includes strong case management, quality providers and integration of services. Workgroup members from Riverside, San Bernardino and San Mateo shared anecdotal evidence in support of these assertions.

Many counties are currently engaged in planning and implementing local coverage expansions. The workgroups prompted others to begin thinking about how the funds for coverage expansion under the federal waiver could be best used in their counties.

On the topic of children's coverage, there was unanimous and strong support from workgroup members for covering all children in the next year. Many workgroup members expressed concern over the sustainability of financing local Healthy Kids programs, the need for simplification of enrollment and retention processes and better outreach. In 2007 the funds for many local Healthy Kids programs will run out. The introduction of the state legislation and ballot initiative to cover all kids may help achieve the goals to cover all kids. This was a high priority set in nearly every workgroup.

At the end of the regional workgroups, workgroup members were asked to share their priorities or goals for the next year. Three overarching priorities from workgroup members resonate at the completion of this year's regional workgroups:

- 1. Cover all children in California**
- 2. Simplify enrollment and retention processes for public programs**
- 3. Develop and test good models and infrastructure for adult coverage expansion**

Workgroup members shared their successes, approaches and challenges, setting priorities and making recommendations for state policy makers to further support their collective local efforts to cover the uninsured.

Introduction

ITUP's regional workgroups bring together a wide variety of local participants including plans, clinics, counties, private providers, advocates, labor, small business and brokers. Workgroups provide a forum for healthcare leaders to discuss and prioritize local and regional strategies, to learn of other's challenges and successes and to make recommendations for state policy makers. The information and discussion allows participants to understand and better negotiate their fit with local partners. Moreover, the discussions highlight each county's and regions strengths, priorities and opportunities in terms of covering the uninsured. The workgroups give members the opportunity to network and share their collective efforts.

This year marks the fourth annual convening of the eight regional workgroups throughout California. The workgroups took place from February through the end of November 2005. Local leaders lent their insight and resources in planning the workgroups, and without their support, the workgroups would not have been successful. Working with them helped guarantee that a variety of stakeholders were represented and that the agenda met their needs. The workgroups addressed the following common issues: new county, regional and state data, the Medi-Cal redesign, hospital financing, coverage expansion opportunities, efforts to expand coverage of all children and legislation affecting the uninsured. A great deal of information, ideas and recommendations were shared, which assist and promote regional efforts to cover the uninsured.

Children's Coverage

*With 10 operational local CHIs and at least 20 more in the planning phase, counties are focused on program **sustainability** to achieve the goal of covering all uninsured children in the state.*

This year, covering all children in California is on everyone's minds. Workgroup members are actively involved in efforts to achieve this goal, from planning to implementation to evaluation of local initiatives to cover all kids. The Schwarzenegger Administration expressed their commitment to this goal as well, but the Governor vetoed two bills, AB 772 and AB 1199, which would have expanded coverage to all kids up to 300% of the federal poverty level citing lack of a financing plan in his veto statement. In response, a coalition formed and developed a ballot initiative that will create \$450 million per year in new funds to cover kids by increasing the tax on cigarettes by \$1.50 per pack. The initiative appears to be popular; according to an opinion poll, 80% of Californians would support a ballot initiative to cover all uninsured kids.¹

While the prospect of a statewide program appeals to workgroup members, as it will free up funds going into local Healthy Kids programs, counties around the state continue to move forward with Healthy Kids programs and other efforts to cover uninsured children. With ten operational local Children's Health Initiatives (CHI) and at least 20 more in the planning phase, the regional workgroup members had a lot to share about their accomplishments, challenges and goals.

Lessons from Local Children's Health Initiatives

The Central Coast Regional Workgroup focused on children's coverage issues for the second consecutive year. Some especially salient messages and recommendations came out of this meeting.

On July 1, 2005, San Luis Obispo began its Healthy Kids program. Fundraising and sustainability are increasingly relevant to the program, as funding at the time of the meeting would only provide coverage for one year. Similarly, at the time of the meeting, no hardship fund had been created, which is crucial for maintaining consistent coverage of children whose families temporarily cannot afford their coverage.

Santa Cruz's Healthy Kids Program, which launched on July 1, 2004, faces additional challenges since the program is operational. Fundraising, retention and re-enrollment are the biggest challenges. To address these problems, they have implemented a multi-pronged

¹*Health Insurance Coverage for All Children: A Goal within Reach.* Health... In Brief. (The California Endowment, November 2005).

Lessons from Local Children's Health Initiatives, cont.

approach, involving parents, CAAs and primary care providers who are all notified prior to the child's renewal date. The county is working on a more unified effort to get CAAs in schools to promote retention. Physicians have been very supportive of the Healthy Kids program overall, due to reasonable reimbursement rates and the emphasis on preventive and primary care within the program. One-E-App is being used successfully, and there was no waiting list for Healthy Kids in Santa Cruz at the time of the meeting.

Santa Barbara was addressing coordination of eligibility between Santa Barbara and San Luis Obispo and sustainability issues at the time of the meeting. Though still in the planning stage, the county was expecting a large waiting list and was working on fundraising so that the program can achieve sustainability for three years. Ventura County was concerned with outreach, fundraising/financing and development issues in their efforts to cover all kids. The picture in Monterey was slightly different; the focus there is on preservation of the safety net infrastructure, following reorganization of health clinics in the county.

In San Joaquin County 2,055 children were enrolled in Healthy Kids as of May 6, 2005. The local CHI reduced the cost per child and cleared the waiting list. Other Central Valley counties were still planning or were about to roll out their CHIs at the time of the Central Valley regional workgroup.

Alliance Healthcare Foundation convened a working group in San Diego County to draft a proposal for covering children in San Diego County. Based on 2001 CHIS data, the group estimated 24,000 uninsured kids below 300% of FPL in the county at an expected cost of \$28 million to cover them. San Diego has a number of unique issues that make coverage of kids challenging. A new entrant in San Diego, Molina Healthcare will soon be offering products for Medi-Cal, Healthy Families, and AIM enrollees. It is unknown what impact this will have on a Healthy Kids effort. In addition, due to recent facility restructuring and relocating, the county will be conducting a system wide assessment of its safety net services to determine what impact these moves will have on the county. Finally, because San Diego County operates a geographic managed care system, it is difficult to use a single built-in network of safety net already available in local initiative and COHS counties. San Diego is currently looking at Sacramento County as a model for its efforts.

Lessons from Local Children's Health Initiatives, cont.

The Santa Clara Children's Health Initiative was evaluated, revealing valuable lessons. The Santa Clara CHI increased enrollment in Medi-Cal, Healthy Families, which brought in more state and federal dollars. In terms of medical care, the CHI reduced the levels of unmet needs significantly; increased access to a usual source of care and to dental and vision care; raised health care use including vision and dental services; and increased confidence and satisfaction.² Future evaluations will address crowd-out and the comparative cost of Healthy Kids programs and private premium payment assistance. Looking towards the future of all local CHIs, many workgroup members cited the need to more actively engage the business community in these efforts.

Hospital Financing

The state and federal governments negotiated a waiver impacting how hospitals are financed, expanding the Medi-Cal managed care system to smaller counties and to the non-Medicare eligible Aged, Blind, and Disabled population. The new financing mechanism for public hospitals abandons selective contracting and operates as a federal/local partnership. Certified Public Expenditure (CPE) will replace the current system of Intergovernmental Transfers (IGT) in response to federal scrutiny of the use of IGTs as match. Workgroup members expressed the need for further clarification of the definition of a CPE. Furthermore, workgroup members were concerned that the shift to CPEs could cause public and academic hospitals to lose funding. Under the new financing waiver, all DSH funds will go to public hospitals, and a DSH-like program for private hospitals will be created.

There was fear among workgroup members that public and academic hospitals in particular will lose DSH and other Medi-Cal funds under the waiver.

Under the federal hospital financing waiver:

→ *What is allowable as a CPE?*

→ *How will public and academic hospitals be impacted?*

²Trenholm, *Santa Clara Healthy Kids Program: Impacts on Children's Medical, Dental and Vision Care*. Final Report (July 2005).

Coverage Expansion Opportunities

The aforementioned waiver designates \$180 million annually for managed care expansions in years one and two and \$180 million annually to be used for general coverage expansion in years three through five. The advantages and opportunities for improvement of this arrangement were discussed at virtually all of the regional workgroups. The latter funding will go towards general coverage expansion. The State solicited proposals and will draft a concept paper for submission to the federal government. A variety of ideas for the best use of this money were discussed at the workgroups as well as coverage expansion efforts already underway.

Managed Care Expansion Efforts

Many counties have experience with moving non-Medicare eligible Aged, Blind and Disabled Medi-Cal enrollees into managed care. Health Plan of San Mateo already serves disabled Medi-Cal beneficiaries and has experienced positive results compared with fee-for-service Medi-Cal in terms of coordination of care and cost-effectiveness. Some disabled multiple users fall through the cracks and do not receive all the needed benefits under Medi-Cal. Inland Empire Health Plan has served disabled beneficiaries for five years and is currently working to develop Centers of Excellence within county facilities to provide comprehensive health care services to disabled members; they are also working with The California Endowment to draft standards for use by health plans transitioning disabled members into managed care. Inland Empire workgroup members agreed that strong case management and medical homes are essential advantages of managed care for disabled Medi-Cal beneficiaries. They are preparing for implementation should the legislature approve it.

In Orange County, CalOptima serves dual eligible beneficiaries and some disabled beneficiaries through a managed care program in which any willing provider can participate. From their experiences caring for this population, they have found that managed care provides more services and better quality care. Conversely it has been a challenge to maintain a strong provider network due to the intensity of care and case management required in caring for this population. At the time of the Orange County regional workgroup CalOptima and other COHS' were operating at a deficit. Similarly, Orange County workgroup members stated that the loss of the DSH subsidy for managed care patients needs to be resolved in order for the system to be sustainable.

San Diego County was picked as one of three counties to pilot the acute and long term care integration project (ALTCI). Prior to this proposal, San Diego had been discussing a similar plan, and a stakeholder group was convened to discuss San Diego's progress in light of this proposal. At the time of the San Diego regional workgroup, the stakeholder group was working to finalize coverage of wrap-around services and the development of a working model for implementation of the Governor's Medi-Cal Redesign plan. Like San Diego, Contra Costa County is also working on legislation to allow them to pilot the ALTCI program for aged and disabled Medi-Cal beneficiaries.

Recommendations for Managed Care Expansion

The county and regional experiences with managed care for disabled Medi-Cal beneficiaries were quite similar, lending themselves to clear recommendations about this transition and implementation. From their experiences, workgroup members agree that managed care offers better coordination of care than traditional fee-for-service (FFS) Medi-Cal while being more cost-effective. The coordination of services will save money and time and control utilization and compliance. Bay Area workgroup members find that many providers will not accept Medi-Cal FFS patients; thus managed care will increase access to providers. The managed care setting also provides more services through strong case management, medical homes and disease management; and managed care ensures that providers are more accountable for quality of care. All of these factors can promote better care overall for disabled enrollees especially since Inland Empire workgroup members cite that many disabled enrollees are currently not getting the care they need.

Strong case management is an essential advantage of managed care and should be implemented at primary care sites.

Despite consensus about the advantages of moving disabled beneficiaries into managed care, workgroup members remarked on specific areas for improvement and made recommendations. In San Mateo County, disabled beneficiaries face limited access to primary care, despite the availability of priority slots at county clinics. Another concern about the provision of care to this population in a managed care setting is the need for better integration of mental health and substance abuse coverage that is now carved out; similarly, LA workgroup members recognized the need for a model that incorporates social services and medical care in order for this system to be successful. The presence of social workers and case managers at primary care sites is essential, especially those who are bilingual in the Inland Empire. Statewide, providers need to be properly reimbursed and the specialty network needs to be up to par. Outreach efforts should be conducted to allay fears among the disabled that they will lose benefits, be forced to change doctors and not receive the care they need under managed care. In Orange County, the market has seen the loss of health plans offering managed care products to Medi-Cal beneficiaries due to inadequate capitation. This concerns workgroup members in the region if the disabled are moved into managed care. Orange County and San Diego workgroup members also expressed concern over DSH subsidy loss since managed care days do not count towards these payments. The consensus among workgroup members is that moving disabled beneficiaries has tremendous potential for improving access, quality and cost-effectiveness so long as planning addresses the potential pitfalls and focuses on integration of systems and case management in implementation.

General Coverage Expansion

The waiver creates a safety net funding pool of \$766 million per year, including \$180 million per year for coverage expansion during years three through five of the waiver. The state must submit a concept paper on the coverage expansion by the end of January 2006, and the waiver will be approved by the legislature at the end of September 2006. The workgroup members are participating in coverage expansion efforts in their respective counties and used the workgroups to share their experiences and formulate potential uses for the coverage expansion funds in their regions. Whether they are considering the new funding available under the waiver or not, some creative efforts are emerging throughout the state. Many workgroup members expressed the need for facilitation of statewide discussions on the topic, which ITUP is doing through its Public/Private Workgroup.

Local Coverage Expansion Efforts

Local coverage expansions are focused on expanding existing programs, new populations, enrollment simplification and innovative new programs to cover the uninsured.

In the Bay Area and Northern Rural regions, ideas and efforts to expand existing programs are circulating. In San Francisco, the Healthy Kids Program was expanded this year to include young adults. The new program, called Healthy Kids and Young Adults, expands coverage to young adults ages 19-24 who are under 300% of FPL and aging out of Medi-Cal, Healthy Families or Healthy Kids, or who are the young parent (19-24) of a child enrolled in one of the three aforementioned programs. At the time of the Bay Area regional workgroup, 1,900 of 2,500 rollover eligible children were enrolled. In Contra Costa County, the Basic Health Care Plan serves uninsured indigents regardless of immigration status following the May 2003 expansion. The plan has demonstrated positive outcomes, including increased compliance, decreased ED visits and better coordination of care.

In Alameda County, the Healthy Kids program began re-enrolling eligible children in 2005, following the termination of Alliance Family Care. At the time of the Bay Area regional workgroup, Healthy Kids in Alameda had 1,000 available slots although it is uncertain whether funding for additional slots will become available. The idea of using waiver funds to expand CMSP eligibility was discussed with Northern Rural workgroup members. CMSP expenditures qualify as a CPE and can receive federal match. Workgroup members agreed that CMSP counties could be the lead on this type of expansion proposal because CMSP is a good model, and the CMSP counties do have clout.

Local Coverage Expansion Efforts, cont.

Previously uninsured employees, childcare workers and taxicab drivers are the focus of some diverse coverage expansion efforts.

Other counties are focusing on new populations with their coverage expansion efforts. San Francisco is looking at coverage for taxicab drivers under a planning grant from California

HealthCare Foundation. This expansion would most likely require raising fees associated with operating a taxicab; this may be a special purpose tax increase under Prop 13 that requires a two thirds majority passage of a ballot initiative by San Francisco voters. Additionally, San Francisco is still considering an employer mandate and waiting on MRMIB to secure matching SCHIP funds for a Healthy Parents program. Santa Clara County is working on a Joint Powers Agreement with Alameda, San Mateo and San Joaquin Counties to cover uninsured adults, starting with the estimated 7,000 childcare workers in these four counties. Kaiser recently awarded Alameda Health Consortium a one-time grant for a one-year health coverage program for outpatient services only called Community Health Adult Care for adults losing coverage under Alliance Care. SacAdvantage Health Insurance Subsidy Program has been operating in Sacramento County since November 2002. Through subsidized sliding fee scales, lower income and previously uninsured employees of small employers in Sacramento County can afford health insurance. At the time of the North Central regional workgroup, SacAdvantage was in negotiations with Western HMO to make a more affordable plan available since the program has been undersubscribed.

Two Bay Area counties discussed their efforts to simplify enrollment. Alameda County is piloting the One-E-App for Medi-Cal and MISAP enrollment, and County Social Services is simultaneously converting to CalWIN. In San Mateo County, the county's WELL Program began using One-E-App on October 24, 2005.

Lastly, San Francisco is working on a new program to cover uninsured indigent adults. Under this program, medically indigent adults would have access to primary and specialty care for a pre-negotiated discounted price. San Bernardino and Riverside Counties also expressed concern to increase access to primary care and urgent care for uninsured indigents. They proposed a regional program that focuses on expansion of primary care in county facilities, outreach and prevention, utilizes case management and encourages collaboration between counties and community clinics. Another idea out of the Inland Empire regional workgroup is to integrate programs for clinic patients including Breast Cancer, CHDP and EAPC that require a great deal of clinics' financial and personnel resources, and use the pooled funds to cover the uninsured.

Medi-Cal Redesign

The Orange County and San Diego regional workgroups discussed the implications of the Governor's Medi-Cal Redesign Plan for a dental benefits cap, beneficiary cost-sharing, children's application processing and state monitoring.

Beneficiary Cost-Sharing

The Governor's plan proposed monthly premiums for individuals with incomes above 100% of FPL and for those seniors and people with disabilities with incomes above the SSI/SSP payment level. While Orange County workgroup members recognized that beneficiary premiums might be preferable to copays from a provider perspective, the proposal may cause healthy beneficiaries to drop out, resulting in adverse selection within health plans. Additionally, those who cannot afford the premiums will leave the program. Consequently, avoidable and preventable ED utilization will rise. The plan creates administrative challenges, as there are logistical hassles and costs associated with collecting premiums and disenrollment due to nonpayment and subsequent reenrollment.

Children's Application Processing

The Administration proposes to allow the Healthy Families processor, Maximus, to process applications for Medi-Cal. San Diego workgroup members pointed to the need for better coordination and simplification of the Healthy Families program itself; Orange County workgroup members agree that many "data silos" already exist and simplification is needed. Maximus has not demonstrated full competence in handling Healthy Families applications, and their ability to handle the more complex Medi-Cal program was called into question. San Diego suggested a pilot program for simplification of the application process that replaces 800 numbers with live assistants, allows eligibility workers to do Healthy Families applications as well and uses a single point of entry in the county.

Dental Benefit Cap

The proposed \$1000 annual cap on dental services including dentures for adult Medi-Cal beneficiaries raised concern among workgroup members. The importance of dental health to overall health was stressed, as was the insufficiency of these funds; however, workgroup members remarked that dental advocates are focusing their attention on many other additional issues.

Priorities

An essential feature of each workgroup is the opportunity for workgroup members to share their recommendations and priorities for covering the uninsured locally and statewide. Specific recommendations as they pertain to the topical discussions of each workgroup have been

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outlined earlier in the report. Three clear priorities emerged from the eight workgroups: Selected priorities from the workgroups are listed below.

- Coverage of children and young adults (Inland Empire)
- Expand primary care and urgent care for low income patients (Inland Empire)
- Use local models, resources and collaboration to cover the uninsured (North Central)
- Cost-containment and affordability (North Central)
- Focus on healthy lifestyle choices and prevention (Northern Rural)

The regional workgroups revealed that a lot of exciting progress is being made toward covering the uninsured at local and regional levels. The exchange of ideas and information is mutually beneficial to the regional workgroup members. The observation, recommendations and priorities of each regional workgroup member enhance ITUP's ability to help workgroup members in other regions expand their efforts to cover the uninsured.