

# DRAFT SUMMARY OF ITUP's 2001-02 REGIONAL WORKGROUPS: PROBLEMS AND RECOMMENDATIONS

## NORTHERN RURAL CALIFORNIA

Northern rural California counties have high percentages of residents below 200% of FPL, rates of uninsured, and health insurance premiums and low rates of employment based coverage. These counties have small populations and poor economic bases.

### **Public Programs:**

#### Healthy Families enrollment is low:

- Eligibility redeterminations are too complex and labor intensive. The process needs to be simplified.
- Providers need a heads up to help their patients with annual redeterminations.
- Payments to certified application assistants (CAAs) for redeterminations need to be increased.
- Counties and clinics need to do their own CAA training on a regional basis.

#### Healthy Families payments to providers are too low:

- Clinic reimbursement needs to be increased to be consistent with Medi-Cal.
- Dental reimbursement rates need to be increased to attract adequate numbers of participating providers.

#### The complex relationship between Medi-Cal and Healthy Families eligibility needs to be repaired:

- Healthy Families style applications and enrollment process should be used for both programs.
- Patients should have a choice of programs.
- Asset tests, which are major eligibility barriers in rural settings, should be eliminated for both the Medi-Cal and CMSP programs.
- There should be a single and coordinated point of entry for all health programs to stop *ping ponging* patients between the programs.

#### CMSP needs an update to work consistently with the other public programs:

- Change the eligibility process to work like Healthy Families: permit mail in applications, electronic applications, continuity of coverage and a simpler eligibility process for outpatient services.
- Deputize clinic staff to assist with applicant enrollment and outstation county eligibility workers in clinics.
- Investigate an 1115 waiver to double CMSP funding with a federal match and improve program eligibility, services and provider payment rates. Solano is already testing whether care for its indigent adults can be improved through its County Organized Health System (COHS) for Medi-Cal patients.

ITUP recommends elimination of the county border barriers to health program eligibility in favor of a regional framework. This strategy will benefit counties whose populations are too small to support multiple program bureaucracies, clinics who serve patients in multi-county settings and migrants and other county residents who lose eligibility as they cross county and state borders.

**Private Coverage:**

Employer premiums are higher and increasing faster in Northern rural counties than in other regions. Employee premium shares are increasingly unaffordable and managed care has pulled out of most of the market.

- Investigate a home grown, locally controlled purchasing pool or HMO for the entire region.
- Mandate that HMOs offer coverage in rural areas at competitive prices.
- Develop a cost control alternative to managed competition in rural areas where providers are scarce and competition is nonexistent.
- Implement the Healthy Families purchasing credit, payroll deductions, uninsured employer and employee buy ins to Medi-Cal and Healthy Families, pilot test vouchers and other premiums subsidies to improve affordability.

## **ORANGE AND SAN DIEGO COUNTIES**

These counties have high rates of uninsured and below average rates of participation in public programs.

### **Public Programs:**

#### Healthy Families enrollment and retention strategies need to be improved:

- Use an umbrella organization to coordinate efforts (Orange model).
- Train and use more Spanish speaking CAAs.
- Focus on closing the deal rather than brand name advertising the product.
- Focus on school (Orange) and employment based (San Diego) outreach efforts in the local communities.
- Improve Electronic Data Systems' (EDS) performance in paying CAAs.
- Focus on improving retention rates.
- Cover Healthy Families parents.

#### Medi-Cal enrollment can be improved with simple common sense changes:

- Eligibility for the program is too complex and needs to be radically simplified.
- Eliminate the asset test; it excludes few but hassles many.
- Change Medi-Cal to eliminate the welfare connection.
- Improve Medi-Cal retention especially for those moving from welfare to work.
- Change the incentives of Medi-Cal eligibility workers to assure that eligible persons are enrolled and retained (San Diego model).
- Improve Orange community clinics' participation in Medi-Cal managed care, emulating the successful transition of San Diego clinics to managed care.
- Use a single application for all programs.

#### County Health:

- Contract with systems of care for the uninsured (including clinics, specialty and hospital care committed to care for the uninsured).
- Simplify the complex and burdensome eligibility verification process and remove the welfare stigma.

- Improve the primary care component of the county health program; few clinic patients surmount the county health eligibility process.
- Increase the number of FQHC certified clinics (there is only one) in Orange.
- Investigate using an 1115 waiver to secure federal matching for county health expenditures and moving medically indigent adults into managed care. Orange County already has disabled adults in managed care, and is testing whether managed care is beneficial to those adults with chronic illnesses using the county health program. There may be no benefits from managed care for young adults with predominantly emergency medical needs.

**Private Coverage:**

- Implement the HRSA grant pilot program for insuring small employers through CalOptima.
- Implement the Healthy Families purchasing credit and provide options for uninsured employers and employees to buy into Healthy Families and Medi-Cal.
- Pilot test vouchers/premium subsidies/refundable tax credits as approaches to increase coverage of flex workers.

**RIVERSIDE AND SAN BERNARDINO COUNTIES**

Delivery systems were centered on strong public clinics and hospital systems in these counties. Inland Empire counties had low rates of employment-based coverage despite some of the lowest PacAdvantage premiums for small employers.

**Public Programs:**

Healthy Families:

- Give families a choice of programs. For some low-income persons, the Healthy Families model is preferable.
- CAAs must be paid in a more timely fashion. EDS needs to improve its performance (it loses applications) and become more responsive to health plan, CAA and patient inquiries regarding eligibility.

- Retention is not a significant issue, but the state should give providers and plans more latitude to help patients with the initial enrollment and retention processes.

#### Medi-Cal:

- State needs to improve its part in the enrollment process.
- Counties need to monitor and improve eligibility workers' responsiveness to applicants.
- State needs to bring Medi-Cal eligibility process and rules for parents into line with Medi-Cal program improvements for children.
- State should pilot test managed care for disabled adults and CCS children through the Local Initiatives.
- Both Medi-Cal and Healthy Families should reduce the volume and extent of enrollment forms and verifications that must be filled out by the applicants and substitute computer cross checks. Do not require applicants and enrollees to repeatedly provide documentation for unchanging information. Accept eligibility determinations already conducted by other public programs.
- Both Medi-Cal and Healthy Families lack sufficient providers in rural areas of the counties. Better reimbursement for the few providers practicing in rural areas is necessary.

#### County Health:

- Access to primary care is good in urban areas. Counties need to improve access to primary care in the high desert and rural communities.
- Counties need to develop better funding and referral relationships with their community clinics.

#### **Private Coverage:**

Successful Inland Empire industries such as agribusiness and tourism often do not offer coverage for their low wage workers.

- Government and industry must cooperate in correcting this inequity.
- Employer resource centers, better opportunities for uninsuring employers to participate in Healthy Families, refundable tax credits for small employers, requirements for employers to offer coverage when seeking public contracts,

subsidies and approval of large scale developments are among the issues that need to be further investigated.

## **CENTRAL COAST**

Santa Barbara has an unexpectedly high percentage of uninsured. Santa Barbara and Ventura have notably strong public outpatient and managed care systems. These counties reported unusual success in enrolling their eligible patients in public programs.

### **Public Programs:**

#### Healthy Families, Medi-Cal and County Health:

- Key to these counties' success in public program enrollment has been provider-based enrollment. In Ventura, enrollment is done onsite at the clinics. Santa Barbara County clinics do program outreach but not enrollment.
- State advertising and outreach efforts for Healthy Families and Medi-Cal have been ineffective. The state needs to rely on local entities to handle program outreach and enrollment.
- Each county has a strong outpatient delivery system.
  1. Ventura's success is based on an entrepreneurial model in which primary care is delivered in county clinics by county contractor (not by employed civil service) physicians. Ventura's public hospital is very competitive in attracting Medi-Cal and private pay patients.
  2. Santa Barbara has FQHC reimbursed public clinics, but no public hospital; it contracts with private hospitals for hospital care to the county indigent.
  3. However, neither county has strong relationships with its non profit community clinics to care for the uninsured. These should be improved.
- It appears a logical next step to ITUP (but not to the counties) for the COHS in Santa Barbara to extend coverage to the county's indigent adults (as Solano and Contra Costa counties have done) as well as to Medi-Cal eligible adults

in San Luis Obispo and Ventura counties (as COHS in Solano and Santa Cruz counties have done with Napa and Monterey counties, respectively).

- Each county prefers increased flexibility from state regulators to expand their successful local innovations as opposed to a statewide 1115 waiver to cover indigent adults through Medi-Cal managed care.

**Private coverage:**

Both counties have a large number of uninsured agricultural workers. Santa Barbara's tourist industry also employs a high share of uninsured low wage workers.

- Each county has a strong local managed care plan. The COHS in Santa Barbara and the county managed care plan in Ventura could be used to expand care and coverage of their uninsured workers. Local providers and employers need to support such efforts.

**CENTRAL VALLEY**

Central Valley counties have the highest percentages of low income, Medi-Cal, Healthy Families and uninsured residents and the poorest funding of care to the uninsured.

**Public Programs:**

Healthy Families:

- Allow patients to choose between Medi-Cal and Healthy Families, as some prefer to pay premiums and Healthy Families has broader choice of plans and providers
- Successful outreach requires local collaboration between community clinics, county health services, schools, churches and other community centers. Outreach needs to be highly targeted.
- Local advertising has been far more successful than the statewide advertisements.
- The numbers of eligible but unenrolled children is very high due to confusing eligibility information and concerns over whether enrollment will jeopardize immigration status. This is particularly problematic for mixed status families.

Community outreach and education using trusted persons are critical to enrollment success.

#### Medi-Cal:

- In some counties, access to care is abysmal due to a combination of factors ranging from reimbursement rates to racism. Local Initiatives in San Joaquin and Kern report signal success in improving access to local providers. Managed care plans in the other Central Valley counties were not as successful and need to improve access to care.
- Programmatic complexity, welfare stigma and inaccessibility of covered services plague the program. More efforts are required to separate the program from its welfare background and simplify it for easier access, enrollment and retention.
- Many of the CHDP visits should have been covered by Medi-Cal and Healthy Families. CHDP needs to serve as a better link to these two programs.
- Very poor counties with high rates of uninsured and Medi-Cal patients such as Tulare receive little or no DSH funding. The state DSH formulas need to be restructured.

#### County Health:

- In the MISP counties, virtually all the county health funds go to the local hospitals, with little or none for the community clinics. Some counties dedicate very little of their available revenues to care for the uninsured. County health departments need to re-examine their funding priorities and build better relationships with the clinics. County Boards of Supervisors need to prioritize caring for the uninsured.
- CMSP is a far better payor for uninsured clinic patients. However, verification and paper work requirements and quarterly status reporting are major obstacles to care for clinic patients. These systems need to be improved.
- Migrant farm workers have particular problems losing eligibility and coverage as they cross county lines.

- The county tobacco settlements and the required county health match should be allocated to improve the generally weak funding for county health programs to the uninsured.
- ITUP recommends that Central Valley counties seek to cover indigent adults through Medi-Cal managed care with federal matching funds pursuant to an 1115 waiver.

**Private coverage:**

Central Valley counties have large numbers of uninsured farm workers.

- Local Initiatives, safety net providers and employers need to cooperate to develop approaches to provide affordable coverage for low wage and migrant agricultural workers.

**LOS ANGELES COUNTY**

Los Angeles county has high rates of uninsured and low rates of employment based coverage. Its county health and trauma systems have been on the verge of collapse for over eight years due to lack of adequate public funding.

**Public Coverage:**

Healthy Families:

- Los Angeles has weaker Healthy Families enrollment compared to other Southern CA counties. The county needs to develop a coordinated and collaborative outreach and enrollment strategy.
- Neither CAA fees nor outreach contracts have been as successful as hoped in improving enrollment. The state and county need to assess their effectiveness.
- The state and county need to move to a single point of entry to reduce enrollment confusion and snafus.
- Healthy Families should cover working parents.

Medi-Cal:

- LA County has strong Medi-Cal enrollment compared to other regions. Coverage for working parents, continuous eligibility and the elimination of quarterly status reporting (QSR) have resulted in improved Medi-Cal

enrollment. Improvements in the Medi-Cal enrollment process must be retained.

- County needs to improve enrollment in state and federal programs for county and community clinic patients -- especially for immigrants.
- County needs to create a system to track applications generated by outstationed eligibility workers and to fix the LEADER computer's programming errors.
- LA community clinics are experiencing a sharp fall off in Medi-Cal visits due to a range of Medi-Cal enrollment problems which need repair, including:
  1. amount of personnel time required to assist successful applicants. The complex application and retention process must be streamlined.
  2. loss of clinic-enrolled patients when a clinician departs. AB 2674 would re-define "provider" to correct this.
  3. performance of outstationed eligibility workers is weak in some regions and needs improvement.
  4. The county, clinics and the Local Initiative need to develop a delivery system that integrates public and private safety net providers for all public payors comparable to the Bay Area health plans.

County Health:

- The LA County health delivery system and its 1115 outpatient waiver network are threatened by a lack of adequate public revenues.
- LA public hospitals are heavily dependent on DSH and SB 1255 funding streams, which are in peril at the state and federal levels. LA's private hospitals receive a large share of DSH and provide a mid-to-low range of uncompensated bad debt and charity care to the uninsured.
- LA community clinics are heavily dependent on the county to finance their care to the uninsured through the county's 1115 waiver and in danger of being dragged down and under by the county's fiscal crisis.
- Los Angeles' challenge is to get its private and public hospitals and non-profit community clinics to cooperatively provide care to the uninsured and

to resolve the County's recurrent structural financial crises. Cooperation with federal, state and county governments is required.

- ITUP recommends the county seek a waiver incorporating its uninsured, Medi-Cal and Healthy Families into a single consolidated managed care program.

State Budget:

- State needs to develop a stable revenue base, which is not as dependent on fluctuations in volatile capital gains, thus putting the funding for the local health system for the uninsured at risk.

**Private Coverage:**

Los Angeles has one of the worst rates of employment-based coverage in the state despite comparatively low premiums. Premiums in the county, however, are rising and steps should be taken to control provider and health plans' costs and prices.

- Reasons for price increases include: prescription drug costs, hospital costs, stockholder equity, medical technology and consumer demand.
- Recommended solutions to be investigated: create purchasing cooperatives, reach self-employed individuals, emulate San Diego's efforts to develop ESI (outreach has doubled AIM enrollment because of their more coordinated approach), test one-third premium subsidies, get agents involved in reaching very small businesses, and encourage health plans to offer subsidized pilot programs to the uninsured.

**BAY AREA**

Bay Area counties have a much higher growth in median income and lower poverty rates than Los Angeles and other Southern California counties over the last decade. They have higher incomes, fewer uninsured and Medi-Cal enrollees and stronger job based insurance. Bay Area Local Initiatives have been particularly creative in developing new approaches to cover the uninsured.

## **Public Coverage:**

### Healthy Families:

- A provider-based outreach effort is primarily responsible for successful Healthy Families enrollment. The faith-based community has also played a significant role in outreach.
- Outreach is most successful on an individual basis. Group presentations are not enough.
- Community clinics and counties compete very effectively for Healthy Families patients.
- Santa Clara's program for all uninsured children stimulates enrollment of the eligible but uninsured children into Healthy Families and Medi-Cal and should be emulated.
- Seamlessness between Healthy Families and Medi-Cal is necessary. Treat populations and providers in the same fashion although enrolled in different programs. This will require an alignment of local policies, prices and procedures in the different programs.
- Community clinics and county facilities should be part of the same delivery networks across all the payor programs.

Public Hospitals: Can be strengthened in a managed care environment; they must however commit to:

- Competing in both the child and adult markets in Medi-Cal and Healthy Families;
- Restructure to lower costs;
- Strengthen their outpatient capacity in coordination with community clinics;
- Develop a strong coordinated network of specialists;
- Build relationships with health plans beyond the Medi-Cal and Healthy Families markets, and
- Shift from a budget management to a revenue generating model.
- Santa Clara Valley hospital is a model worth emulating.

### County Health:

- Contra Costa's Basic Adult Care is a managed care system for indigent adults who don't have access to other programs.
- Contra Costa County's Board of Supervisors has approved an expansion in this program to include entire families up to 300% of FPL. This expansion is funded in part with county tobacco settlement funds.
- Care is subsidized and delivered by the county and managed by the Contra Costa Health Plan. It does not include community clinics in the network.
- Participants pay a sliding scale partnership fee based on income -- starting at \$0 and increasing to \$75 per month at 300% of FPL.
- Contra Costa is a model worth emulating.

### Public Managed Care:

- Bay Area Local Initiatives are typically dominant in their niche markets and creative in developing new approaches to cover segments of the uninsured.
- ITUP recommends that Bay Area counties consider consolidating their managed care plans to create a regional managed care plan.

### **Private Coverage**

Job based insurance is far stronger in the Bay Area counties compared to the remainder of the state:

- Increased employment based coverage requires funding for premium subsidies. Uninsuring employers are not willing to participate unless their contributions are limited to about \$50-75 dollars per month. Uninsured employees will not participate unless their contribution is limited to 1-5% of their wages.
- Healthy Families purchasing credit plus sponsorship and payroll deductions are the first steps to increasing employment based coverage.
- Employee and Employer Associations and Sharp and Kaiser Steps health plans are good models to increase employment-based coverage. More health plans need to develop variations on the Sharp and Kaiser models, which provide a subsidy solution. Health plans need to improve cooperation with

union and employer association efforts to improve coverage for the uninsured.