Health Care Council
Agenda
February 1, 2013

1. Welcome and Self Introductions

2. Covering Californians: The Inner Workings of the Benefit Exchange
   Special Guest:
   David Panush, Director of External Affairs, Covered California

3. The Impact of Medicaid Expansion Options in LA County
   Special Guest:
   John Connolly, Associate Director, Insure the Uninsured Project

4. Update: ACCESS Washington D.C. Health Care Team

Upcoming Chamber Events:

- 124th Annual Inaugural Dinner: Thursday, February 7th

Next Council Meeting:
April 5, 2013
10-11:30 AM
John Connolly  
Associate Director  
Insure the Uninsured Project  

John is a health policy researcher focused on issues related to the uninsured, Medicaid, and health reform. He develops and leads many of ITUP’s policy research activities and is involved in its efforts to develop policy strategies for expanding health insurance coverage through regional and issue workgroups. Prior to joining ITUP in 2012, he was a senior policy analyst at the Kaiser Family Foundation, a research assistant at the Harvard School of Public Health, and a Teach for America corps member. John holds a Bachelor’s degree in political science from the University of Chicago, a Master of Science in Education from Bank Street College, and a Doctor of Philosophy in health policy from Harvard University.

David Panush  
Director, External Affairs  
Covered California  

As the Director of External Affairs, David provides executive leadership for the ongoing legislative and regulatory policy and related activities for the Exchange. Panush previously was the Health Policy Advisor to California Senate President Pro Tempore Darrell Steinberg. He has been a key policy consultant in the Office of the President Pro Tempore since 1986, and has advised the past five State Senate leaders on a variety of policy and fiscal issues.
Last week, the Governor proposed that we use the new federal Affordable Care Act funds available to expand the Medicaid program in one of two ways: 1) the state would contract with managed care plans for their care or 2) the state would contract with counties for their care. Currently, the state contracts with managed care plans for most Medi-Cal eligibles; the state pays providers on a fee for service basis for the rest of the Medi-Cal eligibles.

In 1982-3, during a severe fiscal crisis and under the leadership of then Governor Jerry Brown, the state of California terminated Medi-Cal coverage of the MIAs (Medically Indigent Adults) in large part because there was no federal match for their care. This was called the MIA transfer or dump, in that the state shifted responsibilities to the counties with only 70% of the funds the state used to pay for their care. The state then proceeded to reduce the county subvention nearly every year through Gubernatorial blue pencils. This eligibility group will now become Medicaid (Medi-Cal) eligible with 100% federal financial participation.

MIAs\(^2\) will now become Medicaid eligible under the ACA, specifically parents with incomes between 100-133% of FPL and individuals/couples without dependent children living at home with incomes 0-133% of FPL. This does not mean that all county indigent health eligibles will be eligible, as we will discuss later.

Counties responded to the 1982-3 MIA transfer in four different ways:
- Payor counties, such as Orange, paid their private hospitals, doctors and clinics. Fresno and Merced, block-granted their funds to one of their local community hospitals that had taken over the old “county hospital”.
- Provider counties, like Los Angeles, that operate public hospitals directed their share of these funds into their own county hospitals and clinics; initially most did not reimburse private hospitals or community clinics.
- Hybrid counties, like Tulare, paid private hospitals and operated their own public clinics.
- CMSMP (small rural counties like Imperial or Humboldt) operated a Medi-Cal like fee for service system that paid private doctors, hospitals and clinics. A sub-set of payor counties.

Counties could set and determine their own eligibility and levels of service and their own networks of care, which they did in highly variable fashion.

Over time, the county health programs evolved. The pioneer counties were continuously improving their programs, while others adjusted their programs episodically. Other counties did little to begin with, and some continued that trend over the past 30 years. The state did not interfere with counties’ programmatic decisions other than an occasional audit or oversight hearing.

**Realignment and Other County Health Program Revenues**

To address counties’ unstable funds for care to the medically indigent, the state and the counties agreed to a funding “realignment” in the early 90’s. This would shift a portion of the state sales tax and the vehicle license fees to the counties. There were three separate realignment accounts: health, mental health and social services. Health realignment combined the MIA sub-account that paid for county indigent health with the existing AB 8\(^3\) sub-account that paid for county indigent health and public health. Because it was tied to tax revenues, realignment funding grew and declined with the economy. As the economy tanked during the Great Recession, county health funding sharply fell just when demand grew.

Realignment combined two funding formulas from the late 70’s and early 80’s that have become increasingly out of touch with demographic changes. Counties must pay a local county General Fund match that was capped at their 1988 financial contribution. This realignment matching requirement and formula was carried

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1 The federal Medicaid expansion under the ACA will now cover the all US Citizens and Legal Permanent Residents (LPR’s) with incomes less than 138% of FPL with 100% federal financial participation (FFP).

2 This group is also often referred to as the “working poor.”

3 AB 8 was created in 1979 after the passage of Proposition 13 to help fund county health programs. AB 8 funds were protected by statute and had a statutory COLA; whereas MIA funds were not.
over from AB 8. Some counties use their tobacco litigation funds to support county indigent health; others do not. Some counties, like Los Angeles and Alameda, passed local tax increases to fund county indigent health.

In roughly the same time frame as realignment, the state developed a DSH (Disproportionate Share Hospital) program that paid many public and private hospitals for their unreimbursed care to the uninsured. The state then developed a supplemental payment program (SB 1255) that helped hospitals with emergency rooms pay for unreimbursed care to the uninsured. The match for both of these programs came from the county hospital counties. DSH and DSH supplement funding was concentrated among urban, inner-city facilities and did little or nothing to help pay for care to the uninsured in rural counties and their facilities. County hospitals also secured passage of state legislation to secure a federal match on re-building and redesigning their aging buildings so that many county hospitals were able to build state-of-the-art facilities.

**Rebalancing County Health Programs: Coverage Initiatives and the Federal Waivers**

The fundamental problem with most county indigent health programs, DSH and the DSH supplement funding programs was that they were hospital-focused, and emergency-room-centric, as this was the locus of care for the uninsured by custom, practice and funding. This focus was reinforced by the spotlight on emergency and trauma center closures and repeated incidents of “patient dumping” i.e. denials of emergency care to the uninsured and even Medi-Cal patients.

Alameda County was an early exception that contracted with local free and community clinics to establish a working relationship that dates back to the late 1970’s. In implementing the MIA transfer, San Diego County stood out for developing its contracting relationships with clinics. Only a few other counties put a significant emphasis on building or paying for their primary and outpatient care systems.

In 1995, Los Angeles County, on the verge of fiscal collapse, closed its health clinics, transferred them to community clinic operations and secured a federal §1115 waiver to pay for outpatient care in county clinics and private non-profit clinics contracting with the county. The county provided the match. This was an important breakthrough in securing federal financial participation (FFP) for outpatient care to the uninsured MIAs.

In 2005, the state of California secured a statewide §1115 waiver that, among other things, provided $180 million annually for “coverage initiatives.” After a competitive bidding process, eight provider counties and two payor counties secured funding for their coverage initiatives.

These coverage initiatives\(^4\) required counties to determine eligibility, issue eligibility cards, and provide medical homes. Counties implemented these initiatives differently and at very different rates. The successes were that outpatient care increased, while emergency and hospital care declined quite significantly. San Francisco, Orange, Ventura and Kern were among the leaders in implementing this first waiver.

Notably, in the 2005 waiver, counties with county hospitals began to provide the match for their hospital inpatient rates and were paid at the full cost of their care. The state of California took over the increasingly disputatious role of paying for private hospitals’ DSH and DSH supplements.

In 2010, the state secured a new §1115 waiver that continued to build upon the efforts of the previous waiver and the Affordable Care Act’s early funding for state coverage of the MIAs. Unlike the 2005 waiver, the 2010 waiver afforded each California county the option to expand coverage for the MIAs with a 50/50 federal match. Counties could only cover US citizens and legal permanent residents with this waiver and could set their own income thresholds up to 200% of federal match. Counties could establish their own levels of benefits, provided it covered a minimum benefit package that included prescription drugs and limited mental health. To receive waiver funds, counties were required to meet minimum geographic and timely access standards that were much lower than managed care standards, but an improvement over no standards. Counties were required to pay private hospitals at 30% of the rate that Medi-Cal would otherwise have paid for genuine emergency care. Counties were also required to pay clinics at the FQHC (PPS) rate, but were only

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\(^4\) Eligibility was limited to individuals with citizenship, legal residency and incomes less than 200% of FPL. Counties provided the match.
required to contract with one clinic, which could be their own county clinic. Counties continued to provide the match, with the federal government providing a 50/50 contribution. While there was no cap on the federal match for care to program eligibles under 133% of FPL, counties could cap their enrollment or spending.

Implementation has been highly variable. Alameda, Los Angeles, Orange, San Mateo, San Diego and CMSP counties have been among the leaders in enrolling their program eligibles and implementing the 2010 waiver. And for many “leader counties,” implementation has been phenomenally successful – both in enrollment and in changing delivery of care into primary care and outpatient settings.

Some counties did not implement the program at all; Fresno stood out in this respect, but was not alone. Some counties made enrollment quite difficult, others for the most part would not contract with their local community clinics, and some adhered to geographic and timely access more on paper than in practice. Private hospitals, doctors and community clinics were welcomed as partners in some counties, but were left on the outside looking in in others. A few used their local managed care organizations (MCOs) to help run the program to varying degrees.

The waiver also funded counties with county and UC hospitals to improve the performance of their facilities so they could participate effectively in the Medi-Cal managed care expansion in 2014; this was known as DSRIP (Delivery System Reform Incentive Payments). Those counties paid the match. Finally in a continuation and expansion of the Safety Net Care Pool (SNCP), the state and counties were provided a match for their outpatient and inpatient care to uninsured. As with the prior waivers, these funds were for care to US citizens and legal permanent residents only, and a certain percent of the federal match was deducted off the top, reflecting the use of care by persons who would not otherwise qualify for Medi-Cal reimbursement due to their immigration status.

**Medicaid Expansion for the MIAs and the Residually Uninsured**

The ACA’s expansion of Medicaid and the Exchange relieves the state and the counties of their fiscal share of the costs of care to many, but not all of the uninsured. Recent estimates project 3-4 million residually uninsured, those who are either ineligible due to immigration status, uninformed about the program expansions, unwilling to participate due to religious and other beliefs about health care and/or government programs, or have financial hardships that make them unable to pay the premiums required in the Exchange.\(^5\)

Early enrollment\(^6\) is expected to be dominated by in-reach – i.e. enrollment of those already enrolled in state and county programs, enrollment of those seeking care due to illness, and enrollment of those most easily reached by outreach and enrollment. Costs per enrollee per month are therefore anticipated to be quite high at the outset and then decline as additional members join the program.

What will or might happen to financing of care to the residually uninsured? First, federal DSH funding will be cut in half in 2017, reflecting increased coverage for the uninsured. Second, the federal waiver funding for county coverage ends in December 2013, and the program’s participants must be auto-enrolled in the ACA’s coverage expansions. Third, the federal waiver that funds DSRIP and the SNCP expires in 2015 and may or may not be renewed, and it is unclear in what form. Fourth, the Governor and legislature may choose to redirect, reduce or reallocate realignment funds. And lastly, county governments will decide what and how to redesign their county indigent health programs under Welfare & Institutions Code §17000 and reallocate their realignment and other county health programs.

**Future of MIAs**

\(^5\) Lucia, Laurel et al, After Millions of Californians Gain Coverage Under the Affordable Care Act, Who will Remain Uninsured? (UC Berkeley Center for Labor Research and UCLA Center for Health Policy Research, September 2012) at http://laborcenter.berkeley.edu/healthcare/aca_uninsured.shtml

\(^6\) Medi-Cal enrollment can occur at any time and be retroactive for three months prior to the date of application. Exchange enrollment, however, is limited to the annual open enrollment periods and exceptions for good cause.
What will happen to state and county program patients who are in treatment as they transition into the ACA coverage expansions? For the most part they will shift into Medi-Cal managed care or the Exchange. They will have a choice of plans and choice of providers to make and if they fail to make a choice will probably be default enrolled. Possible scenarios for this transition include:

1) They choose to continue care with their current providers and their current providers participate in the managed care plans offered in the Exchange and Medi-Cal.
2) They choose to switch care to a different provider participating in the plan they choose.
3) They wish to stay with their current provider and the provider does not participate in managed care because of the provider’s choice or the plan’s choice.
4) The patient gets lost in the cracks and confusion as these system shifts occur.

State and local policymakers should not intervene in scenarios one or two, as that is the choice of the patient and provider, other than to assure that there is a free flow of good information to aid patient and provider decision-making. There needs to be a mechanism to assure continuity of treatment in scenario three to assure that the patient’s treatment is not impaired or the provider’s reimbursement is not imperiled during a reasonable transition period of up to six months, depending on the type of care and access to equally effective treatments.

As for scenario four, the state, county officials, and managed care plans did not have an unblemished performance in transitioning SPDs into managed care, and there is much to improve upon as they transition Healthy Families children. These lessons must be rapidly learned and performance improved to ensure that care, treatments and payments do not get lost in the transition cracks. It is imperative that MCOs, providers and patients have the best and most accurate information in a timely fashion as uninsured patients begin to receive managed care in a coordinated, continuous fashion from a doctor chosen by the patient.

**The Role of Counties in a Post-Reform California**

The Governor has suggested that the state and county roles need to be redefined in light of the ACA. The county’s role in public health and prevention improving the health of all county residents will need to increase. Counties’ role in paying for care to the uninsured county indigent will diminish and entirely disappear in many counties. In counties with county facilities, those facilities will play an increasing role in the Medi-Cal managed care program, where most already participate extensively. Their relationships with the local managed organizations and potential partner community clinics will become ever more significant. Their funding through the local County Boards of Supervisors will become less consequential. Consideration should be given to establishing independent governance of county facilities as Alameda has already done. Ideally, county facilities, the local MCO and the local community clinics should evolve into integrated delivery systems like Kaiser. Over time, we would urge that the safety net providers and plans become regional in nature, rather than county based.

The health care component of Section 17000 will become increasingly irrelevant, as it is a relic of the Elizabethan poor laws, established during a time of large public hospitals in many counties, and a time when county governments could raise their own revenues. These times have passed with the passage of the ACA, Prop 13 and the Medicaid program, and it is time to repeal §17000’s mandate for county indigent health.

It is unknown what counties are spending on care to the uninsured. There are no longer comparable data at the state level, and the last reported year for county data was for 2006, over seven years ago. This information may be available at the county level, but it is not reported to the state or other agencies in a standardized way. Hospitals do report the funds they receive from the counties, although not always accurately. Similarly, community clinics report the funds they receive from counties, but with wide variability in its accuracy. There is no report on the spending at county clinics for their care to the uninsured, nor any report on the funds received by private doctors from counties for their care to the uninsured.

How much do counties pay for individual services? This is highly variable among the counties and cannot be readily tracked although it could be extrapolated. In public hospital counties, realignment is typically allocated as an augmentation to the bottom line; it is not tracked and compensated as fee for service expenditures are. In most payor counties, it is paid on an adjusted fee for service basis. Only a few counties experimented with capitation for county indigent health and this was largely abandoned.
What are counties spending on public health? This data is reported and is available; it is important to look at the bottom line, referred to as “Net County Cost”, as this is where realignment revenues are dedicated.

What is to be done with health realignment after the ACA is implemented and many of the county indigent patients are enrolled in Medi-Cal or the Exchange? It seems quite difficult to change too much in counties with county hospitals because the federal, state and county funds are so entwined in the financing of the Medi-Cal program; it will be difficult to pull out one strand of realignment without considering how others are impacted. It is an easier exercise in payor, CMSP and hybrid counties, but for the aforementioned data difficulties.

One option is to leave realignment with the counties and allow them to engage in a transparent process to identify vital local priorities post-ACA implementation. A second option is to leave it only with those counties that take responsibility for all the residually uninsured. A third option is to shift it to the safety net directly for their care to the residually uninsured; the funds could be distributed to doctors and hospitals through the SB 12 Maddy program, and through the EAPC program for clinics. A fourth option is to use it to shore up the underfunded aspects of the Medicaid program, such as the low reimbursement rates, the needed upgrade for behavioral health, or the terminated adult dental care benefit. A fifth option would be to shore up public health programs that promote wellness and health for all the county’s residents; this will require extensive county planning.

Is Governor Brown’s proposed Plan B, the “county option,” viable? We think no and for the following reasons:

- We do not see any advantage to 58 different systems with wide program variability.
- The counties are not equipped to run a modern managed care system and these systems are already available and operational through Medi-Cal managed care plans.
- It makes little sense for a family to be in Medi-Cal managed care with incomes up to 100% of FPL, then have the parents switch back into a county safety net program between 100% and 133% of FPL, then switch the parents into Exchange managed care at 133% of FPL. Would we want to switch a child from Medi-Cal managed care to the county safety net when s/he turns 21, back from the county safety net to Medi-Cal managed care when the young adult becomes a parent and then back to the county safety net when their child(ren) grow up and leave home.
- Provider counties are providers, not payors; they think and operate in their best interests as providers, and will design this niche program to meet their financial and programmatic needs as providers, but not in the interest of broader system reform.

Whether HHS, which will be paying 100% of the costs of this group of eligibles, would give a waiver to keep them in the same systems that California’s counties currently operate is highly doubtful. This is not the “Bridge to Reform” anymore; we already have had that waiver in California. This is the time to implement actual reforms.

To summarize, 1) the state and county responsibilities need to be revamped in light of the ACA and believe the indigent health components of W&I Code §17000 will become superfluous; 2) the financing of care to the residually uninsured is in peril and needs to be rethought and redesigned; 3) the transition into Medi-Cal managed care needs to be well-managed; 4) it will be very difficult to disentangle the web of interlocked financing between the state and the county hospital counties; 5) realignment in other counties needs to be redirected either to upgrade local public health and/or to upgrade aspects of the Medi-Cal program, such as reimbursement and behavioral health, and 6) Plan B is not a viable building block for reform.