

***Open Letter On The Readiness Of Local Communities And Stakeholders For
§1115 Waivers That Cover/Match County Spending On The Medically Indigent
Adults And Extend Managed Care To New Populations***

This is to summarize Insure the Uninsured Project's observations on the opportunity for progress and transition steps to federal reform under an 1115 Medicaid waiver based on the discussions we had at the nine separate regional workgroups, that we conducted throughout California from March 2009 through December 2009. Regional workgroup attendees included clinics, counties, local managed care plans, local hospitals, local physicians and local advocates.¹

Federal reform if passed will extend Medicaid coverage for the Medically Indigent Adults (MIAs) and families up to 133 or 150% of FPL beginning in 2013 or 2014. The federal match will be 100% for two or three years and 90% thereafter. Families and adults between Medi-Cal and 400% of FPL (\$88,000+ for a family of four) can receive coverage through the Exchange, a competitive marketplace where Local Initiatives (LIs) and County Organized Health Systems (COHS) will compete on a level playing field with large and small commercial plans. Within the Exchange, premium and cost sharing subsidies will be linked to an average of the lowest cost plans; subscribers will pay 100% for the incremental cost.

The Senate bill currently allows states to receive conventional federal matching rates for coverage of their MIAs in 2011. The House bill has an 80/20 matching grant for states that want to get a head start on reform beginning in 2011; this could include state Exchanges and Medicaid expansions to the MIAs. The House bill also extends for six months the enhanced federal matching percentage of the federal stimulus package to allow hard-pressed states to maintain the integrity of their Medicaid programs.

The state concept paper envisages expansion of managed care/coordinated care or at least enhanced medical homes to Medi-Cal populations not now participating in managed care and a federal match for unmatched² county expenditures for the

¹ We want to emphasize that these are ITUP's views and distillations of workgroup discussions, not those of any individual participant in the workgroups.

² The county match could be Certified Public Expenditures (CPEs) or a more traditional match. Some have expressed an interest in using IGTs

MIAs, beginning as early as the fall of 2010. There was widespread agreement among the workgroups' participants that California's safety net did not have and would not have sufficient financial resources to survive until the advent of the full scale federal reforms in 2013 and 2014 absent a large waiver and/or the interim funding for clinics, hospital and medical care for medically indigent adults envisaged in the House and Senate reform measures. There was also strong interest in a well-designed expansion of managed care tailored to best address the needs and starting points of the individual county or region.

North Rural

- Clinics and counties³ are ready to try some form of managed care expansion.
- It would need to be designed for sparsely populated rural areas and incorporate a strong telemedicine component with assurance of affordable specialty care access in adjoining regions.
- The region is not conducive to a competition model as there are insufficient providers. A rural, locally governed, county organized health system (COHS) would be best, possibly with state reinsurance coverage of unexpected catastrophic costs.
- CMSP (County Medical Services Program) could be readily incorporated and transitioned into Medi-Cal and serve as the building block and governing board for a COHS. There should be provisions to build upon its signal improvements, such as integration of mental health in local community clinics.
- There is a dearth of mental health services to the uninsured indigent in a number of these counties, which have a high prevalence of mental illness. This is another issue that should be addressed in the context of the waiver.
- The \$285M in CMSP expenditures could serve as a local match for federal funds.

Los Angeles

- Clinics, local managed care plans and the county are ready for the next phase of managed care. Many local stakeholders would like the state to reconsider a locally developed proposal for a unified plan (County Organized Health System) for all the Medi-Cal and uninsured patients.⁴

(Intergovernmental Transfers). The matching rate could be the 50/50 rate or the temporarily enhanced 62/38 rate to the extent Congress extends that rate.

³ One of the key counties in this region is very concerned about the state's reductions in funding for vital county health and mental health services to the uninsured and wants assurances that the waiver, managed care expansion and increased federal match will significantly increase local resources for these vital services, given the severity of recent reductions in state financing and the decline in realignment revenues.

⁴ Los Angeles participants recognized the need for system evolution and want the incentives for all the stakeholders aligned in the same or at least compatible directions. One workgroup participant estimated that it would take the county up to five years to implement an expansion of managed care.

- The next phase of managed care should begin with managed care for the disabled and coordinated/integrated care for the CCS children and coverage of the MIAs. There is a strong need in Los Angeles to coordinate and reintegrate the physical and mental health components of patient care.
- LA Care Health Plan and Community Health Plan ought to merge. The local managed care plans are not as competitive as they should be in the Healthy Families program⁵; they will need to quickly become very competitive to participate effectively in the Exchange.
- The clinics, the county and select local hospitals need to more closely integrate their delivery systems under the auspices of local managed care with provisions for gain sharing and pay for performance to increase their incentives to successfully collaborate in improving outcomes and reducing costs.⁶ Ultimately their goal must be to combine strong quality, low price and linguistic and geographic access that will allow them to be strong, cost effective competitors within the Exchange.
- The county and clinic system for the Medically Indigent Adults will need to make major changes to be ready for Medi-Cal managed care under federal reform; the Public Private Partnerships are a strong building block. The transition would be best done as part of a County Organized Health System⁷ (COHS for MIAs only) for an interim period of 2 years until the MIAs transition into the two-plan model of Medi-Cal managed care. Under federal reform the county is concerned about the degree to which it loses patients and its hospital financing is destabilized.
- Workgroup participants highlighted the need for enhanced training and disposition of primary care practitioners.

⁵ See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008) at www.itup.org/reports for a comparison of safety net plans' share of the Medi-Cal and Healthy Families markets by county.

⁶ We think the Kaiser model does this effectively.

⁷ (There are federal statutory limits on the amount of enrollment in a COHS model that may need to be waived or amended.) The advantage of the COHS model is that it allows the system to internalize the costs of delivery system transformation for MIAs so that savings achieved can be reinvested in areas requiring spending growth. Otherwise the savings accrue outside the system with no assurance of reinvestment. For example in a geographic managed care plan all the savings generated by managed care may accrue to health plans exogenous to the delivery system and may be redistributed to shareholders and health plan managers. The conceptual difficulty with the COHS model is that it lacks the market competitors that help stimulate it to make the tough decisions that improve access to care, quality and cost effectiveness. While California's COHS have not succumbed to this tendency, at ITUP we believe that in a county like Los Angeles where change has been very difficult, the two plan model may over the long term create greater dynamic incentives for positive change. A COHS could also be constructed with competing local delivery system components, which would speed transition through competitive incentives.

Orange

- CalOptima already administers managed care for families, the aged and disabled; it would be an easy step to add in the medically indigent adults if the federal matching funding was adequate and available.⁸
- The county now spends over \$75 million on care to the MIAs, and most of this spending is not matched and could be. The transition to Medi-Cal managed care would be relatively straightforward in Orange as all the local clinics and hospitals are already in both systems. Orange County's MIA program has over 200 active Patient centered medical Homes connected through a web-based system that provides continuity of care data to the linked in providers.
- There are two other logical next steps: the first is to better integrate Medicare and Medi-Cal for the Medi-Medis.⁹ The federal reform package envisages and authorizes better coordination/integration between the two programs, so this step would be consistent with the direction of federal policy.
- The second step would be to develop a managed care program that incorporates institutional and home and community based long term care services. California has strong pilot programs that do this, including SCAN, On Lok, Altamed and other PACE programs. Orange would be well situated for a new site.
- A very high priority for our workgroup participants was to develop an integrated approach to care for the homeless that re-integrates health, mental health and substance abuse services and programs.

Inland Empire

- Managed care in the Inland Empire is strong and competitive in the Medi-Cal and Healthy Families markets.
- The local managed care plan, the clinics and the county are ready to expand managed care to the disabled, aged and medically indigent adults.
- The county has a strong, competitive and well-balanced public system. Community clinics are less developed in the Inland Empire counties than in neighboring San Diego and Los Angeles.¹⁰
- County funding and spending on care to the MIAs is less than in other communities, and the county might lack sufficient certified public expenditures (CPEs) or county match to serve as the match for federal funding to care for the MIAs.¹¹

⁸ Orange has tried this in the past and found that the county financing was insufficient; however, the availability of federal funds may create sufficient financing.

⁹ CalOptima has a product, One Care that has already enrolled over 10,000 Medi-Medis and is a building block for increased enrollment.

¹⁰ See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (at www.itup.org/reports for a comparison of community clinics care to the uninsured by county.

¹¹ See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for a comparison of county funding and expenditures on care to the uninsured by county.

- Local managed care plan is also interested in developing a managed/coordinated care program for long-term care services.

San Diego

- San Diego is ready to expand managed care for more disabled and elderly Medi-Cal patients and for the Medically Indigent Adults and be a pioneer in the implementation of federal reform.
- San Diego has a strong well-organized clinic system that could be the backbone of this expansion.
- The county has over \$50 million in unmatched spending on the MIAs and the uninsured to help match federal funds.
- The workgroup participants are reasonably satisfied with the Geographic Managed Care delivery system and see no reason to exchange it for a different model. Participants want to see the eligibility and enrollment systems simplified, streamlined and administrative costs reduced throughout the system.
- They emphasized the need for deployment of the hospital fee (AB 1383) to bring Medi-Cal reimbursement up to Medicare levels and encouraged Medi-Cal to shift to the DRG model so that Medicare and Medi-Cal have complementary incentives.¹²

Central Coast

- Local managed care (two COHS systems, based in Santa Cruz and Monterey, Santa Barbara and San Luis Obispo) and the community clinics are ready for CCS and mental health re-integration/coordination. Due to the low Medicare payments in this region, expansion of managed care to Medi-Medis is not perceived as viable.¹³
- Local spending on MIAs in Santa Barbara, Santa Cruz and San Luis Obispo are not matched and eligible to match federal funds. All these counties have strong community and county clinic networks that can serve as a building block to managed care for the Medically Indigent Adults, but they are not yet integrated/coordinated with the county in delivering care to MIAs.
- Monterey, which has a COHS, could be a good candidate for expansion of managed care for the MIAs so that their care is coordinated in the same fashion as the rest of the Medi-Cal population.¹⁴

¹² The hospital inpatient per diem reimbursements of Medi-Cal encourage longer stays than do Medicare's DRG payments. Mixed incentives often cancel out each other's policy directions.

¹³ The Farr amendment to the HR 3962 will increase physician reimbursement in the state's non-metropolitan areas and may increase the financial viability of managed care coverage for Medi-Medis in this region.

¹⁴ For our data, Monterey has low funding, spending and access to care for its uninsured county residents and would benefit greatly from a federal match and program transformation. See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for a comparison of county funding, access and expenditures on care to the uninsured by county.

- Ventura does not yet have managed care in place, but does have a strong community clinic network and a strong, balanced county hospital and county clinic network. It may be ready for a full COHS for Medi-Cal and Medically Indigent Adult subscribers. There is not a long history of collaboration between the community clinics and the county on which to build a managed care framework; however the coverage expansion grants were a promising and successful first step.
- It is unclear from the data we have collected how much Ventura County¹⁵ spends on its care to the MIAs and how much is federally matchable since the county has a mix of realignment, DSH and SNCP funds that support the public hospitals and public clinics.

Central Valley

- At either end of the Valley are public hospital counties and public managed-care Local Initiatives in two-plan counties.
- These programs could be readily expanded to include the MIAs, aged and disabled and CCS program.
- Most of these counties have strong community clinic networks that participate effectively and extensively in Medi-Cal.
- The MIA programs in the Valley counties (other than CMSP counties) typically do not have any meaningful participation of community clinics. Some such as Fresno and Merced block grant their MIA funds to a single community hospital.
- Expansion of Medi-Cal managed care to MIAs would be highly desirable.
- MIA funding in counties like Tulare, Fresno, Kings and Stanislaus are not matched with any federal funds and are completely matchable. None of these counties has a public managed care system.
- It is unclear from the data we have collected how much Kern County spends on its care to the MIAs¹⁶ and how much is federally matchable since the county has a mix of realignment, DSH and SNCP funds that support the public hospitals and public clinics.
- We think it makes sense to offer a regional two-plan model throughout the entire Valley region from Kern to San Joaquin.

Bay Area

- All the Bay Area workgroup counties have Local Initiatives, except San Mateo, which has a county organized health system. All are strong successful competitors in the Medi-Cal and Healthy Families markets.

¹⁵ We think the Ventura County MICRS report understates the county spending on care to the uninsured. See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for a comparison of county funding, access and expenditures on care to the uninsured by county.

¹⁶ We think the Kern County MICRS report understates the county spending on care to the uninsured. See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for a comparison of county funding, access and expenditures on care to the uninsured by county.

- Many but not all use their local managed care plans to manage care to Medically Indigent Adults, and many but not all incorporate community clinics in their indigent care networks. Eligibility levels are well in excess of the proposed 133-150% of FPL income levels proposed for Medicaid (Medi-Cal) in the federal reforms.
- The local managed care plans, the clinics and the counties are ready for expansion of managed care to the MIAs, re-integration of mental health, SHMO's (social HMOs) for the homeless, managed care for the disabled, aged and CCS children. They are ready and interested to be pioneers in implementation of the federal reforms. Like LA, they would certainly prefer a transitional COHS for the MIAs;¹⁷ however their public providers and plans are significantly better situated to be competitive.¹⁸
- San Mateo's COHS' has integrated a large share of the Medi-Medis into a coordinated system of care through its Medicare Special Needs Plan; the plan is ready to take the next step, a managed long term care system similar to the On Lok and SCAN models.
- The counties have additional funds available for federal matching, but it is unclear to us how much is already committed and how much is still available for matching.¹⁹ The analysis should include the physical, mental health and substance abuse programs for the medically indigent.
- In our view, counties in this region should begin to consolidate their programs and managed care plans and safety nets into regional plans.²⁰ The stakeholders likely disagree with the need to consolidate regionally.

North Central

- For ITUP, this region extends from Marin and Sonoma to Eldorado and Placer.
- Solano's Partnership Health Plan is in four counties and Sacramento's Geographic Managed Care is in the fifth and largest county in this region.

¹⁷ As discussed above in n. 7, the COHS model for the MIAs gives a safety net system better control of the transition of its indigent care system; however, the two-plan model provides better competitive incentives for systems to evolve and greater choices for patients and providers.

¹⁸ See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for comparison of clinics and safety net plan's participation in the Medi-Cal and Healthy Families programs by county.

¹⁹ The spending in these counties may include spending on persons who due to income or immigration status may not be eligible for federal match. Counties with public hospitals spend a mix of realignment, Prop 99, tobacco settlement and county General and Special Fund revenues that are eligible to match federal financing; however their federal DSH and SNCP (Safety Net Care Pool) funds cannot be used as a match for additional federal funds.

²⁰ Provider networks and patients operate outside the limits of county boundaries. The multiplication of plans by county boundaries may add to administrative costs and impair rather than enhance competition.

- These counties have not used their managed care plans to cover the county indigent except for a brief but successful two year pilot in Solano and the SacAdvantage pilot program for the uninsured employed by small employers.
- The CMSP counties in this region have strong funding and delivery system ties with their community clinics. Most of the larger (non-CMSP) counties, except Yolo, in the region have not integrated their local community clinics into their care to the county indigent.
- The Redwood Community Health Coalition’s member clinics in Sonoma, Marin, Napa and Yolo are jointly developing an electronic medical record to link their information and coordinate their care to 160,000 patients in these counties. From the data we have collected, Yolo stands out as the county with the strongest primary care network for the county MIAs.²¹
- Medi-Cal managed care could be readily used to care for the indigent adults in each of these counties, using the local managed care plans and clinic networks.
- Partnership is the logical plan to expand regionally to smaller counties in the region where the competitive model has little viability.
- The GMC model could be used and expanded in some of the counties in the metropolitan Sacramento region.²²
- There is extensive county indigent funding and spending in each county that could be used as a match for federal funds.

Many thanks for all your help.

Best wishes for the holidays,

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²¹ See California’s Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured for a comparison of county funding of clinic care to the uninsured by county.

²² The advantage of the GMC model is that it most closely parallels the Exchange model being considered at the national level for coverage of the uninsured with incomes above the Medi-Cal threshold and up to 400% of FPL. The disadvantage is that it fails to provide any assurance of reinvesting the “savings” achievable through managed care into the local safety net delivery systems and their transformation.

Appendix

2004-2005 County Spending on the Medically Indigent

REGION	COUNTY	SPENDING*
Bay Area	Alameda	\$90,658,445
Bay Area	Contra Costa	\$41,652,131
Bay Area	Marin	\$7,752,712
Bay Area	San Francisco	\$153,232,284
Bay Area	San Mateo	\$27,448,305
Bay Area	Santa Clara	\$89,036,511
Central Coast	Monterey	\$2,543,285
Central Coast	San Benito	\$2,683,034
Central Coast	San Luis Obispo	\$4,145,363
Central Coast	Santa Barbara	\$18,295,342
Central Coast	Santa Cruz	\$5,512,070
Central Coast	Ventura	\$3,045,216
Central Valley	Fresno	\$18,009,543
Central Valley	Kern	\$17,193,723
Central Valley	Kings	\$6,425,654
Central Valley	Madera	\$7,370,172
Central Valley	Merced	\$3,854,831
Central Valley	San Joaquin	\$21,905,248
Central Valley	Stanislaus	\$14,662,751
Central Valley	Tulare	\$6,843,489
North Central	El Dorado	\$7,752,152
North Central	Napa	\$3,998,594
North Central	Placer	\$3,152,699
North Central	Sacramento	\$50,162,001
North Central	Solano	\$20,752,480
North Central	Sonoma	\$20,364,618
North Central	Yolo	\$2,834,707
North Rural	Butte	\$17,413,624
North Rural	Del Norte	\$2,754,897
North Rural	Humboldt	\$9,457,586
North Rural	Lassen	\$1,871,842
North Rural	Mendocino	\$8,839,290
North Rural	Modoc	\$652,113
North Rural	Nevada	\$2,780,219
North Rural	Plumas	\$960,015
North Rural	Shasta	\$10,149,051
North Rural	Siskiyou	\$2,688,148
North Rural	Sutter	\$4,293,224
North Rural	Tehama	\$13,253,498
North Rural	Trinity	\$1,145,188
North Rural	Yuba	\$5,014,314
So. California	Los Angeles	\$724,513,211
So. California	Orange County	\$50,580,335
So. California	Riverside	\$74,282,141

So. California	San Bernardino	\$130,999,844
So. California	San Diego	\$57,958,179
	Total:	\$1,770,894,079

*County spending for the medically indigent (expenditures)

Sources: Office of County Health Services: County Medical Services Program. "CMSP Summary of Expenditures by Service Type and County, FY 2004-2005" & Office of County Health Services: Medically Indigent Care Reporting System. "County Health Care Program Expenditures for the Medically Indigent Fiscal Year 2004-2005."