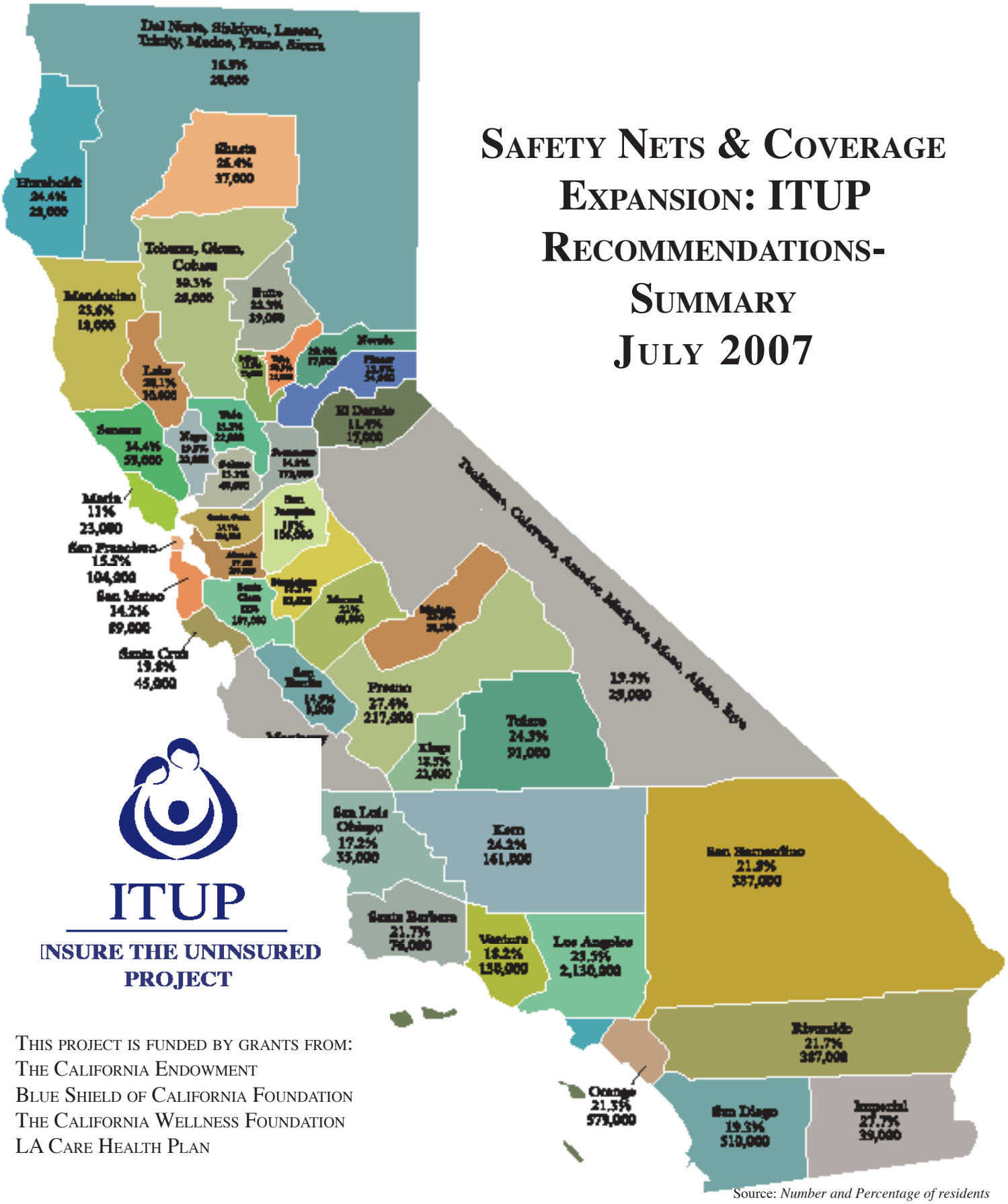
Insure the Uninsured Project

Safety Nets & Coverage Expansion: ITUP Recommendations- Summary July 2007



ITUP

INSURE THE UNINSURED PROJECT

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Source: *Number and Percentage of residents uninsured all or part of last 12 months, age 0-64*, 2005 CA Health Interview Survey

SAFETY NETS AND COVERAGE EXPANSION:
ITUP REFORM RECOMMENDATIONS
Summary

Our purpose in this paper is to de-mystify issues of coverage expansion and local safety nets so there is adequate information for safety net stakeholders to develop consensus on the strongest possible proposal for expanded coverage. California has a diverse and extensive safety net, comprised of free and community clinics, public and private hospitals, emergency room, on-call and volunteer physicians, county health departments and county operated health plans.

In 2007 California has the potential to adopt far-reaching reforms in expanding coverage for the uninsured. These reforms would ease the burdens of uncompensated and underfinanced care on safety net systems for the uninsured.

BACKGROUND ON CALIFORNIA'S SAFETY NET

County Health Programs:
County health is the largest system of care to the uninsured and the repository of state, federal and county funds to care for the uninsured. It spends over $1.7 billion caring for 1.45 million uninsured patients.[1] County indigent health is vastly under-funded, widely diverse and slowly evolving from episodic, emergency room centered care towards managed care delivery systems. On average, California counties spend on health care to the uninsured about 6% of the cost of buying commercial, employment based coverage for insured adults.[2] Some counties are extra-ordinary policy pioneers with strong relationships between clinics, hospitals and local managed care plans.

Financing and spending: Care to the uninsured indigent in county systems is paid for from multiple funding sources including: state realignment and Prop 99, federal Medi-Cal DSH and Safety Net Care Pool (SNCP), county match and over-match and tobacco litigation settlement, patient out of pocket, among others, totaling over $3.8 billion in the most recent fiscal year.[3] In 2002-3, the latest year for which we had complete county spending information available, California counties spent over 57% of available funding for indigent health.[4]

Utilization of services: We compared patterns of care to uninsured adults in county health programs with care to insured adults in a well-managed HMO. Not surprisingly the uninsured receive far less care in under-funded county systems; the care deficit is most severe for outpatient visits; the uninsured received less than 1/6th of the care received by insured adults.

County Infrastructure: While care in many county health programs is concentrated in hospital-based services, it is slowly evolving towards outpatient settings.[5] Some counties have significantly invested in expanding and strengthening their primary care delivery networks. Many counties with county hospitals have heavily invested in rebuilding their public hospitals, and these serve as strong and competitive foundations for local delivery systems.[6]

Eligibility in county systems: There are five major types of county systems for the indigent uninsured.

- Thirty five small counties participate in the County Medical Service Program (CMSP),[7] which pay providers for their care to indigent adults
- Provider counties (such as Los Angeles, San Francisco, Kern or Riverside) deliver care in their own public hospitals and clinics to the uninsured[8]
- Payor counties (such as Orange and San Diego) pay private providers for their care to indigent adults[9]
- Hybrid counties (such as Santa Barbara, Sacramento or Tulare) operate public clinics and pay private hospitals for care to indigent adults[10]
- Block grant counties (such as Fresno and Merced) allocate a fixed sum to a local hospital for care to indigent uninsured adults.[11]

County eligibility rules vary widely with respect to income eligibility, immigration status and other eligibility rules.[12] Yet most patients using county health programs in all but a handful of counties had very low income – below $12,000 annually for a single adult in Fiscal Year 2003-04.[13]

Entrepeneurs: Counties are pioneering new models of coverage for the uninsured.[14] Pioneering counties have in common a strong and competitive county hospital and county managed care plan, and deepening relationships with their non-profit community and free clinics.

Safety Net Health Plans (Local Initiatives and County Organized Health Systems)
Health plans created by county governments organize delivery networks of local safety net providers for Medi-Cal and Healthy Families patients. Patients choose their plan and choose their own doctors from the plan's network. Not all local plans are equally successful competitors, ranging from 60% to nearly 85% of the Medi-Cal managed care market.

Many, but not all, locally owned and operated health plans reinvest their managed care savings in expanding coverage for their counties uninsured. This is the genesis of local plans to cover all uninsured children, uninsured home care and child care providers, uninsured young adults, uninsured cab drivers and, in some counties, all or most uninsured adults.

Private Care to the Uninsured

Private hospitals, private doctors and private non-profit community clinics all deliver a large volume of care and services to the uninsured. At times and in certain counties, this is coordinated with, funded by and supplementary to care in county health systems, but more typically this is a parallel, disconnected system of care.

Private Sector: Care to the Uninsured

	Care to the uninsured	Uncompensated care to the uninsured	Percentage of revenues
Community clinics[15]	$495 million 5 million visits	$136 million	12.6% of clinic net patient revenues

Private hospitals[16]	$1.6 billion	$1.25 billion	3% of hospital net patient revenues
Private doctors[17]	2% of physician services	Not available	2% of physician services

Non-profit free and community clinics provide 5 million visits to the uninsured or 1.0 visits per uninsured Californian. Over 80% of clinic patients have incomes below 200% of FPL, and over half are uninsured. Over the past ten years, clinics have experienced large growth in their visits by uninsured patients and in the complexity of care.[18]

Clinic care to the uninsured is paid for by EAPC, Family PACT, counties,[19] federal 330 grants,[20] patient fees and a myriad of smaller programs. Clinics have strong funding and delivery system connections with their county health programs in some counties (such as Los Angeles, Alameda and San Diego), but little or none in other counties.[21]

Private hospitals with emergency rooms are required as a condition of licensure to treat patients in a genuine emergency regardless of their insurance status. Private hospital bad debt and charity care (mostly to uninsured patients) costs hospitals about $1.25 billion or 3% of total hospital expenses. Private hospitals' care to the uninsured is paid for by a mix of counties, federal DSH, Prop 99, patient out of pocket and the cost shift to private insurance.[22]

In some communities, non-profit clinics and private hospitals work collaboratively in delivering care to the uninsured. Likewise, some private and public hospitals cooperate in caring for the uninsured. Some hospitals help fund community clinics for the uninsured, and others have helped start and fund local coverage initiatives for the uninsured.[23]

Private doctors provide care to the uninsured in their own offices, in clinics and through hospital emergency rooms.[24] National studies found that on average, about two percent of all physician services are uncompensated care to the uninsured.[25]

SUMMARY

To summarize, the uninsured seek and receive care in disconnected public and private settings; some of that care is compensated by an array of public programs and some by the cost shift to the privately insured. Funding is inadequate to the needs of the patients, inequitably distributed, distributed in disconnected silos and not likely to increase absent reform.

REFORM PROPOSALS AND THE SAFETY NET

There are major reform proposals under consideration in California: Governor Schwarzenegger, Speaker Nunez, Senate President Perata, Senator Kuehl, the Senate Republican and the Assembly Republican proposals.[26]

Projected Changes (in Millions) in Coverage for Californians under Age 65

	Before Reform	After Reform		
Total Population	32.3	Governor's Plan	SB 48 Perata	AB 8 Nunez
Medi-Cal and Healthy Families	6.6	+1.6 = 8.2	+0.6 = 7.2	-0.8 = 5.8
Employer Provided	18.8	-0.1 = 18.7	-0.4 = 18.4	+1.5 = 20.3
Non-group	2.0	+0.8 = 2.8	-1.0 = 1.1	-0.6 = 1.5
Uninsured	4.9	-4.0 = 0.8	-3.4 = 1.5	-3.4 = 1.5
New Pool	NA	+1.7 = 1.7	+4.1 = 4.1	+3.2 = 3.2

Source: Gruber, Modeling Health Reform in California (May 16, 2007)

Medi-Cal managed care expansion for the Medically Indigent Adults (MIAs)[27]

Governor Schwarzenegger has proposed covering low income (below 100% of FPL) uninsured adults through an expansion of Medi-Cal managed care, covering about 650,000 individuals now covered by county health services. Speaker Nunez and Senator Perata would cover low income working adults through Medi-Cal managed care. The difference is that the Governor's plan would cover working, self employed and unemployed adults while Speaker Nunez and Senator Perata's proposals would leave self-employed and unemployed workers as a county responsibility.

The Governor's plan will leave about 0.8 million uninsured – undocumented adults with very low incomes. The Speaker's and Senate President's plans will leave 1.5 million uninsured, of whom half have incomes of less than 133% of FPL and nearly three quarters have incomes below 300% of FPL.

California's Uninsured (in Millions) After Reform, by Family Income

	Before Reform	After Reform		
		Governor's Plan	SB 48 (Perata)	AB 8 (Nunez
Total	4.9	0.8	1.5	1.5
Less than 133% of FPL	1.3	NA	0.7	0.7
133% of FPL to 300% of FPL	1.4	NA	0.4	0.4
More than 300% of FPL	1.2	NA	0.4	0.4

Source: Gruber, Modeling Health Reform in California (May 16, 2007)

Expanding coverage to the uninsured through Medi-Cal managed care is favorable to safety net providers such as public hospitals and community clinics as Medi-Cal includes Federally Qualified Health Center (FQHC) reimbursement for community and county clinics[28], cost reimbursement for public hospitals[29] and cross references with hospitals' DSH[30] allocations.

Expanding through Medi-Cal managed care is consistent with existing provider relationships and could provide a medical home for the nearly half of uninsured MIAs who lack an existing usual source of care.[31] The highest priority is finding a medical home for those low-income adults without one. Safety net providers want to retain existing provider-patient relationships and transform that relationship from episodic care into a medical home for their patients and have the opportunity to serve low income uninsured patients who now lack a usual source of care. Safety net managed care plans provide the best opportunity for public and private safety net clinics to retain existing patients and transform their services to a medical home model.[32]

It is an easy transition to a Medi-Cal managed care model for counties and safety net providers in counties using payor, hybrid and CMSP models as these counties are not heavily invested in their own delivery system.[33] Counties with public hospitals and clinics have made major public investments in infrastructure that are qualitatively different from other counties. Some counties with public hospitals are concerned that in the transition to a Medi-Cal managed care model for the MIAs that they will not be competitive with private providers[34] and want a period of exclusivity (a single plan model) for their local managed care plans and safety net delivery systems so that the transition does not destabilize their hospitals.[35] Others are confident they have strong connections with their patients, affordable costs of care and the linguistic and multi-cultural skills to compete effectively in their local markets.

ITUP suggests that counties should be offered the opportunity to negotiate a period of exclusivity not to exceed three years to meet the implementation challenges facing the county. During the period of exclusivity, the local managed care system for the MIAs should meet Knox-Keene standards of geographic and timely access to care, incorporate interested free and community safety net clinics and reimburse non-participating providers at Medi-Cal rates for genuine emergency services to plan members.

Medi-Cal eligibility is complex and cumbersome and should be radically simplified as part of reform.[36] According to one recent report, Medi-Cal has over 150 categories of coverage, "each with slightly different eligibility and documentation" and different income limits for children of different ages.[37] Some simplification of eligibility categories can be done without a waiver, but a thoroughgoing simplification of eligibility will require a §1115 waiver as recommended later in this paper.

Medi-Cal managed care has improved access to primary care and improved management of patient conditions as compared to the old Medi-Cal fee for service system.[38] Issues that need improvement vary from county to county: our interviewees identified different issues depending on their community -- poor access to specialty care, weak systems to manage care for costly and chronically ill patients, and excessive administrative layers/ costs with little productivity in managing and improving patient care and access. Some of these improvements can be achieved with the rate increases proposed for managed care plans in the 2007-08 budget and the Governor's health reform proposal; others require sustained systemic state and plan reform efforts.

Medi-Cal rate increases to Medicare levels: In general, counties and clinics expressed support for this increase and believed it would enhance private sector participation and somewhat improve access and choice

of providers for Medi-Cal patients.[39] An increase in Medi-Cal reimbursement is long over-due; physician rates (other than for obstetrics) have been more or less flat for over twenty years; an increase to Medicare levels will somewhat increase provider participation, but it should not however be over-billed as a panacea.

Coverage for the uninsured with incomes above poverty

The largest share of the uninsured, over 2.3 million adults, has incomes between the poverty line and 300% of FPL.[40] Nearly a million are working parents with children living at home; an estimated 775,000 parents have incomes between 100 and 200% of FPL ($20,000 to $40,000 for a family of four). They have incomes too high to qualify for Medi-Cal, but California could increase eligibility levels under §1931b of the Social Security Act to cover the uninsured parents. There is a strong desire among the safety net leaders we interviewed to see children and their parents in the same plan.

The remainder of uninsured adults between 100% and 300% of FPL are workers without minor children living at home. Of these 861,000 have incomes between 100% and 200% of FPL and may be receiving care through local safety nets, and 523,000 have incomes between 200 and 300% of FPL ($20,000 to $30,000 annually).[41]

All proposals would use MRMIB to purchase coverage for the uninsured over 100% of FPL, but with very different numbers of Californians covered through the new state purchasing pool. Under the Governor's plan, an estimated 1.7 million adults are covered through the new purchasing pool. Under Speaker Nunez' plan, 3.2 million adults and children are covered through the pool, while under Senator Perata's proposal, 4.1 million adults and children are covered through the pool.

All proposals would use benchmark plan(s) for the uninsured with incomes over 100% of FPL, but the benchmark plan is undefined and it is unclear whether benchmark means commercial insurance or public coverage, comparable to Medi-Cal and Healthy Families. Many commercial insurers do not now participate in the Healthy Families program; there will be strong incentives to participate and compete as many individuals are to be covered through the pool. The major private commercial health plans such as Kaiser, Blue Cross, Blue Shield and Health Net already participate in Healthy Families and compete with locally owned and operated public health plans for enrollment. Safety net providers participate in the public health plans and in some Healthy Families networks developed by commercial plans, but participate very little in commercial coverage outside public programs.

In general, counties and safety net clinics strongly preferred a "Healthy Families like" model to commercial coverage[42] as premiums were more affordable, coverage was better, copays and deductibles were less and participation opportunities for safety net delivery systems were stronger.[43] Clinics and counties with county hospitals would prefer a Medi-Cal model to Healthy Families since Medi-Cal reimburses their costs, and they have stronger participation rates in the Medi-Cal program.

Coverage should be seamless for families and individuals so that individuals do not experience gaps in coverage and need to re-apply for coverage.

The current system as well as the reform plans proposed by Speaker Nunez, Senator Perata and Governor

Schwarzenegger have separate programs for individuals based on their income, this creates administrative complexities and costs for subscribers, leading to lack of continuous coverage and interruptions in health care treatment. The goal of counties and safety net clinics is a system that preserves their patients' coverage and courses of treatment.

The "bright line" – a consistent income distinction between Medi-Cal and Healthy Families, as opposed to the zigzag eligibility that divides family members between different programs, plans and family doctors.

Due to the general preference for the Medi-Cal program among safety net providers and plans[44], there is a strong desire to shift the "bright line" proposed by the Governor up from 100% of FPL to 133% of FPL, which is the Medi-Cal income level for young children, disabled and elderly adults.

Consistency between Medi-Cal and Healthy Families policies

Medi-Cal is a better payor for community and county clinic services. Healthy Families does not require public hospitals to pay the state match as Medi-Cal does, and public hospitals do not want to expand a model of hospital reimbursement where they must pay the match. Thus the issues for safety net providers as between Medi-Cal and Healthy Families are 1) compensation for primary care clinics,[45] 2) program simplification, 3) local match and 4) the extent of competition/control. ITUP suggests a reform model that would import some of the simpler and less costly administrative processes used in the Healthy Families program[46] into Medi-Cal and apply Medi-Cal reimbursement models for clinic services into the Healthy Families program.

Undocumented workers

There are an estimated 1.2 million uninsured undocumented adults in California, virtually all of whom work in low wage jobs throughout the state's economy, including agriculture, restaurants and home construction. They are not equally distributed among the state's counties, but are more heavily concentrated in workplaces in the Central Valley and Southern California counties. The studies we reviewed found that undocumented persons used far fewer services and were much less costly to cover than US citizens or legal permanent residents.[47] Medi-Cal coverage for the undocumented is restricted to emergency and maternity services. Federal Medicaid DSH funding is available to some hospitals for their uncompensated care to the uninsured regardless of their immigration status.

Governor Schwarzenegger's proposal anticipates that undocumented adults would remain a responsibility for counties and hospital systems. Under Senator Perata and Speaker Nunez' proposal, the state would collect assessments from employers and sliding fee scale premiums from employees. While financial assessments will be collected from the undocumented workers and their employers, it is less than clear to our interviewees whether the undocumented workers will participate in any form of coverage where they must identify their status and risk deportation.

ITUP suggests California should share responsibility for the costs of care to the undocumented with the federal government and their employers. California should seek to cover emergency care to undocumented adults as part of its broader 1115 waiver application to the federal government[48] and should cover undocumented workers

for a limited and affordable set of basic benefits through their employers' assessments and through their own premium contributions.

Section 17000 obligations for health care to the indigent[49]
Counties believe that Welfare and Institutions Code §17000 will become meaningless if caring for the uninsured becomes a state responsibility and should be repealed, or subsumed in conjunction with state take-over. Advocates believe that Section 17000 health care obligations should remain in place in the context of reform.

Reform should affirm that a county that participates financially in funding the state coverage for indigent uninsured adults has thereby fulfilled the counties' obligation.

County Match: Realignment, Prop 99, County Match and Overmatch
There was general agreement among the persons we interviewed that if the state took over responsibility for the uninsured MIAs below 100% of FPL and for the uninsured MIAs over 100% of FPL, the state should be able to phase in an appropriate take-back of realignment funds from counties reflecting the real shift in responsibilities from the counties to the state.[50]

The unresolved issue(s) include: how much realignment and other funds are used locally for indigent health programs that the state is taking over, how much funding if any is used for care to undocumented persons and any other individuals that remain a county responsibility, and how much is used for public health.[51]

ITUP suggests that for CMSP, payor, block grant and hybrid counties, it is easy to track the county expenditures on indigent adults and "take back" a combination of realignment and Prop 99 funding equal to those counties' expenditures on the indigent who become eligible for the state program(s) as they enroll and thus become a state liability. For counties with a public hospital and clinic system, it is difficult to prospectively disentangle the combination of state, federal and local funds and nearly impossible to currently track and disaggregate expenditures as between citizens, legal permanent residents vs. care to undocumented adults. It should be easier to do so once the state takes over responsibility for the MIAs and could be adjusted based on actual state and county fiscal experience under state take-over.

How would this work? This can be done either as a county match up to a certain agreed upon cap (representing existing county expenditures for the populations covered), or as a re-transfer of a portion of state/county realignment funding. A third alternative, a CPE (Certified Public Expenditure) would not work well for CMSP, payor, block grant and hybrid counties, as the state not the county would be running the new program. The CPE model would work well for counties with public hospitals to capture and reflect the county expenditures during an interim period.

The interplay of state reforms and federal laws:
The federal DSH program pays for hospitals' uncompensated care to the uninsured. Federal law caps DSH payments at each hospital's actual cost for unreimbursed care to the uninsured plus the difference between the hospital's actual cost of care to Medi-Cal patients and its Medi-Cal reimbursement. As California increases

coverage for the uninsured and increases Medi-Cal reimbursement rates to Medicare levels, hospitals and the state are at risk of returning DSH funds to the federal government; this same "Catch 22" interplay may apply to community clinics' §330 funds as well.[52] ITUP suggests that California seek a federal waiver to retain and wherever necessary redistribute "at-risk" DSH funds to support coverage expansion consistent with federal law. The costs of state reform should not create windfalls for the federal government, county government or providers.

Transformation of local delivery systems

There is agreement among the individuals we interviewed that local delivery systems should be transformed to place greater emphasis on primary care and preventive services, that the primary care gate keeper medical home model is a good one, and that management for chronic conditions is critically important. A number of counties are already making these changes in their system, and some are receiving increased funds to do so under the federal coverage expansion grants.

Several of our interviewees pointed out the need to coalesce and coordinate medical care, substance abuse treatment and mental health services in caring for some of their patients. These programmatic intersections need improvement at the local level and are non-existent in Medi-Cal managed care.

Some of our interviewees suggested a state and federal role in financing the transformation of local safety nets and in assuring adequate flexibility in the flow of existing revenue streams to make transformation a fiscal possibility/reality. ITUP suggests that providing a limited transitional period of exclusivity to local delivery systems will enable them to continue to provide culturally competent care and shift toward a primary care model.

Section 1115 waiver

There was strong support among the leaders we interviewed for seeking a large federal waiver that would allow all current county spending on uninsured adults to be matched by federal funds. ITUP suggests that a waiver for the adults should not mirror Medi-Cal; its eligibility, enrollment and retention are complex and needlessly costly and should be simplified as discussed above. The waiver should incorporate some of the county indigent system's best practices and should fix and simplify Medi-Cal.[53] The waiver should preserve federal DSH and Safety Net Pool funds and re-invest them in expanded coverage for the uninsured. The waiver should give local safety net delivery systems the flexibility to retain and shift federal funds from inpatient hospital to outpatient services in their evolving delivery systems.

Local flexibility

Local leaders believe they know and can reconcile competing local needs and interests more effectively than state programs can and are better positioned to make the necessary system changes and transitions. They believe that locally operated managed care plans are better positioned to facilitate these transitions than are statewide commercial plans or state government. Some counties are prepared to extend coverage more broadly than the Governor and legislative leadership. ITUP recommends strong reliance on local managed care entities but with a competitive presence from at least one other plan. We suggest setting a framework where the state reform is

a floor not a ceiling for counties. Those local innovators who are interested in expanding from the state base should be given the programmatic latitude to do so and a process to negotiate needed changes with the state.

(Endnotes)

1 Chen and Wulsin, A Summary of Health Care Financing for Low Income Individuals in California (October 2006) at www.itup.org/reports

2 We divided the total of MISP and CMSP spending ($1,734,899,019) by 6.6 million uninsured, the numbers of Californians uninsured over the course of a year for a total of $267 annually. Some counties seek to provide care for all the uninsured. If divided by 4.9 million uninsured Californians uninsured at a given point in time, the relevant figure is $354 annually.
By comparison California employers spend $4100 annually per insured adult enrolled in an HMO. California Employer Health Benefits Survey 2006 (November 2006) at www.chcf.org

3 We included realignment, Prop 99, county match, net county DSH, federal Safety Net Care Pool funding and tobacco settlement in this calculation, but did not include county over-match. ITUP, Overview of California's Uninsured (November 2006) at www.itup.org Realignment funds and the mandatory county match must be spent on county health. County match funds are frozen at 1988 levels and have not increased since while realignment has steadily and slowly grown. Proposition 99 must be spent on care to the uninsured. County over-match funds are discretionary with each county and in the case of Alameda and Los Angeles counties have been generated in part by special voter approved parcel taxes, which must be spent as directed in the initiatives. Medi-Cal disproportionate share hospital (DSH) federal funding must be spent on uncompensated care for Medi-Cal and uninsured patients. Federal Safety Net Care Pool (SNCP) funding must be spent on the uninsured. Tobacco Litigation Settlement (TLS) funds may be spent on the uninsured as many large counties have chosen to do or may be spent on other county purposes. In Orange County, Proposition H governs the distribution of TLS funds.

4 See Fox, ITUP Presentation to Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org. County health spending is a combination of county reported data through County Medical Services (CMSP) and the Medically Indigent Care Reporting System (MICRS) Net county public health spending accounts for about $535 million or one sixth of the county health pie and is based on county reported spending. "Other county health" is a residual figure derived by subtracting indigent county health and net public health from county health revenues; it may be significantly understated.

5 ITUP, Where are the Uninsured Now: a Ten Year Overview (February 2007) at www.itup.org More than 50% of expenditures is situated in hospital emergency room or hospital inpatient settings and a significant amount of outpatient care costs is concentrated in hospitals as well.

6 California's Uninsured: Ten Years of Change 1995-2005 (Insure the Uninsured Project, 2006) at www.itup.org

7 These small counties limit coverage to MIAs – medically indigent uninsured adults without minor children and income of less than 200% of FPL. Participating CMSP Counties, see http://www.cmspcounties.org/about/participating_counties.html (accessed April 11, 2007).

8 These large mostly urban counties operate public hospitals and clinics that are open to all uninsured patients. They have sliding fee schedules for patients with limited ability to pay.

9 These large urban counties restrict eligibility to MIAs and typically cut off eligibility at 200% of FPL. Some further restrict eligibility to patient with a serious medical condition; thus further limiting the numbers of enrolled eligibles but not the programs' cost since 70% of medical expenses are typically associated with 10% of a given population. This restricted eligibility does impact access to preventive and primary care services for the majority of uninsured MIAs.

10 The public clinics in these counties are an important resource in providing primary care services to uninsured adults. Private hospitals and doctors are paid for hospital-based care to the MIAs.

11 County funding is allocated to one hospital, typically the ex-public hospital, for its care to the county indigent. No funds are

allocated for patients at other hospitals or for community clinic patients.

12 See California HealthCare Foundation, County Programs for the Medically Indigent (2006) at www.chcf.org

13 California Department of Health Services, Medically Indigent Care Reporting System, Fiscal Year 2003-2004 Data. Several counties, including Los Angeles County, had not completed their reports.

14 See Christine Chen, Coverage Initiatives: Design and Effectiveness (January 2007) at www.itup.org and Jolly Mannanal, Directory of Local Efforts to Expand Health Care Access for California's Uninsured (updated January 2007) and Mannanal, Coverage Expansion Waiver Awards: Summary (March 2007) at www.itup.org.

15 See Chen and Wulsin, A Summary of Health Care Financing for Low Income Individuals in California (October 2006) at www.itup.org/reports. We calculated the cost of care to the uninsured by multiplying uninsured visits by clinics' average cost per visit. We calculated clinic uncompensated care by subtracting clinics' uninsured revenues. We calculated percent of net patient revenues by dividing clinics' net patient revenues.

16 Ibid. We calculated the cost of uncompensated care to the uninsured by adding bad debt and charity care and multiplying by the cost to charge ratio. We calculated percent of net patient revenues by dividing by net patient revenues. We calculated care to the uninsured by adding uncompensated care to the uninsured and county compensated care to the uninsured in non-county hospitals.

17 Estimates derive from National studies cited in Hadley and Holahan, Who Pays and How Much: the Cost of Caring for the Uninsured (Kaiser Family Foundation, February 2003 at www.kff.org The authors cite studies finding that about two thirds of doctors reported providing uncompensated care to the uninsured; the other third reported they did not.

18 ITUP, Ten Year Trend Report at www.itup.org

19 Counties may reimburse patients on a fee for service basis for care to county indigents or through grants and contracts. The totality of county funding is reported by clinics either as county patient revenue or as county grants and contracts; there is little consistency in clinics reporting. County grants to and contracts with clinics were reported at $76 million; some of these grants are for care to the uninsured, some for mental health services, some for Ryan White services and other purposes.

20 Federal 330 grants are awarded to the limited numbers of clinics who are federally qualified health centers (FQHCs), these are private and nonprofit community health centers that provide comprehensive primary care services to medically underserved areas and populations regardless of patients' ability to pay. Federal grants and contracts to clinics were reported at $246 million. Grantees are also eligible for enhanced benefits, such as enhanced Medicaid/Medicare reimbursement, discounts on the costs of prescription drugs, and access to the Federal Tort Claims Act (FTCA) program for malpractice coverage.

21 We initially reviewed these arrangements in six urban counties in Wulsin, Clinics, Counties and the Uninsured (Insure the Uninsured Project, 1999) and have updated this information for all counties through our regional workgroups. Clinics in the Central Valley, Central Coast and North Central regions are most lacking in funding, referral and case management arrangements for county indigent patients. Several counties are building clinic referral, information technology and

22 Private hospitals report receiving $372 million from counties for their care to the uninsured county indigent; some private hospitals receive significant private DSH and supplemental ($542 million and $247 million) allocations from the Medi-Cal program to pay in part for their uncompensated care to the uninsured. The cost shift occurs when providers transfer a proportion of the cost of uncompensated care from treatment to underinsured and uninsured patients to insured patients in the form of higher service fees.

23 See Mannanal, Directory of Local Efforts to Expand Health Care Access for California's Uninsured (updated 2007) at www.itup.org

24 Private doctors' care to the uninsured is paid for by Prop 99, SB 12 fines and fees, patient out of pocket, hospitals, counties and the private cost shift. SB 12 created and Prop 99 helps to finance an emergency medical services fund that compensates physicians for emergency care to nonpaying patients. A number of hospitals pay specialty physicians a fee for serving on emergency call panels and contract with emergency physicians for their care to uninsured patients. Many but not all counties pay private physicians for their care to county indigent patients. Many physicians continue to treat their patients who become uninsured and bill and collect at reduced rates reflecting their patients' ability to pay. Other physicians see the uninsured as volunteers or for reduced compensation at local free and community clinics.

25 See n. 16. One third of physicians reported providing no care to uninsured patients. Hadley, Who Pays and How Much: the Cost of Caring for the Uninsured.

26 We reviewed these proposals in Impact of Major Health Proposals on Women's Health Coverage (Insure the Uninsured Project, June 2007) www.itup.org/reports

27 It is important to distinguish between the MIAs (uninsured adults without minor children living at home) and uninsured parents. The uninsured parents can be covered by expanding coverage under Medi-Cal Section 1931b as proposed by Governor Schwarzenegger, Senate President Perata and Speaker Nunez; there are about 1.5 million uninsured parents with incomes below 300% of FPL. This is a plan amendment that the federal government has no authority to deny. The MIAs can be covered by state or state and county funds as Washington state and Minnesota do, or they can be covered under a Medicaid §1115 waiver as Oregon, Arizona, New York and Massachusetts do. This waiver is discretionary with the federal government; there are about 2 million uninsured adults without minor children living at home with incomes below 300% of FPL. The uninsured MIAs are a county responsibility in California; whereas uninsured parents are not and the state already pays through Medi-Cal share of cost for their most costly services when parents are seriously ill or injured, but not for the routine primary and preventive services necessary to maintain and enhance health.

28 FQHC reimbursement pays for a clinic's reasonable and necessary costs. Most but not all non-profit community clinics and most county clinics receive Medi-Cal FQHC reimbursement, and as a result there is little or no Medi-Cal uncompensated care in these sites.

29 As part of the recent federal hospital waiver, public and UC hospitals are paid for their reasonable and necessary costs. As a result there is little or no Medi-Cal uncompensated care in these sites.

30 DSH is fixed pot of federal funds for uncompensated care; it does not increase as uncompensated care increases; however under federal law it decreases as hospital uncompensated care decreases as is discussed subsequently.

31 Nearly half (45%) the MIAs with incomes below the poverty level have no usual source of care. Nearly a third use county and community clinics. About one in five use a private doctor's office and a surprisingly low 2.5% use the hospital emergency room as their usual source of care. See Fox, ITUP Presentation to Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org CHIS Data CITE

32 In the COHS model, there is a single local managed care plan; in the "two plan" model, a local initiative that is required to include the local safety net providers competes with a commercial plan. In general, local public hospitals and community clinics express strong support for their local managed care plans. Many community clinics hedge their bets by participating in both plans. Los Angeles is not a true two plan model county as both the local initiative and the commercial plan are umbrellas for several different plans.

33 In both payor and CMSP counties, safety net providers participate and compete for patients with other providers in the county indigent program and in Medi-Cal. Some safety net providers have strong case management capacities, infrastructure and referral relationships necessary to effectively participate in managed care; others are not as well prepared or as capable and competitive participants at this time. Primary care clinics would be helped quite dramatically as the current county systems in "payor" counties concentrate their programs' resources on the most seriously ill patients.
In block grant counties, there is no county funding for primary care clinics; Medi-Cal managed care will improve primary care and care coordination for the MIAs. It would reduce the demand for services on the ex-public hospital that is the sole source of county funded care for uninsured adults by spreading the patients to primary care sites and other local hospitals. The safety net facilities already participate effectively in Medi-Cal managed care in Fresno, and there is not yet managed care for Medi-cal patients in Merced. In some hybrid counties, the public clinics already participate effectively in both the Medi-Cal managed care system and in the county system; transition would not be difficult. Whereas in others, the public clinics solely participate in the county systems and may face difficulty with the transition to Medi-Cal managed care due to their lack of experience and roles in that market. Community clinics in these counties are not often compensated by the county for their care to uninsured patients. The shift to Medi-Cal managed care would be beneficial and not difficult as they already participate for their Medi-Cal eligible patients.

34 There are two relevant antecedents: mandatory managed care for families in the mid '90s and expansion of OB coverage in

the late '80's and early '90s. In the transition to Medi-Cal managed care, safety net clinics and county hospitals retained and many clinics expanded their patient base. The expanded coverage for OB services occurred in a fee for service context and was accompanied by a large provider rate increase and the inception of DSH payments. At the time of expansion, county delivery rooms were horribly over-crowded and prompt pre-natal services were difficult to access in many county systems. In one very large urban county, the county Health Department did not implement the Comprehensive Perinatal Services Program. In short, private providers had strong financial incentives, patients had strong care incentives and county health was very slow to respond in improving access to care for county perinatal services.

35 Massachusetts offers safety net health plans a period of exclusivity to manage the transition to managed care. A number of California counties with public hospitals have strong primary care networks, integrated delivery systems and new hospital facilities, and they already compete effectively in Medi-Cal and Healthy Families. Some do not compete effectively in the Healthy Families program or for Medi-Cal children and might lose their patient base in a head to head competition with private providers and may need some degree of exclusivity during a specified transition time.

36 It is the erratic on-and-off nature of eligibility for Medi-Cal and Healthy Families that poses the greatest challenge for effective managed care by safety net providers and plans.

37 Simplify, Automate, and Follow the Leader: Lessons on Expanding Health Coverage for Children, California HealthCare Foundation, November 2006, http://www.chcf.org/documents/policy/SimplifyAutomateAndFollowTheLeaderIB.pdf (accessed April 11, 2007).

38 California HealthCare Foundation, Medi-Cal Facts and Figures (May 2007) at www.chcf.org

39 This increase will not provide a measurable benefit to community and county clinics already receiving Medi-Cal FQHC or to public and UC hospitals already being paid for their reasonable and necessary costs of care. The level of enhanced private sector participation may be modest. See Shen and Zuckerman, The Effect of Medicaid Payment Levels on Access and Use Among Beneficiaries Health Services Research (June 2005)

40 UCLA Center for Health Policy Research, California Health Interview Survey 2005

41 California Health Interview Survey 2005

42 Commercial coverage was substantially more expensive for plans and patients. Out of network providers were able to bill (bilk) the commercial system and patients for their "charges"; hospital charges now average four times their costs. Commercial coverage plans relied quite heavily on large copays and deductibles in order to achieve affordable premiums -- a model that low and moderate income patients are unable to afford thus depriving them of necessary access to services.

43 Healthy Families is more favorable than commercial coverage for safety net providers because the Healthy Families program and Healthy Families plans make a priority to recruit safety net providers while commercial coverage plans do not. Healthy Families plans have more affordable shares of monthly premiums and out of pocket responsibilities such as co-payments for moderate-income families than does commercial coverage. Commercial coverage typically pays providers more for covered services, but most safety net providers are insignificant participants in plans' commercial networks. On the other hand commercial plans connect to employers whereas safety net plans and networks lack that critical connection.
Uninsured patients with income between 100% and 200% of FPL mirror the usual source of care patterns of the uninsured with incomes below poverty – i.e. nearly half have no usual source of care, a third use community and county clinics and one fifth receive their care from private physicians. However usual source of care patterns shift quite dramatically for the large numbers of uninsured adults with incomes over 200% of FPL – 40% seek care from private doctors, 36% have no usual source of care and only one in five receive care from community or county clinics.

44 MediCal guarantees a certain percent of the market to the local initiative plan; whereas Healthy Families offers a discount on premiums for the plan with the greatest share of safety net providers.

45 Most county and community clinics are paid at FQHC rates under Medi-Cal but not Healthy Families. Federal DSH allotments do not grow or shrink, depending on whether the uninsured are covered by Medi-Cal or Healthy Families.

46 A waiver request could simplify the public programs such that all individuals below a certain income level would be Medi-Cal eligible, all above that level would be Healthy Families eligible with premium subsidies and those with incomes above a certain

level would be required to secure commercial coverage, possibly with some assistance for those with serious affordability challenges. This could correct the on-off nature of Medi-Cal and Healthy Families coverage that makes managed care difficult for publicly insured patients and safety net providers. The waiver could also modernize the Medi-Cal eligibility and administrative process and reduce costs to the state, counties and federal governments.

47 Much of the care used by undocumented individuals with insurance was for emergency and maternity services. Waidman, The Potential Role for Bi-National Health Insurance (Urban Institute October 2006), and Goldman, Immigrants and the Cost of Medical Care Health Affairs (November/December 2006).

48 The Secretary of Health and Human Services grants section 1115 waivers to states. They permit states to use Medicaid funds in a way that does not follow federal standards, allowing states to make innovative programmatic changes that provide benefits such as increased program efficacy and expanded coverage to low-income populations. Many other states, including Oregon, Arizona, Delaware, Tennessee, Massachusetts, Vermont and New York already have secured 1115 waivers to cover adults. OBRA provisions require Medicaid to cover emergency care services to the indigent as Medi-Cal already does. A waiver to cover adults would/should allow California to secure FFP for emergency care to undocumented adults.

49 Under California's Welfare and Institutions Code § 17000, "California's counties have a duty to 'relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported by their relatives or friends, by their own means, or by state hospitals or other private institutions.'"

50 The state should not "take back" the county match or local tobacco settlement funds. Tobacco settlement funds are used for care to the uninsured in a number of large counties; however this is at county discretion and not all counties use these funds for care to the uninsured. County matching requirements date back to 1978 and have not increased since then although many counties exceed their match requirements and some such as Los Angeles and Alameda secured local voter approval for tax increases devoted to care for the uninsured.
Counties should be given the opportunity to use these funds as match if they so choose or to use them for other important local health priorities.

51 Our research found that counties report spending about $1.75 billion on health care to the uninsured, $577 million on net public health and $740 million on other county health. The spending on "other county health" may be understated as it reflects a residual amount after deducting spending on the uninsured and net public health.

52 Similar problems exist for clinics with 330 grants and the ADAP (AIDS Drug Assistance Program) and drug pricing for clinics and county hospitals under the 340B program. Resolution of these issues should be considered for inclusion in the waiver as well.

53 We recommend pooling financing from low wage employees and their employers and the self-employed with public program funding through Medi-Cal, Healthy Families and county health. We recommend that out of pocket responsibilities be graduated to the subscriber's income and targeted to promote the most efficacious care and treatment. We would also suggest that reformed managed care systems should be the exclusive choice where public subsidies are entailed and that individuals have options to pay the incremental cost of more costly plans and receive discounts for selecting qualified safety net plans and providers.