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ITUP Summary Of California's §1115 Medicaid Waiver For the Hospital Association of Southern California

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Introduction

The §1115 Waiver provides a bridge or stepping-stones to implementation of the Affordable Care Act of 2010 (ACA). The projected value to the state is more than $10 billion in federal match over the next five years. This briefing paper describes the evolution from our current system to the new system outlined in the ACA and the waiver's role in facilitating this transition.

The current system for the uninsured is based in county health programs[1] with significant federal subsidies for safety net hospitals[2] and community clinics[3] that serve large shares of the uninsured. The estimated county spending on care to the uninsured in California is over $2 billion per year.[4] Typical care to the uninsured is episodic and highly reliant on inappropriate use of hospital emergency rooms as the ER is open to all regardless of insurance status or ability to pay.

This system is funded by state realignment (a share of the state sales tax and vehicle license fees) funds to counties, federal DSH and Safety Net Care Pool (SNCP) funds, local matching funds and federal 330 funds.[5] There is significant cross subsidization between the state's Medi-Cal program and county and provider care to the uninsured. Ten California counties received a share of $180 million annually in federal match between 2007 and 2010 for a portion of their improved care/coverage to uninsured adults; these were known as coverage initiatives.[6]

The recently approved federal waiver makes several very important improvements:

1) Funds coverage for medically indigent adults and other low-income adults under 200% of FPL in evolving county programs (Low Income Health Program) with a federal match at county option. (An estimated $2.9 billion in federal match, of which up to $600 million could come from the Safety Net Care Pool)
2) Moves some seniors and persons with disabilities into managed care (projected $180 million in annual state General Fund savings)
3) Better coordinates the care of children in the California Children's Services program
4) Funds a variety of state programs for the uninsured and public providers' uncompensated care through the safety net care pool ($7.5 billion in Safety Net Care Pool funds)
5) Funds the evolution/transformation of public hospitals into models of coverage, known as Delivery System Reform Incentive Pool. (Up to $6.5 billion from the SNCP)

The waiver has been in effect since November 1, 2010. The Low Income Health Program (LIHP) coverage starts June 1, 2011 although the funding for the 10 coverage initiative counties was likely to be effective since November 1, 2010. The managed care expansion to seniors and persons with disabilities is effective June 1, 2011. The details of the Delivery System Reform Incentive Pool are still being negotiated between the state, CMS and the California Association of Public Hospitals.

In 2014, the ACA will cover uninsured adults and children up to 133% of FPL ($14,000 for an individual) through Medi-Cal managed care, and it will subsidize private coverage for the

uninsured, low-wage small employers and the private individually insured with incomes up to 400% of FPL ($88,000 for a family of four) through private (and public if any participate) health plans contracting with the Exchange.[7] The federal government will pay 100% of the costs of the new Medicaid eligibles, phasing down to 90% by the year 2020. The potential benefit of these provisions to California is maximally estimated at $18 billion annually by 2018.[8] Beginning in 2014 most of California's 6.5 million[9] uninsured will have a choice of managed care plans, providers and benefits.

More than 4 million of California's uninsured will be eligible for the Medi-Cal expansion (1.7 million) or subsidies in the Exchange (2.3 million).[10] In April 2010, states that covered their Medically Indigent Adults (MIAs), like Arizona, Oregon, New York, Massachusetts, Maine, Vermont and Minnesota, became eligible for federal Medicaid matching funds. This new waiver allows California counties, who choose to participate in the waiver funding for care to MIAs, to receive comparable match during the years 2011 through 2013, but they must upgrade their systems to meet the minimum standards set by the waiver.[11] In 2014 (Medicare) and 2017 (Medi-Cal), the federal government will begin to reduce federal DSH fund subsidies for hospital uncompensated care, based on the assumption that most of the uninsured will enroll in coverage, reducing hospitals' uncompensated care.[12]

Low Income Health Program for MIAs and Other Uninsured Adults: Federal Match for County Care/Coverage

County governments under Welfare and Institutions Code §17000 are responsible for care for the county indigent with no other source of coverage. Counties implement this responsibility in several different ways: 1) they provide the care in their own hospitals and clinics (provider counties), 2) they pay for care delivered in private hospitals, clinics and doctor's offices (payor counties), 3) they provide outpatient care in their own clinics and pay for private hospital care (hybrid counties), or 4) they collectively pay private providers for care to the county indigent in 34 small counties (CMSP counties). In Southern California, Imperial is a CMSP county, Santa Barbara a hybrid county, Orange and San Diego payor counties, and Los Angeles, Riverside, San Bernardino and Ventura are provider counties.

In 2014, most uninsured Californians will move into managed care through Medi-Cal or the Exchange. The residually uninsured will be the undocumented workers (up to 1.4 million uninsured).

All eight Southern California counties now have the option to secure federal financing for their care to MIAs during the interim period (2011-2013)[13] if they are prepared to make the changes described below. This is particularly important to Southern California counties and providers as each county has a very high percentage of uninsured residents[14] and most Southern California counties are "under equity,"[15] i.e. they have a below average share of the state's resources for health care to the uninsured.

The Low Income Health Program (LIHP) will consist of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very low-income adults with incomes of less than 133% of FPL, and most importantly, its federal funding through the waiver is uncapped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200% of FPL, and its expenditures come from the waiver's federal safety net care pool (SNCP) funding allocation, which is capped at $600 million. Both programs are at county option. This is an opportunity for county health departments to improve

coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and most importantly, build the right delivery systems for a disenfranchised population with a 50/50 match of existing county health spending for the newly eligible. The state projects that 512,000 adults would be eligible under LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI.

Financing: County match is through local certified public expenditures (CPEs) on the eligible population – in other words, the county match is what the county spends on this population.[16] The county spending on care to the MIAs (medically indigent adults who are not otherwise eligible for federal Medicaid match) and to parents[17] (100-133% of FPL) is now eligible for the regular 50/50 federal match.[18] For example, if Orange spent $100 million on this population, it would now qualify for a $50 million federal match.

Counties must maintain their 2006 levels of financial effort.[19] For example, if a county spent $10 million in 2006 and received federal matching funds of $5 million under the waiver, it could not then reduce its county contribution to $5 million; rather it must maintain its 2006 county spending levels. This could be problematic in some counties because their state realignment funding fell roughly 10% between 2007 and 2010 due to the decline in state sales tax and vehicle license fee revenues.[20]

Counties will want to carefully review their health, mental health, substance abuse, public health, SB 12, EMS and other programs to determine CPEs that may serve as the basis for a federal match.[21] UC and district hospitals will want to conduct the same thorough analysis in conjunction with the county.

Who is eligible?

Legal status: Only US citizens and legal permanent residents (LPRs) are eligible for full benefits. The undocumented and new LPRs are not eligible for full scope Medi-Cal, but only for services restricted to emergencies.[22]

Income: Each county determines its own eligibility rules and sets its own income eligibility standards, but not more than 200% of FPL. For example, Los Angeles might choose to set its eligibility level at 133% of FPL, whereas Orange might choose to use 200% of FPL.[23]

In the payor counties of San Diego, Orange, Imperial and Santa Barbara (in part), the county program's eligibility standards are the same as the federal eligibility rules under the waiver. However, in the provider counties of Los Angeles, Ventura, Riverside and San Bernardino, the county will need to distinguish between care to the MIAs (eligible for federal match) and care to the undocumented (not eligible for this program), because the county hospital treats all patients regardless of insurance or immigration status.[24]

Process: The county must individually determine eligibility, issue ID cards and track and report program expenditures.[25] Eligibility must be determined through the county health or social services department.[26]

Wait lists, spending caps and entitlement: Counties can establish enrollment caps and wait lists if their program expenditures exceed federal and local allocations under the waiver. If the county adopts wait lists, MCE eligibles must have absolute priority over HCCI eligibles. In other words, before a county can cap program enrollment for MCE eligibles, it must first cap, then eliminate enrollment for HCCI eligibles. In effect, counties can ration/prioritize their scarce program revenues by the income status of their enrollees (as opposed to queuing and triaging their services by the degree of medical need).

Welfare and Institutions Code Section 17000 may prohibit county wait lists

Retroactive eligibility: Counties may offer up to three months of retroactive eligibility for its program if they so choose.[27] If counties prefer no retroactivity, eligibility begins the first of the month when an individual applies and is thereafter determined eligible. In many counties, eligibility begins with the date of application; this will be a modest improvement.

County health or social services agency employees must determine eligibility under the waiver with a transition towards a Medi-Cal style determination process. Counties typically use a more expedited and streamlined process through the county health department than Medi-Cal does through the county social services department. The ACA will shift eligibility determinations from the county health department into the Exchange while the applications and any application assistance will spread out into many venues, including local social services and health departments, hospitals, clinics and doctor's offices.[28]

Benefits - minimums and maximums: Counties must offer a core set of benefits:[29]

- Inpatient, outpatient and emergency hospital services
- Physician services
- Lab and x-ray services
- Prescription drugs, medical equipment and supplies, prosthetic and orthotic appliances and devices
- Podiatric care

- Mental health (mental health is mandatory for MCE eligibles only, it is optional for the higher income HCCI eligibles)

Most counties already cover these basic services, although a few do not cover prescriptions, and a few only cover hospital-based care; these counties will need to upgrade their services. Other counties only pay for care for serious medical conditions and will need to upgrade to cover preventive and primary care.

Counties can offer (and receive federal matching for) more extensive benefits, such as adult dental care or any other service for which federal Medicaid matching is available; most counties do not cover dental, hearing aids or eyeglasses for their MIAs.

Out-of-network emergency care: Counties must cover out-of-network emergency services and pay at least 30% of the average Medi-Cal rates.[30] Payor counties, such as Orange, San Diego and Imperial, already pay their local hospitals and doctors for emergencies, regardless of the site of care. This provision will be extremely consequential in provider counties such as Los Angeles, Ventura, Riverside and San Bernardino, where the county pays for emergency care in its own hospital system, but typically does not pay other private facilities.[31] This obligation is limited in two ways: first, it only applies to genuine emergencies meeting the Emergency Medical Treatment and Active Labor Act (EMTALA) standards; and second, it only applies to diagnosis, treatment, required stabilization and limited post-stabilization care. These costs to a county may be significant.[32]

This requirement may apply for out-of-county (but not out-of-state) emergency care as well; this will need to be clarified with CMS and the State Department of Health Care Services.[33] Thus, for example, a hospital located in Santa Barbara county that provides emergency care to an uninsured low income Ventura county resident may look to the Ventura County Health Care Agency for reimbursement. To the best of our knowledge, only the 34 small CMSP counties (including Imperial) currently comply with this requirement. These costs are likely to be minor.[34] Under the ACA, all the uninsured who receive coverage and all the insured will be covered for out-of-network emergency care.

Counties and hospitals can use the Medi-Cal hospital fee as a match to enhance payments and coverage under this provision if they so choose. [35]

Mental and behavioral health services: Counties must cover minimum mental health services that meet a defined medical severity threshold (significant impairment in life functioning or probability of significant deterioration in important life functioning):

- 10 days of inpatient care
- Psychiatric pharmaceuticals
- 12 outpatient visits annually

Most counties cover a broader array of mental health services for the uninsured with severe mental illnesses, which will now be eligible for federal matching. Counties may wish to expand their thresholds and networks of mental health care with the new funding.

Counties can either integrate their mental health program services with their physical health care, or maintain a separate, carved-out mental health services and delivery system.

Matching is also available for county substance abuse services.[36]

The ACA requires parity in treatment of behavioral health services in 2014. The waiver requires the state to begin cataloguing state and county behavioral health services and developing plans to meet federal parity requirements in 2014.[37]

Cost sharing: Cost sharing must comply with Medicaid rules.[38] In other words, co-pays must be nominal, and county enrollment fees and premiums for the lowest income uninsured enrollees (below 133% of FPL) must be eliminated. The cost sharing for the higher income uninsured (HCCI, more than 133% of FPL) must not exceed 5% of the subscriber's income.

This will require some counties to reassess their requirements for patient contributions to the costs of their care. The cost impacts may be minor for hospital services, but could be significant for prescription services.

Managed care: The waiver does not require county systems caring for MIAs to use a managed care delivery system. Some counties may choose to do so, using either their local managed care plan as a third party administrator (TPA), or as a risk-bearing entity. Some Bay Area counties are already using their Local Initiative or COHS as a TPA for the county's care to the MIAs and others are considering this option. In Southern California, Orange County has discussed the possibility that CalOPTIMA could be the risk-bearing MCO or the TPA for its county indigent, but to our knowledge, no other Southern California county is planning to do so.[39]

Managed care systems for the uninsured covered through the waiver must comply with federal rules governing MCOs (managed care organizations).[40] A closed panel county delivery system is considered a MCO.[41] The implication of this would be that Los Angeles, Ventura, San Bernardino and Riverside may well be operating MCOs subject to federal HMO laws.

While the ACA does not specify the use of managed care for the newly insured, it is nearly 100% certain that California would use Medi-Cal managed care for the low income MIAs. Higher income MIAs enrolled in the Exchange can choose between an HMO or a PPO. The financial incentives are likely to lead most lower income Exchange subscribers to select the least costly coverage option.

Timeliness of care: Primary care appointments must be within 30 business days of request for the first year of the waiver, and within 20 business days of request in the second and subsequent years. Urgent care appointments must be within 48 hours of request. Specialty care services must be within 30 business days of request.[42] This is one of the most important upgrades for county health and is vital to making local safety nets competitive to newly insured subscribers in 2014.[43]

Timeliness of care has been particularly problematic for some specialty services in some counties, where wait times of six months are reported to be quite common. County systems may find it necessary to devolve their specialty care to more timely and cost effective sites– i.e. move specialty care out of central county hospital settings into clinics and doctor's offices.

Timely primary care access has also been a serious problem in some counties. Some county systems will need to broaden their primary care networks to meet the timeliness standards by creating new county clinics, contracting with non-profit community clinics or contracting with private physicians. The DSRIP funding can be used to enhance the primary care delivery system in a county.

Freedom of choice: Enrollees must have a choice of at least two primary care providers and the right to request a change of provider. This is a very modest and cost-neutral change towards 2014, when subscribers will have very broad freedom of choice of plan and provider.[44]

Geographic access: Access to a primary care provider must be within 30 miles or 60 minutes from the patient's address.[45] This is a modest requirement; it will likely require counties like San Bernardino, Riverside and Los Angeles to assure more convenient access for the uninsured in the more rural regions of their counties.

The waiver is quite specific in requiring Los Angeles County to assure geographic access by contracting with local community hospitals or paying for transportation services to county or contracting hospitals.[46]

FQHCs: The county must contract with a least one FQHC and pay it according to Medi-Cal FQHC rate methodology.[47] This can be met by contracting with the county's own clinics or a private non-profit clinic. This is a very minor requirement, but there are some counties that do not contract at all with local non-profit FQHCs for their care to the county indigent.[48]

Credentialing: All providers must be appropriately credentialed.[49] This may pose some problems in some county or contractor facilities.

Data: Counties must collect and report their spending and encounter data.[50] Large counties have not reported their spending data since 2007, although the small CMSP counties (like Imperial) do continue to report their data. Prior data reports were of highly uneven quality between counties.[51]

Reimbursement rates: Payments to providers may not exceed the Medicare Upper Payment Limit (UPL) or cost as determined by federal cost reporting rules. In my judgment, this will require counties with public hospitals to change their reimbursement methodology for hospital care in their own facilities. Counties may wish to align their reimbursement incentives with some of the new Medicare innovations, such as pay-for-performance, accountable care organizations (ACOs), bundling and other features to improve the quality and outcomes of care.[52]

Due Process: Fair hearing appeals of eligibility, wait lists and benefit denials will be required in county systems.[53]

Medi-Cal Managed Care for Seniors and Persons with Disabilities & a Pilot Program for CCS

Seniors and persons with disabilities (SPDs) make up a small share of the Medi-Cal population, but a large proportion of Medi-Cal spending; they are roughly 25% of program eligibles, and account for 62% of spending.[54] Most are in fee-for-service plans and spending per eligible has grown faster for this population than those enrolled in managed care.[55]

California has four types of Medi-Cal managed care: 1) Geographic Managed Care (San Diego) where subscribers choose among multiple private insurers, 2) County Organized Health Systems (Orange, Santa Barbara and soon Ventura) where subscribers must enroll in a single plan, 3) Two Plan (Los Angeles, Riverside and San Bernardino) where subscribers choose between a local organized non-profit safety net plan and a private insurer and 4) unmanaged fee-for-service (Imperial). The COHS plans already cover this population.

The state's waiver requires only some SPDs to enroll in managed care. This expansion of managed care does not impact the Medi-Medis or dual eligibles, who have both Medicare and Medi-Cal coverage, but it does impact those SPDs who have only Medi-Cal coverage.

Roughly 388,000 persons accounting for $7.5 billion dollars will be impacted by this aspect of the waiver.[56] The state expects to save about $180 million annually on an ongoing basis[57] and believes this will improve the care to this population with extensive medical needs. SPDs have been enrolled in managed care in COHS counties like Orange and Santa Barbara for many years, and these programs have reported success in managing and improving patient care.[58]

Enrollment: In Two Plan and GMC managed care counties, the waiver authorizes and the state will require SPD enrollment in managed care. To date, Medi-Cal managed care in these counties has enrolled primarily children and families, so there will be a challenge and learning curve in designing managed care for more costly, medically fragile populations. Beginning June 1, 2011, mandatory enrollment will begin on a rolling basis based on an individual's date of birth over a twelve-month period.[59]

Freedom of choice: Beneficiaries have a choice between at least two plans in Two Plan counties, and between multiple plans in GMC counties (San Diego). Beneficiaries have a right to change enrollment annually or for cause during the plan year.

Continuity of care: Default enrollment will be linked to the beneficiaries' prior use of particular providers to preserve continuity of care for those who do not exercise choice.

Advance and ongoing subscriber education: There will be an outreach and communication strategy to explain this change in advance and on an ongoing basis.

Plan networks: The plan networks must be adequate to provide access to all covered services, including prevention, primary and specialty care, in reasonable geographic proximity. Networks must be culturally competent for the populations covered.

Specialty care access: Enrollees with special health care needs must have direct access to a specialist appropriate to the individual's condition.[60]

Special conditions of the waiver: Plans must have in place: care coordination and continuity of care; timely and standardized assessments of an individual's medical needs;

person-centered planning and treatment; discharge planning; linkages to HIT (health information technology); and monthly submissions of accurate encounter data.[61]

Four Pilot Programs for CCS (California Children's Services) Children

CCS is a long-standing program for children with special health needs. CCS covers children from several different programs: Medi-Cal, Healthy Families, private insurance supplement and uninsured low and moderate income children for the CCS conditions (family incomes up to $40,000 a year or uncovered medical expenses in excess of 20% of a family's income). CCS is a program primarily used by pediatric specialists and pediatric tertiary care facilities. Its Medi-Cal costs are $1.7 billion for over 175,000 children.[62]

Currently, 60% of CCS children are enrolled partially in Medi-Cal managed care and partially in fee-for-services (FFS) through the CCS program, which is carved out of managed care.[63] These children receive their primary care services and other services unrelated to their CCS condition through a Medi-Cal or Healthy Families managed care plan, and their specialty care for their CCS-covered condition through the CCS program specialists. Three COHS plans include CCS services, while the others have CCS services carved out. In all Two Plan and GMC counties, CCS services are carved out.

The state's proposal to CMS was to pilot test four different models of integrating the services of these children. The federal waiver approval gives the state an additional 180 days to flesh out a request for CMS to approve the four proposed CCS pilot programs. Under the state's waiver proposal, CCS children may be enrolled into one of four pilot programs developed by the state and local partners to improve care coordination, patient satisfaction and effectiveness of the programs.

1. Enhanced primary care case management (PCCM)
2. Provider-based accountable care organization (ACOs)
3. Specialty health care plan
4. Existing managed care plan.

In essence, CMS has given the state an additional six months to flesh out and develop a strong base of support for these pilots.

Safety Net Care Pool (SNCP) Funding: State Programs, Providers' Uncompensated Care and the Evolution of Public Hospitals Towards Coverage Models

The new waiver provides $7.6 billion (an average of $1.5 billion annually) in federal matching funds for care to the uninsured in state, county and public hospital programs.[64] The 2005-2010 waiver allocated about $580 million annually,[65] so this is a very substantial increase in SNCP funding. SNCP funding can only be spent on care to the uninsured and cannot be spent on non-emergency care to the undocumented and new LPRs. It can be spent on state programs up to an annual cap of $400,000, the county HCCI programs up to a cap of $600,000 annually, and the county DSRIP programs up to fluctuating annual caps beginning at $1 billion and increasing to $1.4 billion.[66]

1) The state can use part of the SNCP funds to help finance state programs for the uninsured. The state's share of SNCP cannot exceed $400 million annually or $2 billion over the course of the waiver.[67] The waiver provides federal matching funds through the SNCP for state funds spent on the following state programs' care for the uninsured:

- Breast Cancer And Cervical Cancer Screening And Treatment
- Medically Indigent Adult Long Term Care
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Expanded Access to Primary Care Program (EAPC)
- AIDS Drug Assistance Program (ADAP)
- Department Of Developmental Services (DDS)

SNCP funds cannot be spent on non-emergency care to the undocumented or new legal permanent residents (LPRs). As a result, 13.95% of expenditures are treated as funds spent on non-emergency care to the undocumented and new LPRs.[68] However, the state can show a lower or no disqualified expenditure on any of the above programs other than CCS and GHPP. In addition, the state can spend its share of SNCP funds on workforce development programs through OSHPD, such as the Song Brown Workforce Training Program to develop the workforce needed to provide services under federal reform. While the federal SNCP funds for state programs are capped at $400 million annually ($2 billion over 5 years), in my view, many of the state programs will become superfluous (except for the undocumented) once the Medi-Cal expansion and Exchange refundable tax credits become operational in 2014.[69]

2) Counties with public hospitals (provider counties) can receive federal matching funds through the Delivery System Reform Incentive Pool (DSRIP) for specified activities to develop reform readiness. Over the next five years, counties can claim up to $6.5 billion for the following activities to prepare public hospitals for federal reform:

- Infrastructure development (e.g. expanding information technology, increasing primary care capacity, adoption of telemedicine or improved interpretation services)
- Innovation and redesign (e.g. expansion of medical homes, expansion of chronic disease case management and primary care redesign)
- Population focused improvement (e.g. diabetes care management, chronic disease care management, reduction in readmissions, improving healthy eating and other healthy behaviors for high risk populations)
- Urgent improvement in care (top level performance on two or three hospital-based interventions).

Initial and future funding is tied to demonstrable progress on an identifiable plan with measurable outcomes for each public hospital system receiving these funds. Public hospitals can provide the match for these funds with IGTs (Intergovernmental Transfers) rather than CPEs. In other words, the public hospitals can write a check and receive a federal matching amount to spend on these improvements without first incurring the expenses and then seeking to recover half the incurred costs (the CPE approach). In my view, these opportunities should be carefully designed, developed and implemented over the full five years of the waiver as it is unclear what the public system's infrastructure needs will be after most of the uninsured have access to coverage on January 2014.[70]

3) SNCP payments for uncompensated care can also be used to pay for care to the uninsured in hospital, clinic or other provider settings that are not otherwise reimbursed by the county Medicaid expansion funds or DSH.[71] This includes the state programs referenced above, as well as county programs, such as the HCCI program for MIAs and other uninsured adults between

133 and 200% of FPL. In my view, this spending authority will be superfluous after January 2014.[72]

- The match is through CPEs. The match can be provided by government-operated hospitals, the state, a county, a city and can include a district hospital or UC hospital.
- These SNCP funds cannot be used for non-emergency care to new legal permanent residents and the undocumented. A discount of 13.95% is assumed to be non-emergency care to new LPRs and the undocumented.

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[1] Welfare and Institutions Code §17000 requires counties to provide for care to the county's indigent residents. We estimate that counties spend on average less than $300 per uninsured – a figure we derive by dividing total reported county spending on the uninsured by the California Health Interview Survey reports on the numbers of uninsured Californians.
In 1983, the state of California terminated eligibility for the medically indigent adults (MIAs) who were not eligible for a federal match, and returned this responsibility to the counties with 70% of what the state at that time paid for their care. That funding eroded over time and with gubernatorial vetoes, and was combined with state's AB 8 county health funding into a financial package, referred to as realignment (a share of the state sales tax and vehicle license fees). There are three separate realignments to county government: health, mental health and social services, and counties can transfer funds among these accounts in a very limited fashion.
[2] Hospitals receive federal Medicaid DSH funds to pay for their uncompensated care to the uninsured and Medi-Cal patients. In the 2005 waiver, DSH funds were split between public and private hospitals; publics paid the match for their share of DSH funds with a local match, and the state paid the match for the privates. Private hospitals received $475 million for virtual DSH and public hospitals received over $1 billion annually for DSH. DSH hospitals may also receive federal Safety Net Care Pool (SNCP) funding for their care to the uninsured. SNCP was also a construct of the 2005 waiver and replaced SB 1255 funds, which were used to pay for care to the uninsured in hospital trauma centers and emergency rooms. Private hospitals received $292 million through the private supplemental program, and public hospitals received $580 million annually through SNCP. Counties also have special funding arrangements with hospitals, such as the Los Angeles County arrangements with trauma centers and with private hospitals in the closed MLK Hospital's catchment area.
[3] Some community clinics receive federal §330 funds that help pay for their care to the uninsured; clinics reported receipt of over $350 million in federal grants and contracts in 2009. In the past most clinics also received state Early Access to Primary Care (EAPC) funding for care to the uninsured; this funding has been decimated by recent state budgets. Clinics are eligible to receive SNCP funding as well for their care to the uninsured. Los Angeles with its PPP (Public-Private Partnerships) is a good example of clinics collaborating with a county system while being funded by federal waiver funds.
[4] County spending has been reported by counties under the MICRS and CMSP data sets. When the state cut/eliminated Proposition 99 funds for county health, counties stopped sending MICRS reports; thus there is no good data for county health spending in large counties after 2007. Small (CMSP) counties continue to report, but the extent of this data has in our judgment deteriorated since CMSP subcontracted with Blue Cross.
[5] All of these funding streams are reported in Yoo, 2006-2009 Overview of California's Uninsured (ITUP, November 2010) at www.itup.org. They are reported for each individual county and for the hospitals and clinics in each county at http://itup.org/regional-workgroups.html
[6] These initiatives and their progress are described in a series of ITUP reports. Espejo, Overview, Update and Summary of California's §1115 Waiver Coverage Expansion Initiatives (November 2007) at http://itup.org/reports.html#waiver and Pizzitola, California's Coverage Initiative, Year One Challenges and Successes and a Forecast for Year Two (ITUP, December 2008) at http://itup.org/public-private-workgroup.html See also, UCLA Center for Health Policy Research, Interim Evaluation of Health care Coverage in California (August 13, 2009) at http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx Orange, San Diego, Los Angeles and Ventura received funds through this competitive grant process. Ventura sought to enhance primary care and working relationships with clinics as did Los Angeles. San Diego targeted high-risk patients with diabetes following the Project Dulce model. Orange overhauled its entire system and was able to increase outpatient care, reduce emergency and inpatient care and nearly double the numbers of uninsured indigent treated in the county system.
[7] ITUP, Section by Section Guide to Health Reform (April 12, 2010) at http://itup.org/reports.html States also have an option to provide basic health plan coverage to the uninsured between 133 and 200% if FPL if they are willing to accept a 5% reduction in their federal Exchange allocation; some safety net providers favor this option. This might look like the Healthy Families program for children or a slimmed down Medicaid benefits package. ACA §1331
[8] See ITUP, Before and After Reform in California (March 2010) at http://itup.org/reports.html In this analysis, we compared 2006 county spending on the uninsured, the 2014 projections and the 2018 projections for implementation of ACA. We used the CBO analyses of ACA and the California Department of Health Care Services analyses of the impacts on ACA in California. The analyses are for each county and for statewide implementation. The statewide figures are that California counties reported spending $1.7 billion on the uninsured in 2006. The projected benefit to

California of ACA in 2014 for the Medi-Cal expansion and the Exchange subsidies is $5 billion. By 2018 as we reach full enrollment and if health costs continue to rise at 6% annually, the projected benefit to California of ACA in 2018 reaches nearly $18 billion.

[9] California's uninsured numbers are climbing due to the recession-induced loss of employment-based coverage. Lavaredda, Brown et al, Number of Uninsured Jumped from 6.5 Million to More than 8 Million from 2007 to 2009 (UCLA Center on Health Policy Research, March 2010) at www.healthpolicy.ucla.edu/pubs/publist.aspx?subTopicID=26

[10] Lavaredda, Brown et al, National Health Care Reform Will Help Four Million Uninsured Adults and Children in California (UCLA Center on Health Policy Research, March 2010) at www.healthpolicy.ucla.edu/pubs/publist.aspx?subTopicID=26

[11] Center for Medicare and Medicaid Services, California Department of Health Care Services Bridge to Reform Demonstration, 11-W-00193/9 (November 2, 2010) Sections 42-76.

[12] ITUP, Section by Section Guide to Health Reform (April 12, 2010), ACA Section 2551. The federal Medicaid DSH reductions start at a modest $500 million in 2014 and reach $5 billion annually in 2018.

[13] Bridge to Reform Demonstration, Section 42. See ITUP Waiver Appendix. We calculated that if Southern California counties participate in this aspect of the waiver to the maximum extent possible, they could receive up to the following funds annually: Imperial ($6 million), Los Angeles ($330 million), Orange ($90 million), Riverside ($61 million), San Bernardino ($63 million), San Diego ($87 million), Santa Barbara ($12 million) and Ventura ($20 million). We divided the projected federal allocation for LIHP by 2.5 years (June 2011 through December 2013). We calculated each county's potential share by dividing the annual total by that county's share of the state's uninsured. The limiting factors are: 1) enrollment of identified eligibles, and 2) a county's actual certified expenditures.

[14] The uninsured percentages by county are as follows based on the 2007 California Health Interview Survey: Los Angeles (23.5%), Orange (21.3%), Riverside (21.7%), San Bernardino (21.9%), San Diego (21.3%), Santa Barbara (21.7%) and Ventura (18.2%).

[15] For inter-county comparisons of funding and expenditures, see Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (October, 2008), Figures 1 and 3 at http://itup.org/reports.html#californiascounties. Orange, Riverside, San Bernardino, San Diego and Ventura are particularly disadvantaged due both to their rapid population growth and changing demographics.

[16] California Department of Health Care Services, California Section 1115 Comprehensive Demonstration Project Waiver, A Bridge to Reform (June 2010)

[17] CMS, California Bridge to Reform Demonstration section 36-42 and 100-105.

[18] Ibid.

[19] Ibid.

[20] Yoo, 2006-2009 Overview of California's Uninsured (ITUP, November 2010) Table 20, p. 20.

[21] There are restrictions on CPEs; for example a county cannot match the same dollar twice and federal funds cannot be used to match federal funds.

[22] The general federal Medicaid rule is that US citizens, legal permanent residents in the country for at least 5 years and permanently residing under color of law are eligible for full scope Medicaid, while undocumented workers and new LPRs are only eligible for emergency services including delivery. 42 CFR 435.406 and California Bridge to Reform Demonstration section 40. Orange, San Bernardino, San Diego and Santa Barbara are explicit that they do not cover the undocumented in their MIA programs; Imperial covers the undocumented only for emergency services. Blue Sky Consulting, County Programs for the Medically Indigent in California (October 2009). Under the ACA, the undocumented will be explicitly ineligible for coverage through the Exchange with or without the refundable tax credits.

[23] See Blue Sky Consulting, County Programs for the Medically Indigent in California (October 2009) at www.chcf.org Every Southern California County other than Los Angeles reports using 200% of FPL while LA reports using 133% of FPL.

[24] See n. 22.

[25] California Bridge to Reform Demonstration

[26] Ibid. §59

[27] Ibid § 61

[28] ACA § 2201 and 2202

[29] California Bridge to Reform Demonstration §63

[30] California Bridge to Reform Demonstration §63 (f)

[31] Counties with public hospitals often do not reimburse private hospitals for their emergency care to the county indigent maintaining they provide the bulk of the care to the uninsured in their communities. This has been a dispute of long standing between public and private hospitals. Counties may make exceptions for overflow, geography or to preserve a local trauma center or hospital emergency room. Some private hospitals receive private DSH payments that cover a part of their uncompensated bad debt and charity care to the uninsured.

[32] Providers must notify the county within 24 hours of admission and comply with the county's protocols for care post-stabilization. Counties typically devote 8-10% of their spending on care to the indigent towards emergency

services. It is unknown how much uncompensated care private hospitals provide to the county indigent; however the total cost of bad debt and care in private hospitals was $2.1 billion according to the 2009 OSHPD data. See Yoo 2006-2009 Overview of California's Uninsured, Table 19.
[33] California Bridge to Reform Demonstration §63 (f) makes no distinction between in and out-of-county care.
[34] It is unlikely that much emergency care to a county's indigent is delivered out-of-county.
[35] California Bridge to Reform Demonstration §63 (g)
[36] California Bridge to Reform Demonstration §65 (b)
[37] Ibid. §66-69.
[38] Ibid. §70.
[39] San Francisco, San Mateo, Contra Costa, Alameda and Orange are all considering or planning to use the Local Initiative or COHS as the third party administrator for the LIHP program; several already use their local MCO as TPA for their county indigent.
[40] California Bridge to Reform Demonstration §71
[41] Ibid.
[42] Ibid §72
[43] There is a concern among some county officials that in 2014, many of their patients will shift to private sector doctors and hospitals if adequate numbers are available and actually participate in Medi-Cal. The best prevention is to improve the timeliness and quality of public safety services.
[44] California Bridge to Reform Demonstration, Expenditure Authority §3 (1)
[45] California Bridge to Reform Demonstration, Terms and Conditions §72
[46] Ibid.
[47] Ibid. §72 (f)
[48] A number of California counties (mostly those with their own clinics) do not contract with and do not reimburse community clinics. The 1995 waiver for Los Angeles County and the 10 coverage expansion initiatives funded by the 2005 waiver allowed/encouraged counties to contract with community clinics and this has been very successful, wherever implemented. See California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured, Figure 7 for a chart describing the extent of clinic/county reimbursements.
[49] California Bridge to Reform Demonstration, Terms and Conditions §73
[50] Ibid. §74. The large counties no longer report their encounter data to the state so this will need to change. Furthermore, the data reports were of highly uneven quality; Ventura County, in our experience, vastly under-reported its expenses and encounters.
[51] Ibid.
[52] It is imperative that as a state, we develop reimbursement methodologies that encourage quality, cost efficiency and improved patient outcomes. Counties with public hospitals often use a version of global budgeting for their medically indigent, which has strong incentives for cost efficiency, but few incentives for quality, accountability or improved patient outcomes. Counties ought to test ACO models of payment that encourage better patient outcomes and collaboration among clinics and hospitals during the waiver.
[53] California Bridge to Reform Demonstration, Terms and Conditions §76
[54] California Department of Health Care Services, California Section 1115 Comprehensive Demonstration Project Waiver, A Bridge to Reform
[55] Ibid.
[56] Ibid.
[57] Ibid.
[58] There is often heated dispute among interest groups about the impacts of Medi-Cal managed care. One of the early positive assessments is from Freund, Deborah et al, "Interim Findings from the Medicaid Competition Demonstrations" Advances in Health Economics and Health Services Research 20 (2) 1583-81 (1989); a more recent one is from Oleske, Denise, "A Comparison of Capitated and Fee for Service Medicaid Reimbursement Methods on Pregnancy Outcomes" Health Services Research 33:1 (April 1998). A more recent study is from Bindman, Andrew et al., "Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee for Service and Managed Care" (California HealthCare Foundation, February 2005) at www.chcf.org
[59] California Bridge to Reform Demonstration, Terms and Conditions §80
[60] Ibid. §81
[61] Ibid.
[62] California Department of Health Care Services, California Section 1115 Comprehensive Demonstration Project Waiver, A Bridge to Reform
[63] Ibid.
[64] California Bridge to Reform Demonstration,
[65] Dam and Wulsin, A Summary of Health Care Financing for Low Income Californians 1998-2008 (August 2008) at http://itup.org/reports.html#lowincomecalifornians
[66] California Bridge to Reform Demonstration, §§35-41
[67] California Bridge to Reform Demonstration, §35

[68] Ibid. §40
[69] In 2014, when the ACA's Exchange and Medicaid Expansions with 100% federal funds become operational, it is likely that all overlapping state and county programs will be subsumed into those programs. It may prove important to retain consolidated residual coverage for the undocumented.
[70] In the next two and one half years of build up to full implementation, counties will need to bolster their primary care and specialty care networks so that they will be attractive to their subscribers once coverage with full freedom of choice begins in 2014. But at the same time, counties need to be cautious about investing in hospital-based care, which may not be in high demand post-2014. It may be more advantageous to contract for increased capacity as opposed to owning it, given the great uncertainties surrounding the necessary attributes of a safety net delivery system post-2014.
[71] Medicaid expansion program (MCE) funds should be billed first as there is no cap. The DSH program should be billed for hospital care to the residually uninsured – the undocumented who are otherwise ineligible. SNCP should be billed as a last resort for hospital and outpatient care to indigents with incomes 133-200% of FPL
[72] The Exchange and Medicaid expansion will pay for care to all but the undocumented. SNCP cannot be billed for non-emergency care to the undocumented, while Medicaid (Medi-Cal) can be billed for emergency and perinatal care to the undocumented.

Appendix 1

	STATE LAW	2005 WAIVER	2010 WAIVER	ACA (2014)
Eligibility	MIAs with no other source of coverage	Citizens and LPRs, county determines income eligibility standards up to 200% FPL		Citizens and LPRs, 0-133% FPL Medi-Cal, 133%-400% FPL get subsides in the Exchange
Minimum Services	Left up to counties (care in own hospitals/clinics, pay for care delivered in private settings, provide outpatient care in own clinics and pay for private hospital care, or collectively pay private providers for care to county indigent in 34 CMSP counties)	No minimum services outlined, focus on medical home, primary and preventive services	Inpatient, outpatient and emergency hospital services, physician services, lab and x-ray services, prescription drugs, medical equipment and supplies, prosthetic and orthotic appliances and devices, podiatric care, and mental health (counties may receive match for services offered beyond the minimum requirements)	**Medi-Cal:** Drug/alcohol treatment, inpatient/ outpatient, LTC, case management, mental health, administered drugs, physician/podiatry services, pharmacy, EPSDT, medical equipment. **Exchange:** Ambulatory, emergency, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitation, laboratory, preventive/wellness, chronic disease management, pediatric (incl. dental and vision)
Reimbursement	Left up to county (see minimum services).	Provider reimbursements may not exceed Medicare Upper Payment limit or cost as determined by federal cost reporting rules	Provider reimbursements may not exceed Medicare Upper Payment limit or cost as determined by federal cost reporting rules	For the first two years, physicians will receive Medicare rates for providing primary care services to Medicaid beneficiaries
ER	Emergency Medical Treatment and Active Labor Act (EMTALA) requires anyone needing emergency healthcare treatment be treated, regardless of citizenship, legal status, or ability to pay. County determines whether and what to pay and for whom	N/A	Out of network emergency care must be reimbursed by county, at least 30% of Medi-Cal rates	Out of network emergency care must be reimbursed
FQHC	Left up to county	N/A	County must contract with at least one FQHC and pay according to Med-Cal FQHC rate methodology	Clinics must be included in Medi-Cal and Exchange plans and paid at FQHC rates. Allocates $11B (nationally over 5 years) in funding for health centers to expand capacity
Managed Care	Left up to county	N/A	Counties not required to put MIAs into a managed care delivery system, counties can choose to use third party administrator, such as a LI, COHS or MCO. Closed county systems appear to be subject to Federal HMO laws.	Uninsured adults up to 133% FPL will be covered through Medi-Cal likely in managed care. Those between 133% and 400% FPL will be in the Exchange and choose between HMOs and PPOs and among four levels of benefits.
Access to Care	Left up to county	Beneficiaries must be assigned to a medical home and receive a health identification card.	Primary care provider must be within 30 miles or 60 minutes from patient's address. Appointments must be within 30 business days of request in the first year and 20 days thereafter. Urgent care appointments within 48 hours of request. Specialty care within 30 business days of request. Cost sharing must comply with Medicaid rules (nominal copays and no fees/premiums for MCEs). HCCI pop'n cost sharing not to exceed 5% of subscriber income.	Increases access to primary care and prevention by removing cost sharing from prevention visits and requiring coverage of prevention and primary care services. HMO rules on timely and geographic access to care apply.

Appendix 2

Community Clinics by County (OSHPD, 2009)					
	Uninsured Visits[1]	**Visits per 1000 Uninsured[2]**	**County Payments to Clinics**	**Uncompensated Clinics' Care to the Uninsured[3]**	**As a % of Clinic Expenses**
Imperial	42,374	927.5	$1,053,629	$903,010	5.92%
Los Angeles	1,825,542	717.4	$97,612,287	$73,786,412	14.29%
Orange	343,873	550.7	$17,008,172	$4,049,849	4.96%
Riverside	144,839	275.2	$5,244,417	$3,552,428	7.80%
San Bernardino	96,769	209.0	$3,233,074	$2,015,059	5.89%
San Diego	768,756	1240.6	$20,554,915	$13,045,429	4.96%
Santa Barbara	87160	1277.5	$460,224	$2,240,653	5.24%
Ventura	118,429	788.7	$5,878,440	$5,794,548	15.53%

Hospitals by County (OSHPD, 2009)				
	Services per 1000 Uninsured (In/Out)	**County payments to hospitals**	**Hospital Bad Debt/Charity Care[4]**	**As a % of Hospital Expenses**
Imperial	29.3/312.0	$7,336,336	$11,108,853	6.64%
Los Angeles	91.1/223.2	$933,133,388	$548,114,707	3.08%
Orange	67.1/103.5	$62,829,974	$169,289,054	3.30%
Riverside	35.6/118.5	$57,311,184	$112,027,930	5.23%
San Bernardino	31.3/132.1	$79,242,349	$179,167,562	5.51%
San Diego	60.2/73.4	$83,506,696	$260,966,292	4.95%
Santa Barbara	42.2/40.2	$4,727,200	$26,767,571	3.89%
Ventura	24.4/174.3	$43,858,454	$45,967,398	3.73%

[1] We include self pay, no pay, county pay, EAPC, CHDP, Breast Cancer and Family PACT as uninsured.
[2] We use the 2007 California Health Interview Survey for the numbers of county uninsured.
[3] We multiply visits by average cost per visit and subtract clinic revenues for the uninsured.
[4] We adjust to cost by multiplying by the cost to charge ratios.

Appendix 3

Coverage Expansion Projections by County				
	0-64 Uninsured[5]	**19-64 Unins. Adults (0-133%/134-200%)[6]**	**Unins. Paid for by County[7]**	**ACA Coverage (Medi-Cal/Exchange)[8]**
Imperial	36,000	13,000/9,000	10,616	9,943/19,021
Los Angeles	2,084,000	774,000/323,000	431,357	539,735/1,032,495
Orange	539,000	203,000/64,000	74,544	146,665/280,565
Riverside	401,000	141,000/42,000	15,726	100,376/192,016
San Bernardino	362,000	105,000/46,000	47,276	103,435/197,868
San Diego	511,000	129,000/62,000	43,813	143,133/273,808
Santa Barbara	58,000	20,000/10,000	20,614	19,483/37,271
Ventura	125,000	40,000/10,000	2,238	33,354/63,805
Southern California	4,116,000	1,425,000/566,000	646,184	1,096,125/2,096,850
California State	6,400,000	2,159,000/909,000	1,119,976	1,689,000/3,231,000

[5] We use the 2007 California Health Interview Survey for the numbers of county uninsured.
[6] We use the 2007 California Health Interview Survey for the numbers of county uninsured by poverty level.
[7] We use the most recently reported MICRS or CMSP data for the county's reported numbers of unduplicated users.
[8] We use the UCLA Center for Health Policy Research, projections as to the numbers of uninsured who qualify for subsidies through Medi-Cal and the Exchange and assume 100% participation.

Appendix 4

Imperial County (CMSP)			
	County System[9]	**2005 Waiver[10]**	**2010 Waiver[11]**
Funding	$15,157,835	N/A	$6,141,506
Use of Services	15.7/248.6	N/A	-
Enrollment (Actual/Target)	12,128	N/A	3,002
FPL (0-133%/134-200%)	N/A	N/A	2,267/736
Expenditures on Unins. % of County Health Funding	69.60%	N/A	-

Los Angeles County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$1,763,516,550	$54,000,000	$331,401,280
Use of Services	21.5/721.1	-	-
Enrollment (Actual/Target)	406,504	27,020/94,000	162,016
FPL (0-133%/134-200%)	N/A	-	122,306/39,710
Expenditures on Unins. % of County Health Funding	59.10%	-	-

Orange County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$242,495,807	$16,871,578	$90,053,488
Use of Services	72.2/198.8	-	-
Enrollment (Actual/Target)	81,421	26,253/17,000	44,025
FPL (0-133%/134-200%)	N/A	-	33,235/10,791
Expenditures on Unins. % of County Health Funding	28.20%	-	-

Riverside County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$144,687,308	N/A	$61,631,780
Use of Services	22.4/66.2	N/A	-
Enrollment (Actual/Target)	14,574	N/A	30,131
FPL (0-133%/134-200%)	N/A	N/A	22,746/7,358
Expenditures on Unins. % of County Health Funding	45.60%	N/A	-

San Bernardino County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$206,215,867	N/A	$63,510,060
Use of Services	64.7/190.6	N/A	-
Enrollment (Actual/Target)	45,465	N/A	31,049
FPL (0-133%/134-200%)	N/A	N/A	23,439/7,610
Expenditures on Unins. % of County Health Funding	60.60%	N/A	-

[9] This is the county reported number of unduplicated users and expenditures through MICRS (2007) and CMSP (2008).
[10] This is the county's allocation and projected enrollment in the 10 coverage expansion initiatives after 1.5 years; a number of the counties exceeded their federal allocations and their projected enrollment quite substantially.
[11] We divided the LIHP allocation by two and one half years as federal enrollment begins 1/1/14; we then divided by the county's share of the state's uninsured (CHIS, 2007).

San Diego County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$226,175,503	$13,040,000	$87,884,628
Use of Services	53.9/211.3	-	-
Enrollment (Actual/Target)	26,478	3,642/3,260	42,965
FPL (0-133%/134-200%)	N/A	-	32,434/10,531
Expenditures on Unins. % of County Health Funding	27.70%	-	-

Santa Barbara County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$21,590,105	N/A	$11,962,916
Use of Services	50.3/642.2	N/A	-
Enrollment (Actual/Target)	21,764	N/A	5,848
FPL (0-133%/134-200%)	N/A	N/A	4,415/1,433
Expenditures on Unins. % of County Health Funding	45.10%	N/A	-

Ventura County (MICRS)			
	County System	**2005 Waiver**	**2010 Waiver**
Funding	$67,776,366	$10,000,000	$20,479,422
Use of Services	7.3/33.1	-	-
Enrollment (Actual/Target)	3,733	11,355/12,500	10,012
FPL (0-133%/134-200%)	N/A	-	7,558/2,454
Expenditures on Unins. % of County Health Funding	4.80%	-	-