



## CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

### **Waiver Coverage Initiative CAPH-LAC Concept Proposal Response to DHS Request for Stakeholder Input November 3 2005**

#### **Summary**

The health coverage initiative at issue resides within the state's Medi-Cal Hospital/Uninsured Care Demonstration Waiver that governs payments to safety net hospitals for care to Medi-Cal and uninsured patients. The \$180 million in federal funds per year for three years that is available to fund the initiative would be drawn down by certified public expenditures (CPEs) generated by health care delivered in the public hospitals affected by the waiver. Those same hospitals are located in counties where more than 80 percent of California's uninsured reside. Therefore, the health coverage initiative should be seen within the context of the waiver as a mechanism for safety net hospital financing, recognize the role of counties that generate CPEs to draw down the federal money and used to improve care for the uninsured persons that live in those counties and seek care from the safety net.

The California Association of Public Hospitals and Health Systems and Los Angeles County Department of Health Services propose a health coverage program (HCP) for uninsured persons. The program would operate through a defined provider network comprised of public hospitals and clinics -- those county and University of California hospitals enumerated in the waiver -- as well as providers contracted by the county. The program would be administered by the counties that operate public hospitals or have a UC hospital. Those counties would oversee and play the coordinating role between the participating providers and enrolled persons.

Generally, uninsured adults under 100 percent of the federal poverty level would participate in the program. Counties would have the flexibility to target sub-populations of the uninsured and tailor services to meet the needs and improve care to the targeted group.

#### **Principles and Priorities**

CAPH and LAC recommend that the state adopt the following principles and priorities in developing the waiver coverage initiative.

- The priority population served by the initiative would be low income uninsured who are not eligible for other state programs such as Medi-Cal or Healthy Families.
- The initiative would cover services that will improve the system of care for uninsured, such as by better coordinating and increasing access to needed health care services for the targeted uninsured population.

- Counties would be the operating entities to implement the coverage initiative.
  - Counties would have flexibility within set parameters of the state's coverage initiative to tailor programs to the local needs of the uninsured and the care delivery system that serves them.
  - Counties that elect to participate in the initiative would be responsible to develop, coordinate and oversee their local initiative programs, within established guidelines set by the state and approved by CMS.
  - Counties are the logical entity for this initiative given their central role in serving the uninsured in California, and the fact that nearly all of the uninsured (more than 80% according to the 2003 California Health Interview Survey) are concentrated in counties that operate public hospitals or have University of California hospitals.
- The initiative would support and help sustain those providers (public and UC hospitals) that primarily serve the target uninsured population.
- If county certified public expenditures (CPEs) are the source of the non-federal share to draw down the \$180 million per year for three years, those federal matching funds should be directed to county health systems.
- The initiative would be structured and scaled in a way that recognizes that \$180 million per year for three years is limited funding, given the scope of the problem of the nearly 7 million uninsured in California.
  - Rather than spreading the limited funds thinly across a too wide-scale program or allowing funds to be lost to layers of administration, a focused program would be crafted that promotes access to care for the targeted uninsured population and strengthens the delivery system that serves them, and Medi-Cal patients.
  - The initiative would not require creation of a major new program structure at the state level, given that the funds are limited funds and scheduled to be available only for three years.

**Additional Perspective on Why the Federal Funding Should be Directed to Strengthen the Delivery System that Serves the Uninsured**

Structuring the coverage initiative in a way that is supportive of public and UC hospitals provides an opportunity not only to improve care to uninsured individuals specifically targeted under the initiative but also to enhance the systems and services that overall serve Medi-Cal and uninsured patients.

Additionally, because the structure of the waiver will likely create a severe financial strain on public and UC hospitals by year three when the coverage initiative begins, these hospitals will not be able to sustain their services to the uninsured without the \$180 million coverage initiative funds. That is because as costs rise, it will take more of the capped funding available under the waiver to provide the same level of services the hospitals provide today. Further, technical

changes to public and UC hospital payments that go into effect in year three will have severe negative financial impact on them.

Consequently, a coverage initiative that does not ensure adequate funding to help sustain the public health care safety net may result in assistance to a small number of uninsured while millions of other uninsured that rely on public and UC hospitals for their care would be losing access to services as those providers are forced to make cuts. The net result would be a negative impact on access to care for the state's uninsured.

### **Description of Proposed Program**

The HCP would seek to demonstrate several positive outcomes resulting from this approach.

1. Better coordinated care for uninsured Californians;
2. Reduction in inappropriate health care use by uninsured persons;
3. Improvement in services provided by public safety net providers to uninsured and Medi-Cal patients;
4. Reduced demand on the Medi-Cal program.

### *Program Elements*

**Eligibility:** Uninsured adults ages 18-64 under 100 percent of the federal poverty level and possibly uninsured parents of children enrolled in Medi-Cal or Healthy Families. To be eligible, persons must be ineligible for state programs such as Medi-Cal and Healthy Families. Counties would have the flexibility to target subset populations of the uninsured that fit within these general parameters, such as chronically ill, frequent users of the emergency room and other categories. Eligibility would not constitute any entitlement and total program enrollment would be based on available funding.

**Financing:** The program would be financed by CPEs used as the non-federal share to draw down the federal \$180 million per year for three years.

**Benefits Package:** Covered benefits would include inpatient, outpatient and prescription drug services, with an option for counties to focus on specific services to meet the needs of the targeted sub-set population. These include services to bridge gaps in care and provide greater coordination of care and case management.

**Medical Home:** All patients enrolled would be assigned to a primary care provider and provided coverage cards and a description of covered services.

**Chronic Care Management:** Counties at their option may focus the HCP on identifying enrollees with chronic conditions (e.g. diabetes, hypertension, congestive heart failure and asthma), and providing case management services such as telephone nurse advice, health education and self-care support services, and creation of patient registries to improve enrollee health status and promote the prudent use of health care services.

**Delivery System/Provider Network:** The program would be administered through a county-defined provider network comprised of public hospitals and clinics and other providers, such as community clinics, contracted by the county. The public hospitals would be those county and University of California hospitals enumerated in the waiver.

**Local Implementation:** Because the program is intended to provide access to Safety Net Care Pool funds made available through the waiver, it would be administered in those counties with public hospitals enumerated in the waiver that choose to participate. Counties that elect to participate would have the responsibility to develop, implement and oversee their own HCP. This county-level approach allows programs to be developed that most appropriately prioritize and address the needs of the uninsured in a community and maintains local control over health care decisions and delivery.



✓  
Chair  
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November 4, 2005

TO: Rene Mollow, MSN, RN  
Associate Director, Health Policy

From: Casey Kaneko

RE: Healthcare Coverage Initiative

The Department of Health Services has invited the Urban Counties Caucus to respond to a series of questions regarding the Healthcare Coverage Initiative of the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Due to the short time allowed for responses, the UCC Board of Directors has not reviewed the information, but county staff has discussed the concept of a Health Coverage Initiative similar to the model outlined here. Therefore, these comments should be considered as preliminary. The Urban Counties Caucus Board will meet on November 30, 2005 and one of the items on the Board's agenda will be a UCC proposal for the Health Coverage Initiative. The proposal under discussion is consistent with the information below.

**Who should be covered?**

Uninsured adults age 18 – 64 under 100% FPL and possibly uninsured parents of children on Medi-Cal and Healthy Families, particularly those who are chronically ill or who frequently use hospital emergency rooms. The program would not be an entitlement and would be based on available funding.

**What services should be provided?**

Inpatient, outpatient, and prescription drug services would be provided. Each enrollee would be given a coverage card that could be presented for care at a participating provider as described below. Each enrollee would be assigned to a primary care provider who would help provide case management services such as telephone nurse, health education, and self-care support services to improve enrollee health and promote the prudent and appropriate use of health care services. The goal would be better outcomes for the enrollees, improved services by public safety net providers, and reduced demand on the Medi-Cal program.

**What would constitute a "participating provider?"**

The program would be administered through a county-defined network of public hospitals, clinics, and contract providers. The public hospitals would be those county and University of California hospitals enumerated in the Medi-Cal Hospital/Uninsured Care Demonstration Waiver.

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**Board of Directors:** Chair: Supervisor Rich Gordon, San Mateo County Vice Chair: Supervisor John Tavaglione, Riverside County Treasurer: John Guthrie, Finance Director, Santa Clara County Members: Supervisor Keith Carson, Alameda County; Supervisor John Gioia, Contra Costa County; Supervisor Don Knabe, Los Angeles County; Supervisor Tom Wilson, Orange County; Supervisor Roger Dickinson, Sacramento County; Supervisor Paul Bianc, San Bernardino County; Supervisor Greg Cox, San Diego County; Supervisor Chris Daly, San Francisco County; Supervisor James Beall, Jr., Santa Clara County; Supervisor Kathy Long, Ventura County.

**Should it be implemented statewide or in limited areas (as pilot projects or optional county programs)?**

Because the program is intended to provide access to Safety Net Care Pool funds made available through the Medi-Cal Hospital/Uninsured Care Demonstration Waiver, it would be administered in those counties with public hospitals enumerated in the Waiver that chose to participate.

**What sort of matching funds would be available for this purpose?**

Counties would submit for matching with Safety Net Care Pool funds those local funds that they spend on providing care for the above-mentioned population, provided those funds are not used for Certified Public Expenditures elsewhere under the Waiver.

THE CALIFORNIA  
PARTNERSHIP



November 4, 2005

Secretary Kimberly Belshé

California Health and Human Services Agency  
1600 Ninth Street, Suite 460  
Sacramento, CA 95814

**Re: Request for Submission of Two-Page Proposal for Medi-Cal Hospital/Uninsured  
Demonstration Healthcare Coverage Initiative Concept**

Dear Secretary Belshé,

Thank you for inviting consumer advocates to submit a preliminary proposal for how funds for the Medi-Cal Hospital/Uninsured Care Demonstration should be utilized. We are a coalition of health consumer advocates that represent primarily low-income Californians, most of whom are either enrolled in a publicly-funded health program or uninsured. Thus, any expansion in coverage will affect our clients directly. We appreciate the Administration's efforts to hear from all stakeholders before the initial concept is developed.

While the length requested of the proposals and the short time frame for response limit the level of detail we could provide for our Coverage Initiative Proposal, we hope that our proposal will assist you in prioritizing which recommendations should be pursued in the weeks and month ahead. As stated in our proposal, we view this Demonstration as an opportunity to begin to build the basic infrastructure for the eventual universal coverage of all low-income Californians. It is just as importantly an opportunity to simplify the burdensome requirements and complexities of the public programs that currently cover some of these people.

In addition to our two-page proposal, we are also submitting our Health Coverage Guiding Principles. These Guiding Principles are what we use to measure any coverage expansion proposal and determine how it will affect low-income Californians. We ask that whether you can implement our proposal or not, you use these Guiding Principles to build a program that improves access to coverage in a meaningful way.

The following organizations have signed on to both the Coverage Initiative Proposal and the Guiding Principles. Please contact Angela Gilliard at Western Center on Law and

Poverty or Lucy Quacinella at California Partnership with any questions or for further clarification. We look forward to working with you in this process.

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Health Consumer Alliance  
Maternal Child Health Access  
National Immigration Law Center  
National Health Law Project  
Fresno Health Consumer Center/Central California Legal Services  
Health Consumer Center of Los Angeles/Neighborhood Legal Services  
Orange County Health Consumer Action Center/Legal Aid Society of Orange County  
Health Rights Hotline/Legal Services of Northern California  
Consumer Center for Health Education and Advocacy/Legal Aid Society of San Diego, Inc.  
Health Consumer Center of San Mateo County/Legal Aid Society of San Mateo County  
Bay Area Legal Aid

*Health Consumer Advocates' Coverage Initiative Proposal*  
*November 5, 2005*

- 1) **Overarching goal:** Contribute to building the basic infrastructure for eventual universal coverage in California by maximizing Medicaid, S-CHIP and all other available federal funding streams and equitable state funding sources to provide comprehensive quality care for all state residents with income up to 300% of poverty using consumer-friendly enrollment and retention procedures.
  - a) This blended program would be called California Health.
  - b) It would take effect no later than September 2007, the start of the Coverage Initiative.
  
- 2) **Eligibility for California Health with Simple Rules.** California Health would cover all state residents with family income up to 300% of poverty with simple eligibility rules.
  - a) Eligibility to 300% of poverty for all state residents
  - b) Simplify existing program rules in the following ways:
    - (1) A "standard income deduction" to replace current income exemptions and deductions
    - (2) Self-declaration of income with monitoring through sampling
    - (3) No assets test
    - (4) Complete elimination of "deprivation" test for adults
    - (5) No quarterly or mid-year status reporting
    - (6) Passive annual renewal
  
- 3) **Cost-sharing.** Cost-sharing would be based on ability to pay in order to protect very low and low-income people from unaffordability:
  - (1) No cost-sharing beyond Medi-Cal's current rules for people with family income at or below 200% of poverty
  - (2) Premiums and co-pays at no higher than current Healthy Families scale/levels for those with family income from 201% to 300% of poverty
  
- 4) **Enrollment.** The enrollment process must be quick, easy and consumer-friendly:
  - (1) County/state: "Accelerated enrollment" at the county and at the Single Point of Entry (seek waiver to include adults)
  - (2) Provider-based: One-step simplified e-app through CHDP Gateway for kids (AB 624 (Montañez) and adults (seek federal waiver to extend to adults) and implementation of SB 24 Newborn Hospital and Prenatal Gateways

*Health Consumer Advocates' Coverage Initiative Proposal*  
*November 5, 2005*

- 5) **Program Structure.** California Health would draw down and maximize federal matching funds to cover children, parents and other adults in a single, unified program:
- a) Medicaid and S-CHIP for children and “traditional” groups of adults
  - b) Parents: Medicaid through expanded Section 1931(b) Medi-Cal program (state option) and/or S-CHIP by implementing approved S-CHIP waiver
  - c) Other adults: Seek Medicaid waiver from categorical linkage requirements
- 6) **Financing.** The federal and state governments, private insurance corporations, large and medium-sized businesses, and consumers with income over 200% of poverty would all contribute:
- a) Federal Medicaid and S-CHIP matching funds
  - b) Coverage Initiative funds
    - i) \$540 million federal funds from Sept 2007 through Sept 2010 (3 years)
      - (1) Blend into the comprehensive coverage proposal, but can earmark for comprehensive Medi-Cal coverage and Medi-Cal targeted case management for people with chronic conditions, e.g., asthmatics, diabetics, and people with high blood pressure.
  - c) Non-federal funds to draw down federal Medicaid match
    - (1) \$1.3 to \$1.4 billion dollars a year (LAO estimate) from closing HMO tax loophole.
      - (a) HMOs to pay the gross premiums tax, like indemnity insurers do, instead of only the corporate tax based on net income apportioned to our state.
    - (2) Savings from Medi-Cal HMO fiscal reforms promoting quality and equity
    - (3) Employer payments to California Health for eligible employees and their dependents, scaled for affordability for small businesses
      - (a) No wraparound: California Health is primary coverage
      - (b) No crowd out
    - (4) Premiums/co-pays for persons with family income from 201% to 300% of poverty, at no higher than current Medi-Cal/Healthy Families scale/levels

## **Health Consumer Advocates Health Coverage Guiding Principles**

The undersigned diverse group of health consumer advocacy organizations presents this set of Health Coverage Guiding Principles to measure any proposals to expand coverage to health care in California. All health coverage proposals must be measured and evaluated under these Principles to ensure that eligibility, benefits, access, quality of care, choice of providers, and the due process rights of beneficiaries remain fully intact and are not negatively impacted, even if the consequences are unintended, and to ensure affordability of coverage and meaningful access to services that meet the needs of low-income Californians.

Our primary constituencies are low-income Californians who are eligible for publicly-funded health programs, such as Medi-Cal and Healthy Families, as well as low-income individuals who are not currently eligible for public programs. These principles should be read along with the *Working Guidelines for Evaluating Medi-Cal Reform*, which were developed by a number of advocacy organizations in response to the Administration's "Medi-Cal Redesign" proposal.

### **1. Eligibility**

- **Any proposal for health coverage must ensure that groups and individuals currently eligible for public health coverage programs maintain eligibility.**
  - Individuals currently eligible for Medi-Cal and Healthy Families should remain eligible.
  - Persons eligible for and/or enrolled in Medi-Cal should have the option, but not be required to accept other comprehensive health coverage and thereby give up primary coverage under Medi-Cal.
  
- **Any expansion must streamline and simplify eligibility rules and requirements in existing public health coverage programs.**
  - Current policies that result in a lapse or loss of coverage for those eligible for Medi-Cal or other public health programs should be eliminated.
  - Complex rules and requirements should be reduced and/or simplified so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome.
  - Eligibility, including application, reporting, and retention rules and requirements, should be no more restrictive than required by federal law.
  - Simplification should include removing barriers that unnecessarily discourage beneficiary participation or impede access to care.
  - Confidentiality of participants' information should be maintained and used only for program purposes as currently provided by law.
  
- **Any proposal to cover children and parents under publicly-funded health programs should be expanded to the maximum extent allowable under federal law in order to maximize all federal dollars available to contribute to the cost of health coverage for Californians.**

- Expansions of coverage through federal Medicaid and SCHIP funds should be pursued to provide coverage for additional low-income families and other vulnerable populations.
  - Expanding eligibility through publicly-funded health programs to additional low-income individuals or groups should not compromise existing categories of eligible individuals or the scope of benefits currently available under these programs.
- **All low-income people with income up to at least 300 percent of the Federal Poverty Level (FPL) should be included in any proposal to expand health coverage.**
    - Low-income parents and their children must be provided health coverage (as parents' health coverage impacts the well-being and self-sufficiency of the entire family).
    - All low-income residents of the state, including low-income adults without children as well as others who are not currently eligible for public programs, must be covered (as they substantially contribute to the economic stability of the state).
  - **Any proposal to expand health coverage should maximize portability of coverage and continuity of care and coverage.**
    - Health coverage should be portable so that whenever possible, coverage should not depend on employment status or other changes in life circumstances.
    - Health coverage should promote and protect continuity of care with existing providers to the maximum extent possible.
    - Health coverage should continue for as long as a beneficiary is eligible without imposing new barriers that may interrupt coverage for eligible beneficiaries.

## 2. Scope of Benefits

- **Any proposal to expand health coverage must preserve the existing amount, duration, and scope of benefits for Medi-Cal and Healthy Families beneficiaries.**
  - Benefits for Medi-Cal eligible individuals must remain available at existing levels in order to preserve meaningful access to medically necessary care and must not create differences in access based on income levels.
  - The current scope of benefits available for Healthy Families eligible individuals, including medical, mental health, dental and vision coverage must be preserved.
- **Any proposal to expand health coverage for low-income individuals and families must ensure that a comprehensive benefits package is available, including coverage for medical, mental health, dental and vision services.**
  - Health coverage must include benefits that cover the broad range of (Knox Keene Act covered) inpatient and outpatient medical and mental health services, laboratory and diagnostic services, prescription drugs, specialty care services, family planning, pregnancy-related, and prenatal services, dental services, skilled nursing and long term care services, and medical equipment and supplies.
  - Benefits should not be capped on a monthly, annual or lifetime basis in amount or duration that would unreasonably restrict, compromise the efficacy of, or prevent access to necessary and appropriate health care treatment and services.

### **3. Cost Sharing and Affordability**

- **Any proposal for health coverage must ensure that any deductions, cost sharing, co-payment, premium or similar charges imposed upon Medi-Cal beneficiaries must be nominal in amount and used only as a last resort.**
  - Medi-Cal beneficiaries should not be forced to choose between basic necessities of life and health care.
  - Cost-sharing imposes a real barrier that reduces access to health care for Medi-Cal beneficiaries.
  - Cost savings from imposing cost-sharing will not be realized due to the higher cost of acute care when preventative and on-going care is not sought by low-income beneficiaries.
  - Medi-Cal beneficiaries should not be subject to any additional or higher cost sharing than what the current law provides.
  - Medi-Cal beneficiaries should not be refused treatment or services if they cannot afford even nominal cost-sharing amounts.
  - Monitoring and enforcement against providers or health plans of cost-sharing rules and limitations must be ensured through state regulation by the appropriate agency.
  
- **Any proposal for health coverage through public programs other than Medi-Cal must ensure that total cost sharing imposed upon low-income beneficiaries does not exceed an appropriate amount based upon the individual or family's ability to pay.**
  - Cost sharing mechanisms must be designed to recognize that low-income individuals and families do not have resources to spend on their health care, nor are they financially able to pay cost sharing, even if it later may be reimbursable.
  - Cost sharing should be capped so an individual or family pays no more than a specified percentage based upon the family's income, size, and other relevant factors affecting their ability to pay.
  - Cost sharing, including premiums, imposed upon children with family incomes up to 300% FPL should not exceed amounts currently allowable under the Healthy Families program.
  - Low-income beneficiaries should not be subject to co-payments, premiums, co-insurance or deductibles they cannot afford.

### **4. Access and Choice**

- **Any proposal for health coverage must ensure that beneficiaries currently eligible for public health coverage programs continue to have access to the necessary level of care and services.**
  - Beneficiaries must be able to access medically necessary care, including preventative and specialty care services, in a timely manner.
  - Beneficiaries must have access to appropriate and qualified providers who can ensure that the linguistic and cultural needs of those beneficiaries are adequately addressed.
  - Beneficiaries with disabilities must have physical access to appropriate and qualified health care providers, services and equipment to meet their unique needs.

- Beneficiaries must have meaningful access to appropriate and qualified providers and services that are located in a geographically convenient location.
  - Health care expansion proposals must seek to diminish health care disparities, not exacerbate them.
- **Any proposal to expand coverage for low-income individuals and families must incorporate adequate, enforceable standards for access, medical necessity, care management, and linguistic and cultural needs.**
    - Individuals must have access to medically necessary care, transportation, medical interpreter services, and geographically and physically accessible services.
    - Care management should promote coordination of care and provide routine preventive and screening services.
    - Standards should be developed with a broad range of stakeholder input (e.g. LEP populations, persons with disabilities).
    - Standards should be measurable and enforceable.
    - Services must be designed to address the specific needs of special populations, including seniors, LEP populations, and persons with disabilities.
- **Any proposal to expand health coverage must provide beneficiaries with as much freedom of choice of providers or services as possible.**
    - Beneficiaries should have the choice of a variety of providers and provider networks from whom they can seek care and treatment.
    - Beneficiaries should have a choice among health plans and managed care restrictions should be minimized.
- **Any proposal to expand health coverage to low-income individuals and families should ensure an adequate provider network to meet the needs of beneficiaries in urban and rural communities.**
    - Rates must be adequate to ensure a sufficient number of providers in each area of care, including preventative and specialty care services.
    - Reimbursement rates must be adequate to ensure linguistically appropriate providers are available in all areas of care and located in geographically convenient areas.
- **Any proposal to expand health coverage must ensure providers are able to authorize treatment or make medical decisions with as much clinical autonomy as possible.**
    - Medical necessity criteria must not be overly restrictive, nor may they incorporate financial criteria which may diminish access to necessary care.
    - Limiting beneficiaries' access to care through use of prior authorization or other measures designed for cost containment should be minimized.
    - Requirements that treatment be "evidence based" in order to be covered must not restrict appropriate access to successful medical treatment options which may be considered experimental, investigational or unproven by medical evidence or research on subjects who are similar to the patient.

## **5. Quality of care**

- **Any proposal to expand health coverage should provide a mechanism to ensure that the quality of care and effectiveness of services are tracked and monitored.**
  - The health plans and providers must be required to monitor and track medical and other health outcomes by measuring and publicly reporting on key health outcome indicators and the effectiveness of care.
  - The health plans and providers must measure and publicly report on the outcomes concerning patient satisfaction and complaints or grievances filed by beneficiaries.
  - Plans and providers should be required to adhere to specific practice guidelines that ensure timely access, certain quality standards of care, and appropriate training and education regarding the needs of special populations (e.g. LEP and disability access issues), among others.
  - The health plans must ensure that services are culturally and linguistically appropriate to meet the needs of particular populations.
  - Health plans and providers must be appropriately sanctioned, up to and including removal from participation, for providing inappropriate or poor quality of care.
- **Any proposal to expand health coverage should promote the integration and coordination of health services delivery systems to more efficiently and effectively meet the needs of beneficiaries.**
  - Health plans should ensure that referral and communication systems between primary care providers and specialists are effective and designed to ensure early intervention and prevention treatment.
  - Health plans and providers should be required to ensure that networks contain an adequate supply of providers to meet the needs and demands of beneficiaries.
  - Health plans should be required to provide effective case management, including disease management services for beneficiaries with special or high health care needs.

## **6. Procedural protections**

- **Any proposal to provide health coverage must ensure that due process rights and protections available to Medi-Cal beneficiaries are preserved.**
  - Medi-Cal beneficiaries must be entitled to the same or better notice and hearing rights as currently provided under state and federal law.
  - Medi-Cal beneficiaries must be entitled to existing emergency drug supplies and aid pending appeal of disputes regarding eligibility, coverage and benefits denials or delays.
  - Beneficiaries must have access to expedited appeals procedures and meaningful review by an independent entity.
- **Any proposal to expand health coverage to additional low-income populations must include specific complaint and grievance protections to enable beneficiaries to challenge adverse actions or decisions regarding coverage and benefits.**
  - Newly eligible Medi-Cal beneficiaries must be entitled to the same notice and hearing rights as provided under existing state and federal law.

- Beneficiaries must have access to emergency coverage of drugs or other services pending an appeal of coverage.
- Beneficiaries of health plans must have access to independent medical review regarding coverage and benefits disputes.

## **7. Financing**

- **The government and employers should share the burden of financing health coverage expansion to low-income people.**
  - The government should prioritize and fund health care coverage as a matter of public policy for those California residents with incomes up to and including at least 300% FPL.
  - State and federal funds should be maximized to cover all low-income individuals and families.
  - Large- and medium-size employers must participate in funding health coverage of low-income workers, including any expansions to those not eligible for public health coverage programs.
- **Any tax or fee imposed to finance health coverage expansion must not be regressive in design so that it unfairly burdens low-income individuals and families.**
  - The burden of paying or financing the costs of health coverage expansion must be distributed according to ability to pay and no fee shall be charged that exceeds individuals' and families' ability to pay.
  - The sharing of risks of costs of health coverage must not disproportionately fall on the highest users of health care, including those with poor health status or disabilities.

November 3, 2005

Sandra Shewry, Director  
California Department of Health Services  
1501 Capitol Mall  
Sacramento, California 95814

Re: \$180 Million Annual Funding for Coverage Expansion

Dear Sandra,

Thank you for the opportunity to comment on coverage expansion opportunities under the state's 1115 waiver. Insure the Uninsured project (ITUP) would urge that the funds be allocated in response to competitive grant proposals submitted by interested local and regional coalitions. The goal should be to increase coverage and funding of the uninsured with **no** supplanting of existing state, federal, local and private funding. The funds should be targeted to local needs of the uninsured, opportunities to increase coverage of the uninsured identified by local and regional partnerships and promising pilots that have the potential to become statewide models. California should use local pilots to identify, develop and promote the most promising approaches to use in a statewide federal coverage expansion waiver when this waiver expires.

We think there are three possible models that have great promise but need local testing: 1) improving affordability of employment based coverage for low wage workers (e.g. FOCUS in San Diego), 2) constructing public private partnerships with premium contributions from government, employers and employees (e.g. local Healthy Kids programs and coverage for home care workers) and 3) re-building and expanding county coverage (e.g. Solano or Contra Costa managed care models).<sup>1</sup> Each of these approaches has weaknesses as well, such as program ramp up and uncertain initial participation levels, difficult and time-consuming coalition building and reliance on flat or faltering local revenues.

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<sup>1</sup>FOCUS was administered by Sharp Health Plan, and provided sliding premium subsidies averaging 50% for low wage uninsured small business employees. When after three years the premium subsidies were discontinued about 80% of employers continued to offer coverage. Similar successes occurred in Michigan with a one third public subsidy and two thirds from employers and employees. However, SacAdvantage offering subsidized coverage through PacAdvantage, the small employer purchasing pool, has not had comparable success.

A number of California counties have developed strong local public private partnerships to fund and deliver care to uninsured children, to uninsured older home care workers and to young uninsured working adults; the essential difference from the first model is that coverage is built through local safety net plans and the premium subsidies are far deeper.

Contra Costa and Solano each use well run local health plans 1) to organize, manage and deliver services to uninsured county indigents and 2) to expand program eligibility and participation. These may prove excellent models for other counties.

**Eligibility: target uninsured low wage workers without minor children living at home**

In our view the funds are best targeted at increasing coverage for low wage uninsured workers. Where possible, local safety net health plans should be the delivery network. Where feasible, uninsuring employers and uninsured low wage employees should have the opportunity to buy into the coverage offered. We expect that each local or regional coalition would have different targets, priorities and approaches. In some rural areas, the target could be uninsured farm-workers. In other areas, it might be uninsured child care workers, foster parents, garment workers, low wage service industries, low wage small business or low wage light manufacturing or construction.

We do not think the new coverage expansion funds should be used for uninsured Healthy Families parents as the state already has approved federal waiver funding that should be used for these purposes. We do not think that the funds should be used for covering uninsured children as the state also has federal waiver funding available for these purposes. We recommend the funds should be used for uninsured workers with no minor children living at home for whom there is otherwise no possibility of federal financial participation. We urge that the waiver coverage expansion funds be coupled with implementation of the already approved federal waiver to cover parents of Healthy Families children.

**Services: target preventive and outpatient services**

ITUP's research found county health systems are very poorly funded to care for the uninsured, and county funding streams such as realignment and Prop 99 are not keeping pace with the growth in the uninsured.<sup>2</sup> Among poorly funded county health services, hospital based and emergency services are significantly better funded; outpatient, primary care and preventive services are substantially worse funded, and adult dental services are the worst funded. There are very wide variations in funding and priorities from county to county. If a county or a region were building on its county health system, expanding coverage of a limited outpatient benefit package would be our highest recommended priority in most counties.

However if a county or region is building on a voluntary system such as either employment-based coverage or individual purchasers, the highest priority for individual purchasers appears to be catastrophic coverage. There is little evidence that employers or individuals will purchase an outpatient only benefit package. Covering only catastrophic costs provides important financial protection, but does not produce meaningful health benefits. We recommend covering those preventive and outpatient services that will improve individual and public health and reduce the demand on hospital emergency rooms combined with coverage for catastrophic hospital costs. In the interests of balancing improvements to access to care with affordability to individuals, outpatient services might have a small or no deductible and inpatient services a substantial deductible or expenditure cap.

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<sup>2</sup> Wulsin et al., Counties, Clinics, Hospitals, Health Plans and California's Uninsured (ITUP, 2004) at [www.itup.org](http://www.itup.org)

**Delivery Networks -- use local safety net health plans to construct the delivery network**

The cost, efficacy and quality of care vary widely among providers. Local safety net providers are the bulwarks of care to the uninsured. We recommend using local safety net health plans with broad flexibility to develop the most cost and quality effective networks of care possible.

The local plan(s) must creatively resolve the natural tension between local safety nets that may prefer to narrow choice to only their own networks and the uninsured, who want access to a broader selection of culturally appropriate, quality providers. To the extent that uninsured participants and uninsuring employers are expected to pay sliding fee scale premiums, choice of providers becomes a paramount consideration. Without relying on premium contributions in the plan design, the most important design feature is improved access through convenient, culturally appropriate outpatient services.

**Matching Funds -- maximize funding for the expansion**

Coverage expansion should maximize coverage by maximizing all potential funding. State, county and local funds spent on the uninsured should all be available to be used as match. Private funding cannot be used as the match, but should be encouraged in the coverage expansion design. Opportunities for funding from employers and employees should be available and encouraged. Counties and regions should be given flexibility and support to build coverage that wraps around or incorporates existing state and federal program funding such as Medi-Cal and Healthy Families. Counties and regions participating in the coverage expansion should be required as a condition of participation not to supplant existing local funds during the three-year pilot.

While we recognize the substantial state budget deficit makes it unlikely that state government will provide the match, we would encourage the state to make coverage expansion a high priority and budget state funding for the \$180 million annual match in years three to five of the waiver. If counties are to pay the match with local CPEs (certified public expenditures for the uninsured), there needs to be clarity as to what qualifies as a CPE and what does not. Some have suggested that the counties must certify at a rate of 2/1 or two dollars in local expenditures on the uninsured for each dollar in new federal match; it should be clarified with the federal government that the local matching rate for coverage expansions is 1/1.

**State Matching Opportunities**

As discussed earlier, we think the state should encourage experimentation with local pilot programs. If the counties are not interested or if the state wishes to provide the match and run a state program, we think there are several state programs that could be expanded using state General Funds as the match for the new federal funds: EAPC (Early Access to Primary Care), MRMIP for the medically uninsurable, GHPP for persons with severe medical conditions, CMSP for the low income uninsured and cancer screening and treatment programs for the low income uninsured. EAPC pays for free and community clinic services to the uninsured; it is currently configured as a last resort bad debt pool for clinics; it could be transformed into coverage for primary care services for low-income

adults, similar to the Utah model. MRMIP provides coverage for medically uninsurable individuals; the program could offer sliding fee premium subsidies for low-income medically uninsurable individuals. GHPP pays for specialty services through a limited provider network for uninsured individuals with designated medical conditions; the covered conditions and individuals could be expanded. CMSP pays for medical care to low income uninsured adults; it could be expanded with matching funds to cover uninsured adults with incomes up to 200% of FPL and transformed into a well-run managed care plan following the model of Solano Partnership discussed above.

If the state wishes to create a new state-run program as a foundation for future expansion, we think Maine's Dirigo Plan, Washington Basic Health Plan, MinnesotaCare and MassHealth are excellent models for state expansion. Some common themes are: coverage of basic health services, purchasing pool, successful interface with existing funding, and opportunities for employer and individual financial participation.

#### **Funding Frequent User Initiatives**

Several large urban counties are interested in doing a better job of managing care for chronically ill individuals who need and use a range of services from county health, mental health, social services and other county programs. Los Angeles, San Francisco, Alameda and other counties have been pioneers in these efforts, and the California HealthCare Foundation has funded several important pilots. These efforts are important models that should be more widely tested; many need one-time infrastructure investments in data systems and case management systems with immediate costs to the county and longer-term returns on the investment. They do not appear to be coverage expansions; however they could and should be funded through a similar competitive grants process under the \$180 million annually designated as managed care expansion funds. The target population for frequent user initiatives has many characteristics in common with a subset of the SSI disabled population that is proposed to be enrolled in managed care under separate provisions of the state waiver.

While the 1115 waiver funds are limited, we think this is an extraordinary opportunity for California to use local pilots to test and build consensus among the many promising coverage approaches for low income uninsured workers. We deeply appreciate the opportunity to comment on the concept paper, and thank you for your kind consideration of our comments.

Sincerely,

Lucien Wulsin Jr.  
Project Director, Insure the Uninsured Project



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*budget and policy*

*analysis*

October 27, 2005

TO: DEPARTMENT OF HEALTH SERVICES  
FROM: JEAN ROSS, EXECUTIVE DIRECTOR  
SUBJECT: HEALTHCARE COVERAGE INITIATIVE

The California Budget Project (CBP) submits this memo in response to the Department's solicitation of input regarding the healthcare coverage initiative component of the safety net hospital financing waiver. The CBP looks forward to engaging in the process of designing the coverage initiative.

The CBP's initial comments revolve around two points:

- (1) The waiver that provides the funding for the coverage initiative is primarily designed to fund safety net hospitals. These hospitals, and public hospitals in particular, face financial difficulties, and they have raised concerns that their Medi-Cal funding will not keep pace with rising costs under the waiver. The coverage initiative should serve to support the safety net hospitals and to ensure their long-term financial viability.
- (2) The funding provided under the waiver is time-limited. The state should carefully consider continuity of care issues that may arise when the funding expires at the end of the waiver.

#### Financing Mechanisms

The state should choose the source of the non-federal share of funds to support the initiative carefully in order to protect funding for safety net hospitals. Since public hospitals are a cornerstone of the state's healthcare safety net and, in particular, the state's trauma system, the financing of the healthcare coverage initiative should provide support to these hospitals. One possible financing method is to use certified public expenditures (CPEs), the primary financing mechanism of public hospitals under the waiver.

The CBP outlines a number of options for financing coverage expansions in a February 2005 publication that merit your consideration.<sup>1</sup> These options include generating and reinvesting cost containment savings (including increased pharmaceutical savings); raising additional state revenues; and seeking approval to use tobacco tax proceeds from the share of tobacco taxes allocated to the state's First 5 Commission.

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<sup>1</sup> California Budget Project, *Lasting Returns: Investing in Health Coverage for California's Children* (February 2005). The CBP would be please to provide the Department with a copy of this report upon request.

The National Governors Association proposes increasing Medicaid rebates from pharmaceutical companies, and the Senate Finance Committee recently passed a measure implementing higher rebates, lending support to the idea that more savings could be achieved in Medi-Cal pharmaceutical expenditures.<sup>2</sup>

#### Coverage Product

The design of the coverage product, including those covered, the range of services provided, and providers under the initiative, should consider the comments at the beginning of this memo. The CBP also encourages the Department to carefully target the population covered by the new program, since the funding available is far less than the amount needed to cover all uninsured Californians. Clearly, the program should only cover those individuals who are not eligible for existing health insurance programs. The Department should also design a product that can be implemented with a minimal lead time and start-up costs, since newly covered individuals may only be covered for three years, less for those enrolled later in the initiative, assuming that the coverage component of the waiver may not be extended. Preference should be given to providers that are willing to continue to treat patients absent coverage initiative funding.

The Department should consider anchoring the coverage product around public hospitals for three reasons:

- (1) Public hospitals and associated clinics provide a range of services to uninsured individuals;
- (2) Public hospitals are primary recipients of funding under the waiver; and
- (3) Public hospitals will likely treat many of the newly covered individuals after the waiver funding expires, helping to minimize continuity of care issues.

#### Scope of Implementation

Since the coverage initiative is time-limited, the CBP encourages the Department to consider pilot programs. Since many safety net hospitals are owned and operated by counties, counties should be allowed to opt into the initiative. In addition, pilot projects may reduce implementation and administrative costs, in part by limiting the geographic scope of the newly covered individuals.

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<sup>2</sup> Senate Finance Committee, *Chairman's Mark of the Deficit Reduction Omnibus Reconciliation Act of 2005* (October 25, 2005).

✓

**WORKING PARTNERSHIPS USA**  
**Health Insurance for Low Wage Adults – a Multi-purchaser Model**

A major objective of the Healthcare Coverage Initiative (HCI) should be designing strategies to provide insurance for low wage and moderate wage working adults – those with incomes less than 300% of FPL. Recent research indicates this is the category of Californians that is most likely to lose employer sponsored coverage and become uninsured during the next five years. By 2010, only 30% of adults with incomes below 300% of FPL will have insurance coverage through their employer and more than 44% will be uninsured.

At the present time, most uninsured people in this income category receive medical care from county hospitals and clinics, private institutions with county contracts, or through emergency rooms. Providing these families with health insurance would improve both the cost-efficiency of care and the medical effectiveness of care, since insurance can encourage access to and use of preventive services. However, neither the state nor local governments have the resources to provide a new public insurance alternative for these individuals and their spouses.

The public policy challenge is, therefore, to find a way to use existing resources already committed to health services to leverage other new resources to enable development of an insurance program for this target constituency. One pilot project in Santa Clara County that might meet this challenge and that would be eligible for funding by the HCI would be a county based, multi-purchaser insurance plan.

The multi-purchaser plan would provide affordable health care coverage for uninsured workers and dependents under 300% of FPL who live in Santa Clara County. The plan would offer comprehensive benefits including preventative care, prescription drugs and hospitalization to up to 140,000 non-elderly uninsured adults currently eligible for the program. Financing for this health insurance model requires contributions from workers and employers and a third party, possibly a subsidy from the Santa Clara County Health and Hospital System.

Santa Clara County's Health and Hospital System already operates an HMO for county employees. Under the pilot project, the county could serve as the participating provider and designate some portion of the funds that it currently makes available for direct services to the uninsured as subsidies for HMO membership. The county subsidy could leverage three other sources of funds:

- a) Federal funds under the HCI for which the subsidy is the local match;
- b) Individual worker premiums (the plan assumes there is some premium that is affordable to even low wage workers)
- c) Employer premiums (the plan assumes there is some premium low enough to allow the plan to be successfully marketed to even small businesses).

The pilot achieves savings through the more efficient delivery of care to an

insured population. It secures new revenues by attracting employee and employer premiums for constituencies that previously appeared to the system as unsponsored and uninsured. During the three year pilot, the plan could test premium levels, marketing strategies, crowd out strategies, programs to encourage preventive care and healthy living as well, the feasibility of additional funding sources, and the long term economic viability of the approach. At the end of the three-year period, the project could either demonstrate the ability to continue without the federal subsidy (the new revenue from employers and employees for previously unsponsored patients offsets the costs of plan operation) or demonstrate its viability with a small external subsidy. In the latter case, state and local governments would have to determine which revenue streams might be available and whether the increase in the health and well-being of the target constituency justified the increased expenditure.

Since counties vary widely in the types of health services they make available, this kind of project should be made available as a local option not as a statewide program administered at the local level.

#### Contact information

Working Partnerships USA  
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Ingrid Lamirault  
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Health Plan of San Joaquin  
John R. Hackworth, PhD  
Chief Executive Officer

Inland Empire Health Plan  
Richard Bruno  
Chief Executive Officer

Kern Family Health Care  
Carol Sorrell  
Chief Executive Officer

L.A. Care Health Plan  
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Chief Executive Officer

San Francisco Health Plan  
Jean S. Fraser  
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Santa Clara Family Health Plan  
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Analysis

Mary Adams  
Association Coordinator

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James C. Gross  
Nielsen, Merksamer, Parrinello,  
Mueller & Naylor, LLP

November 3, 2005

Mr. Stan Rosenstein  
Deputy Director, Medical Care Services  
Department of Health Services  
PO Box 997413, MS 4000  
Sacramento, CA 95899-7413

RE: Hospital Financing Waiver – Healthcare Coverage Initiative

Dear Mr. Rosenstein:

On behalf of Local Health Plans of California (LHPC), I am pleased to provide input on the Healthcare Coverage Initiative component of the Hospital Financing 1115 Waiver. LHPC represents the eight local initiative not-for-profit managed care health plans in nine Two-Plan Model counties that serve over 1.4 million Medi-Cal, Healthy Families, and Healthy Kids beneficiaries.

The local initiative health plans were created to facilitate quality, cost effective health care to Medi-Cal beneficiaries while protecting the vital safety net system. It is with this mission in mind that LHPC writes to you today as DHS prepares for a large public stakeholder process on this important coverage initiative for the uninsured.

It is vital that DHS keep at the forefront in its deliberation that the initiative is a component of the Hospital Financing 1115 Waiver. As a result, initiative funding is intended to expand coverage to the uninsured using the hospital safety net system. One of the guiding principles of the initiative is that coverage should rely on the existing relationships between the uninsured and the safety-net health care systems, including public hospitals, and community clinics.

We recommend that the Healthcare Coverage Initiative support the safety net providers, utilize the benefits of managed care, and promote local control and development of best practices. To that end, we urge that the initiative allow each county to design a program to enroll uninsured people into a managed care network of safety net providers and ensure them access to a set of defined benefits. Such a program would bring the benefits of managed care – increases in preventive care and decreases in unnecessary hospitalization and emergency department usage – while utilizing the expertise and building upon the relationships between safety net providers and their patients.

On behalf of Local Health Plans of California, I appreciate the opportunity to communicate our viewpoint on this very important issue. We look forward to working with the department and others through the public stakeholder process.

Sincerely,

Cherie L. Fields  
Chief Executive Officer

cc: Sandra Shewry, Director, Department of Health Services  
Vanessa Baird, Chief, Medi-Cal Managed Care, Department of Health Services  
Renee Mollow, Associate Director, Health Policy, Department of Health Services  
Local Health Plans of California Governing Board

1225 Eighth Street, Suite 440 ★ Sacramento, CA 95814  
Phone: (916) 448-8292 ★ Fax: (916) 448-8293 ★ Email: lhpc.org



## INLAND EMPIRE HEALTH PLAN

November 4, 2005

Via Email

Medi-Cal Redesign  
California Department of Health Services  
1501 Capitol Avenue, MS #4400  
Sacramento, CA 95899  
(916) 449-5100  
[MCRedesign@dhs.ca.gov](mailto:MCRedesign@dhs.ca.gov)

**Re: Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative**

To Whom This May Concern:

Inland Empire Health Plan ("IEHP") is a Local Initiative of the Two-Plan Model in Riverside and San Bernardino counties. Thank you for giving us an opportunity to provide feedback regarding the Medi-Cal Hospital/Uninsured Healthcare Coverage Initiative project. Following are IEHP's comments on the requested questions:

**1. Who should be covered?**

We propose two (2) options to expand the healthcare coverage:

- a. Parental Expansion – the Initiative can expand the coverage to parents of children who enrolled in Medi-Cal or Healthy Families Program. Few years ago the Managed Risk Medical Insurance Board (MRMIB) proposed this expansion project; however, due to the budget limitation, the project has been on hold.
- b. Children Expansion – the Initiative can expand the coverage to children up to 24 years of age. Currently, children ages 0-18 can obtain the affordable health coverage through Medi-Cal or Healthy Families if they meet the income requirements. The program will fill the coverage gap for children ages 19-24. Many research have shown that most of these children are uninsured; hence, they usually forgo the less-expensive preventive care and seek more-expensive care at the Emergency Room. A Public Health report reveals that for every \$1 spent on early intervention, society saves \$7 or \$30,000 to \$100,000 per child.

**2. What services should be provided?**

- a. Parental Expansion – the coverage can be mirror the Healthy Families Program.
- b. Children Expansion – the coverage can be mirror the Healthy Families Program.

303 E. Vanderbilt Way, San Bernardino, CA 92408  
Tel (909) 890-2000 Fax (909) 890-2003 TTY (909) 890-0731  
Visit our web site at: [www.iehp.org](http://www.iehp.org)

A Public Entity

**3. What would constitute a "participating provider"?**

Health plans that currently participate in Medi-Cal or Healthy Families Program can participate in this expansion project.

**4. Should it be implemented statewide or in limited areas (as pilot projects or optional county programs)?**

The Initiative should be implemented statewide.

**5. What sources of matching funds are available for this purpose?**

Matching funds may include the un-expensed SCHIP funds and State's General funds for Medi-Cal.

Above is our recommendation for the Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative. We also would like to be included in the Department's project update contact list and in the project Workgroup at your approval.

If you have any questions, please contact me at (909) 890-2176, email at [pham-t@iehp.org](mailto:pham-t@iehp.org).

Sincerely,

Thomas Pham  
IEHP Product Manager

Cc: Greg Kono, Sr. Compliance Manager  
Inland Empire Health Plan

November 4, 2005

Sandra Shewry, Director  
California Department of Health Services  
1501 Capitol Mall  
Sacramento, California 95814

Re: \$180 Million Annual Funding for Coverage Expansion

Dear Ms. Shewry,

Thank you for the opportunity to comment on coverage expansion opportunities under the 1115 waiver.

I urge that the funds be allocated to meet the varying needs of different counties within state guidelines. The focus should be on uninsured low-income adults who are legal residents of the county but do not qualify for Medi-Cal. Innovative models that have the potential for expansion statewide should be encouraged. Such models might include expanded coverage of preventive services, management of chronic diseases, intensive case management of high cost users, assignment of patients to medical homes, etc.

The county, or a combination of counties if they wish, should be assigned the lead role in creating the local plan. If the county declines to accept such a role, then proposals from others in the community - such county organized health systems, local initiatives or similar - should be considered for this role.

In summary, I am advocating local flexibility within state guidelines, with an emphasis on innovation in coverage and program design, under county leadership.

Very truly yours,

*Robert C. Gates*

Robert C. Gates  
MSI Project Director  
Orange County Health Care Agency  
405 W. 5<sup>th</sup> Street, 7<sup>th</sup> Floor  
Santa Ana, CA 92701  
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# County of Santa Cruz

## HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVE., SANTA CRUZ, CA 95061-0962  
TELEPHONE: (831) 454-4000 FAX: (831) 454-4770 TDD: (831) 454-4123

### HEALTH SERVICES AGENCY ADMINISTRATION

November 4, 2005

#### **Input On Healthcare Coverage Initiative for Uninsured Adults County Indigent Care in the non-CMSP, non-County Hospital Counties**

Santa Cruz County appreciates the opportunity to provide input regarding options for creating a Coverage Initiative utilizing federal funds from Hospital Contracting Waiver. As DHS considers the many possibilities for expenditure of these funds, we request consideration for those counties that act as insuring entities and purchase indigent care services via contracts with the private sector. These counties include Santa Cruz, Placer, Yolo, Stanislaus, Merced, Santa Barbara, Tulare and San Luis Obispo. These counties did not receive the growth in realignment revenues that the CMSP counties did, nor have they benefited from the DSH/Selective Contracting process that supports public hospital counties. Santa Cruz County requests that the new coverage waiver allow us to secure federal matching funds for our local expenditures on indigent health care.

In the early 1980s, the State Legislature shifted responsibility for the Medically Indigent Adults (MIAs) from Medi-Cal to the Counties and promised them 70% of what the state would have spent on that population. This arrangement was supported by Counties that operated their own hospitals; they believed they could increase patient volume in the county hospitals and care for the MIAs at less cost than the state. Over time, the Medi-Cal program assisted County hospitals by providing federal matching funds via the DSH and Selective Contracting programs.

At the time of the MIA transfer, Santa Cruz supported the creation of the County Medical Services Program (CMSP) as a way of protecting small counties. Santa Cruz had closed its small, inefficient county hospital in 1973 and purchased care for county indigents from local community hospitals. We were not able to benefit from DSH and/or MediCal selective contracting arrangements even though County funds were taken by the State to provide match to those programs.

Santa Cruz's indigent care program, known as MediCruz, demonstrated how a public/ private system of care could be designed and managed to provide comprehensive services economically. County eligibility staff visited local hospitals daily to enroll uninsured patients in MediCal and MediCruz. County-employed physicians provided primary care and case management in county-operated clinics that also offered pharmacy, lab and x-ray services. MediCruz staff approved specialty care visits and access to non-emergency hospital services, including tertiary care in Bay Area hospitals. Program eligibility tracked with Medi-Cal and permitted the working poor to become eligible after incurring a "share of cost" or spending down their assets on health care.

By choosing to operate its own indigent care program however, Santa Cruz County and its MIA residents were financially disadvantaged. The formula for distribution of revenue growth in the realignment accounts allowed CMSP (which was operated by the State) to have first claim on any new dollars. CMSP and other program budgets were made whole before realignment growth flowed to the Counties. In 1984-85, Santa Cruz received \$4,159,950 in state funds to

care for the MIAs. In 2003-04, almost 20 years later, Santa Cruz received \$4,146,549 or \$13,000 per year less! Clearly the promise of 70% State financing for the medically indigent adults was not kept.

With flat state support, an increasing population and exploding medical care costs, the MediCruz program has suffered reduction after reduction in benefits, eligibility and services. The once successful program is now a shadow of itself. Our private sector partners are very disappointed with MediCruz rates; access to specialty care is restricted; eligibility standards have been cut repeatedly and co-pays imposed; even the number of primary care appointments per month is limited.

Over the years Santa Cruz has investigated rejoining CMSP in order to take advantage of the formula that keeps that program solvent. However, in order to join we would need to pay the equivalent of our county's share of realignment revenue growth that we weren't eligible to receive. This would require tripling the County's general fund spending on indigent care services. Thus we can't afford to operate our own MediCruz program, we can't afford to join CMSP and we don't get any financial support for indigent care via the DSH or selective contracting program.

**Who should be covered? Who provides services? What are the benefits?**

In summary we are proposing that counties operating their own indigent care programs be allowed to match local expenditures with federal funds via the new Coverage Expansion Initiative. Ideally Counties would continue to set their own indigent care program standards and would receive federal match for their certified public expenditures for indigent medical care. This would permit a locally managed system of care with attention to the most economical way to provide services. Just as the COHS Plans have succeeded in containing costs while providing excellent services to MediCal beneficiaries, locally managed indigent care programs can do a good job of serving the indigent uninsured client.

Creation of a statewide "entitlement" program with standard eligibility, benefits etc. could become a federal requirement for use of these new funds. This could pose many problems. Could all parties agree on the parameters of a statewide program? Would there be any mechanisms to contain costs or would participating counties be exposed to open-ended requirements to finance 50% of all care provided? Would the new program become a MediCal clone with elaborate eligibility rules, TARs, provider enrollment processes and court challenges? Ideally we would create a fair but flexible system and not recreate the complications of replicating the MediCal program.

I hope that that DHS will be able to support this proposal and will give Santa Cruz County and other non-CMSP, non-County Hospital Counties the opportunity to work with you to help us access additional funding for indigent care.

Sincerely,

Rama Khalsa, Ph.D.  
Health Services Agency Director  
County of Santa Cruz

## POSITION PAPER Healthcare Coverage Initiative

The California Primary Care Association (CPCA) represents more than 600 not-for-profit community clinics and health centers in California who provide comprehensive, quality health care services to primarily low-income, uninsured and underserved Californians. Community Clinics and Health Centers (CCHCs) are mission driven to minimize the impact of barriers to health and health care access including poverty, lack of health insurance, immigration status, ethnicity, language and culture, disability, homelessness, geographic isolation and other diverse needs.

### **Position Statement**

The California Primary Care Association (CPCA) and its individual members actively pursue the goal of universal access to health and health care for all -- regardless of ability to pay, immigration status, language, employment status, disability or illness, geographic location, community of interest or other special needs. Although universal access is the goal, incremental steps can advance the longer-term agenda. The Healthcare Coverage Initiative presents an opportunity for a meaningful incremental step toward universal coverage.

CPCA offers the following recommendations for the development of the Initiative.

### ***Support Cost-effective, Primary and Preventive Health Care Services***

The Healthcare Coverage Initiative must include access to affordable primary and preventive care services. Ensuring adequate primary and preventive care is cost-effective. Failure to provide for affordable access to primary and preventive care has been shown to result in preventable illness and expensive service use, such as higher use of inpatient services and emergency rooms. In this context, CCHCs represent a cost-effective, culturally and linguistically appropriate delivery model that should be embraced and replicated to keep overall health care costs down. Health coverage must include the full range of comprehensive primary and preventive health care services. Cost-sharing requirements, such as copayments and annual deductibles, must not serve as barriers to timely primary and preventive care for low- and moderate-income persons.

### ***Ensure Adequate, Actuarially Sound Provider Reimbursements***

The Healthcare Coverage Initiative should be carefully implemented and aggressively monitored to ensure that reimbursements, particularly for nonprofit providers also serving the uninsured, are sufficient to support continuing access to care for the remaining uninsured. Reimbursement rates should encompass the costs of providing the range of comprehensive services that are needed by underserved populations, such as language services and outreach. Inadequate provider reimbursements have serious negative consequences on access to care, especially in programs serving low-income individuals.

### ***Protect Federal Reimbursement Requirements for FQHCs and RHCs***

Under federal law, persons enrolled in Medi-Cal and Medicare are entitled to receive services from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). FQHCs and RHCs must continue to receive their federally mandated reimbursement for all persons enrolled in Medi-

Cal and Medicare, including those Medi-Cal recipients who receive their coverage through private health plans and Medicare recipients with employer-sponsored insurance.

***Ensure Culturally and Linguistically Responsive Programs and Delivery Systems***

California's population is culturally diverse and complex and the health system must continually adapt and respond to the needs of diverse communities. Integration of this principle requires much more than mandatory translation of materials. The Healthcare Coverage Initiative implementation should include strategies to support and replicate successful models of culturally competent care, such as the CCHC model.

***Implement Effective Quality Monitoring and Quality Measurement***

Access to health care must fundamentally include strategies to improve health status indicators. Regular monitoring and quality measurement should identify whether barriers to care persist or are exacerbated. In addition, the State should regularly assess consumer satisfaction and monitor quality. In order to ensure access to quality health care, CCHCs have aggressively worked to reduce health disparities and focus on improved health outcomes for the patients and communities they serve. The CCHC model delivery system also strives to reduce and eliminate the underlying cause of poor health in underserved communities through health promotion and education, chronic disease management, case management and prevention programs. The Healthcare Coverage Initiative implementation should promote and reward these approaches to care and quality improvement.

***Involve Communities and Community Providers in the Implementation Process***

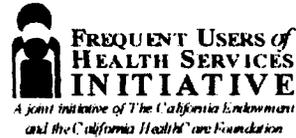
Implementation of the Healthcare Coverage Initiative must necessarily involve those communities, providers and agencies, including community clinics and health centers, which know and serve the populations targeted for access expansion. Agencies implementing the Healthcare Coverage Initiative must involve CCHCs and their representatives in the planning and implementation process.

***Protect and Involve Health Care Consumers***

Patient rights must be protected and assured within the health care system. Consumers must have good information and education, and the supportive assistance required to help them make informed health care decisions and manage their own health care and wellness. Health care must be truly affordable for patients, especially for the working poor. CCHCs have from their inception directly involved their patients and communities as Board members and decision makers in determining how services are organized and delivered. The Healthcare Coverage Initiative implementation should involve patients and their representatives in the process.

***Protect Consumer Choice of Their Primary Care Provider by Preserving and Sustaining CCHCs, if a managed care model is used.***

Consumers recognize that CCHCs provide cost-effective, quality, culturally and linguistically appropriate care and should be able to make the choice to continue receiving their care through the CCHC system. **CCHCs should be guaranteed participation as contracting providers with all private health plans, providing CCHCs meet reasonable provider participation and quality requirements.** However, current health plan contracting requirements often serve as barriers to CCHC participation, including: failure to recognize the CCHC service delivery model where providers are employees of the CCHC, requiring CCHCs to establish or participate in Independent Provider Associations or organized medical groups, enforcing minimum patient assignments to individual providers rather than at the clinic level and limiting the number and type of providers in a plan's network.



**Health Care Coverage Concepts  
Supporting the Frequent Users of Health Services  
Response to DHS Request for Stakeholder Input, November 3, 2005**

As policymakers and stakeholders weigh the options for a new health coverage initiative, the Corporation for Supportive Housing and the Frequent Users of Health Services Initiative (Initiative) recommend special attention to a small but important group that we call "frequent users" of health services. Frequent users are adults who repeatedly and ineffectively seek care for medical and psychosocial problems in hospital emergency departments (EDs). Health insurance coverage for low-income frequent users is necessary but not sufficient; providing a payer to support the wasteful, ineffective use of high cost services is not enough. We recommend that some of the new federal funds be used to provide services that will redirect the frequent user into more appropriate community based services. Not only will this produce better health outcomes for frequent users, who are some of the neediest and most vulnerable uninsured patients, but it will also address important statewide health issues, including the overcrowding of emergency departments and the high cost of health care delivered in safety net hospitals.

**Background:** The Corporation for Supportive Housing (CSH) is a nationally recognized leader in supporting innovative solutions to the housing and health needs of homeless people with disabilities, particularly those who are disabled by mental illness, substance abuse and other chronic health conditions. CSH is the program office for the Initiative, which is jointly sponsored by the California HealthCare Foundation and The California Endowment. The Initiative seeks to address the challenge of EDs that are inundated with patients, a small proportion of whom have complex, unmet needs that are not effectively or efficiently dealt with in high-cost, acute care settings.

**Who are the Frequent Users?** Supported by grants from the Initiative, six California communities (Alameda, Los Angeles, Sacramento, Santa Clara, Santa Cruz and Tulare counties) developed data on the number and characteristics of their frequent users. Each community identified a core group of individuals who repeatedly used hospital emergency departments (in some cases weekly), often for medical crises that could have been avoided with appropriate, ongoing care. Sometimes the presenting issue is not a medical crisis, but is related to a chronic health condition, mental illness or a psychosocial issue, such as drug or alcohol use. Many are hospitalized but often fail to receive follow-up care and the social supports that could lead to genuine recovery. The health care system spends hundreds of millions of dollars on these individuals and yet they are not being treated appropriately. They receive expensive emergency and inpatient services while other critical needs go unmet. Everyone is frustrated, but no one has the responsibility or the authority to access and coordinate the resources needed to change this situation.

**Can the Frequent User be helped?** Yes! Programs that use flexible funding to provide intensive individualized support, with linkages to primary care, mental health services, alcohol and drug treatment, and housing are demonstrating effectiveness in reducing unnecessary hospital emergency and inpatient utilization. Frequent user patients enrolled in such programs have the opportunity to gain stable housing and a medical home, and help securing insurance coverage and a regular income. Preliminary evaluations show these programs are cost effective; a small investment in services saves many times that amount in hospital and other costs. For example, our Santa Clara County grantee worked with 80 frequent users who had a

total of nearly 1,000 ED visits in the year prior to receiving services. During their first year, ED visits dropped by 32 percent, and for those who received services for two years, ED visits declined by 73 percent. Our Santa Cruz County grantee showed similar reductions in ED visits, as well as reductions in hospital days, ambulance use, arrests, and days of incarceration.

Our grantees are demonstrating what many other innovative programs around the country have shown: effective programs for the frequent user are not traditional interventions. They actively reach out to and engage the frequent user; provide care that is continuous rather than episodic, and deliver care in the most appropriate settings, in close coordination with community-based organizations and providers. Effective programs address the underlying psychosocial and health problems that fuel frequent, ineffective, and inappropriate use of acute services, and work to help the frequent user recover his or her health.

**Funding effective programs:** The six Initiative programs were started with three years of foundation funding, which in turn leverages local resources. Efforts to develop new programs or to expand existing programs are stymied by the lack of Medi-Cal reimbursement for care provided to indigent and uninsured adults. While savings in reduced utilization of health care can be documented, it is extraordinarily difficult to re-direct public and private spending to support more effective community-based services. Unless other sources of funding can be found, even our very successful programs may not continue after the end of the grant period and expansion or replication of effective models will be stalled.

**How can the Coverage Initiative help?** We recommend that the State use a small portion of the new federal funds to create a program focused on low-income, adult, frequent users of hospital services. The frequent users program could be similar to the Medi-Cal chronic disease management program currently under development. Instead of managing patients with diabetes or heart failure, the program would support and redirect frequent user patients away from acute services that are not meeting their needs into a continuum of community programs and services. The new program would need to establish criteria for frequent users, such as five or more ED visits in year, and could include other risk factors, such as mental illness, homelessness and drug and alcohol use. At the state level, the new program could be managed and overseen by one or more contractors with in-depth knowledge of the frequent user population and the programs that help them, such as the those currently operating with Initiative funding and other independent efforts. Alternatively, DHS could develop staff capacity to manage and support the local programs. The contractor (or DHS) would establish program criteria, provide technical assistance, collect and analyze data and assure program quality and productivity. Local programs would be operated by a County or by a partnership of health care providers that includes a County and would be approved for a specific number of slots at an agreed upon cost. The local programs should be able to provide some or all of the certified public expenditures necessary to draw down the federal funds.

Ideally frequent user patients will receive health coverage from Medi-Cal and/or the new federal waiver program. However, traditional coverage alone does not meet their needs; merely enabling continued dysfunctional use of acute hospital services is in no one's interest. California needs to invest in a program that stabilizes and supports frequent users in the community and focuses on improving their health by truly meeting their needs. Such a program will assure that funds spent on coverage are used effectively and that the health care system itself becomes better coordinated and more rational.

For more information, please contact Melissa Welch, MD, MPH, Initiative Project Director, at 415/203-3936 or [podsdm@sbcglobal.net](mailto:podsdm@sbcglobal.net), or Carol Wilkins, CSH Director of Intergovernmental Policy, at 510/251-1910, ext 207 or [carol.wilkins@csd.org](mailto:carol.wilkins@csd.org). You may also check our website: [www.frequenthealthusers.org](http://www.frequenthealthusers.org)

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**San Diegans for Healthcare Coverage  
Hospital Safety Net Waiver Coverage Initiative  
Comments – November 4, 2005**

These comments are being submitted on behalf of San Diegans for Healthcare Coverage (SDHCC), a non-profit corporation led by a Board of Directors (Attachment 1) representing business, labor, health plans, health providers, government, consumers and others. SDHCC was established in 2001 by the San Diego Improving Access to Healthcare Coverage (IAH) Project, a project established by the County Board of Supervisors in 1999 to develop and implement short and long-term strategies to expand access to healthcare through both private and public healthcare coverage. IAH created San Diegans for Healthcare Coverage (SDHCC) to continue focused efforts to pursue coverage expansion.

SDHCC has reached consensus on a coverage expansion program through a series of Business and Labor Roundtable sessions in 2004 and 2005. The goal of these roundtables has been to identify consensus points and trade-offs related to key elements for expanding coverage including general principles, target populations, essential basic benefits, co-payment and deductible levels by income group, premium shares and general plan design. These principles are addressed in the response to the specific State questions, as well as general principles that follow.

**SDHCC Response to State Questions:**

*Who should be covered?*

Target the working uninsured and their families. Working families are the largest segment of the uninsured population (75%) and that population is growing each year; more and more businesses cannot afford to offer and/or pay for employee coverage. In addition, there is evidence that integration of private and public funding sources represents a less costly, more stable method of expanding coverage. Therefore, programs to maintain and expand employer-sponsored coverage for low to modest wage families should be a high priority.

The primary target should be the adults with and without eligible children; children should be included in family coverage whenever possible to ensure stability (see State funding offset notes below).

*What services should be provided?*

An essential, basic benefits package should be included. The benefits package should encourage access to early intervention and improved health outcomes, including disease management education and management programs (for specific populations). Deductibles and co-payments should be based upon family income. Healthy behavior incentives (or disincentives) should be incorporated into the benefit package.

Individuals enrolled in a new coverage program who become *episodically* eligible for a State program (e.g., pregnant women) should remain enrolled in the new coverage program (subject to continued eligibility) to ensure continuity of coverage and care and administrative simplicity and reduced costs; any benefits not covered by the new program could be provided through a wrap-around if necessary.

*What would constitute a "participating provider"?*

No new rules should be established for participating providers, including new administrative structures for provider certification. There are ample State regulations for provider certification through State agencies.

*Should it be implemented statewide or in limited areas (as pilot projects or optional county programs)?*

The Hospital Safety Net waiver provides an opportunity to demonstrate more cost effective and innovative methods for maintaining, as well as expanding, health care coverage to the growing uninsured population. Therefore, to be meaningful, the Coverage Initiative should be limited to a few pilot projects designed to demonstrate innovative and potentially replicable methods of expanding healthcare coverage, including county programs that meet this criteria.

*What sources of matching funds are available for this purpose?*

There are several potential sources of funding, including those associated with existing programs.

- ♦ As a State waiver for a State program, the State should have some “stake” in the program; the Coverage Initiative should be viewed as an investment in identifying new, innovative and less-costly methods of maintaining and expanding healthcare coverage.
- ♦ Indigent care funds from counties that have innovative new coverage initiatives will very likely be a primary source of matching funds. This can be accomplished by expanding County coverage if coupled with innovative coverage expansion programs and using existing and additional County funds as match; maintenance of effort (financial), innovation and leveraging other funding sources should be key criteria.
- ♦ There are significant offsets to State coverage programs (e.g., Medi-Cal, Healthy Families, AIM) that would occur over time for individuals enrolled in a new coverage program. For example, many uninsured individuals that might be enrolled in a new coverage program would have been episodically enrolled in Medi-Cal (e.g., upon verification of pregnancy, renal disease, temporary disability or other medical condition linking them to Medi-Cal). These are savings to the State and Federal government that would result by enrolling in a new coverage program and should be considered as offsets to coverage expansion.

### **San Diegans for Healthcare Coverage (SDHCC) Waiver Principles**

In no particular priority order, SDHCC urges the State to incorporate the following principles in developing a coverage initiative.

- Establish State Pilot(s) that Demonstrate Innovative, Potentially Replicable Coverage Programs
  - ♦ Limit number of pilots based upon potential to demonstrate innovative, replicable State expansion
  - ♦ Pilots should represent broad-based constituency support and participation
  - ♦ Establish meaningful demonstration criteria rather than statewide equitable allocations.
  - ♦ Simplify eligibility and administration; establish a meaningful evaluation component
- Target Working Uninsured Families
  - ♦ Include business community in pilot programs
  - ♦ Pilot programs that address integration of private and public funding sources
  - ♦ Leverage employer, employee and other sources of funding for coverage
  - ♦ Demonstrate a less-costly method of providing and expanding coverage (including to those eligible for publicly funding coverage)
- Establish Meaningful Health Coverage
  - ♦ Establish a meaningful, essential basic benefits package
  - ♦ Establish deductible and co-payment levels based upon family income to ensure access
  - ♦ Establish realistic premiums that ensure access to care (provider payments)
  - ♦ Encourage healthy behaviors and compliance through incentives and access
  - ♦ Coverage should provide timely access to appropriate, culturally competent health care
- Establish Crowd-Out Rules and Accounting
  - ♦ Establish crowd-out rules for employer coverage (eligibility and funding)
  - ♦ Establish maintenance of effort rules for counties and other public entities
  - ♦ Establish accounting for existing public program offsets (e.g., pregnancy related Medi-Cal)
- Leverage Other Funding Sources
  - ♦ Eliminate public and private funding silos that result in lower income working families falling through the coverage gap.
  - ♦ Make coverage through the workplace more affordable to business and therefore, coverage less costly to public.

**Attachment 1**

**SDHCC Board of Directors**

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**Robert Hertzka, MD**, President, San Diegans for Healthcare Coverage  
Immediate Past President of the California Medical Association  
Member, San Diego County Medical Society

**Greg Knoll, Esq.**, Vice President, San Diegans for Health Care Coverage  
Executive Director, Legal Aid Society of San Diego

**Olivia Puentes-Reynolds**, Past President  
Latino Health Council

**Sylvia Hampton**, Director  
Health Care for All/CA, San Diego Chapter  
League of Women Voters

**John Nerseirian**, Vice President  
North Island Credit Union  
Board Member, San Diego Regional Chamber of Commerce

**Victoria Penland**, CEO  
Council of Community Clinics

**Steven A. Escoboza**, President/CEO  
Hospital Association of San Diego-Imperial Counties

**Jean Shepard**, Director  
County of San Diego  
Health & Human Services Agency

**Jean Shepard**, Director  
County of San Diego  
Health & Human Services Agency

**Vicki Mizel**, Assistant Deputy Director,  
Health Policy and Regional Program Support  
County of San Diego  
Health & Human Services Agency

**Richard Ledford**, CEO  
Ledford Enterprises  
Chair, San Diego Business Healthcare Connection  
Chair, American Red Cross  
Board member, San Diego Regional Chamber of Commerce

**Mary Lewis**, COO  
Alliance Healthcare Foundation

**Dr. Harriet Seldin**  
San Diego County Dental Society

**Sara Steinhoffer**, Manager  
UCSD Healthcare

**Diane Strum**, Director of Government Relations Consultant  
Kaiser Permanente, Healthy San Diego Health Plans

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**Other Coalition Participants**

**Vincent Mudd**, President and CEO  
San Diego Office Interiors  
Board Member, San Diego Regional Chamber of Commerce  
Member, Governor's Committee on Workers' Compensation Reform

**Peter Zschiesche**, President of Machinist Union Local 389  
Member, Executive Board of the Labor Council of San Diego and  
Imperial Counties  
Trustee, SD Community College District

**Kamal Mullenburg**, Executive Director  
San Diego Business Healthcare Connection

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Consultant, San Diegans for Healthcare Coverage  
[Jan-mithras@cox.net](mailto:Jan-mithras@cox.net)  
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**Lee, Bud (Elwood) (DHS-MCOD-HDQ)**

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**From:** MCRRedesign  
**Sent:** Monday, October 31, 2005 10:15 AM  
**To:** Lee, Bud (Elwood) (DHS-MCOD-HDQ)  
**Subject:** FW: Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative

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**From:** Rockoff, Bobbe [mailto:BRockoff@co.marin.ca.us]  
**Sent:** Monday, October 31, 2005 9:57 AM  
**To:** MCRRedesign  
**Cc:** Rockoff, Bobbe  
**Subject:** Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative

**Response to Medi-Cal Redesign re Healthcare Coverage Initiative Concept**

The County of Marin's Children's Health Initiative Coordinating Committee offers the following input regarding options for use of federal matching funds for uninsured individuals.

**Target population:** parents of children on Healthy Families (revive previous state concept and waiver) - research shows that children access care more appropriately when their parents also use the health care system

**What services should be provided:** Benefits should be comparable to Healthy Families

**Participating providers:** Should include all Healthy Family and Medi-Cal providers so that families experience a common provider network

**Implementation:** Should be statewide

**Matching funds:** State should fund the match with dollars saved by reducing uncompensated care

Bobbe Rockoff  
Health & Human Services  
10 North San Pedro Road, Ste. 1012  
San Rafael, CA 94903  
BRockoff@co.marin.ca.us

10/31/2005

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(415) 499-3283

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Email Disclaimer: <http://www.co.marin.ca.us/nav/misc/EmailDisclaimer.cfm>

10/31/2005

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**Swan, Pam (DHS-MCS)**

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**From:** Moira Fordyce [mfordyce@cox.net]  
**Sent:** Thursday, October 20, 2005 9:14 AM  
**To:** MCRRedesign  
**Subject:** Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative

Cover all uninsured state wide. Focus on preventive care - teach in schools about diabetes, high blood pressure, and how to reduce the risks of these deadly diseases. Target pregnant women with preventive health care so that the baby is born as healthy as possible.

Organize support for the caregivers of chronically sick people, tap into national and local resources, volunteers, faith-based etc.

(Caregivers of chronically sick who do this without help or respite get sick - heart disease, depression, alcohol use).

These would be a start and would favorably impact the burden of chronic illness and its complications.

Moira Fordyce MB ChB, MD, FRCPE, AGSF

**Swan, Pam (DHS-MCS)**

**From:** Bost, Sue [Sue.Bost@dof.ca.gov]  
**Sent:** Thursday, October 20, 2005 7:27 PM  
**To:** MCRRedesign@dhs.ca.gov.  
**Cc:** Delgadillo, Terri (CHHS); Munso, Joe (CHHS); Topp, David (CHHS); Robyn Boyer; Kacy Hutchison; Kemp, Patrick; Sands, Bob  
**Subject:** FW: Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative

Thank you for the opportunity to respond.

The Department of Finance would expect the Healthcare Coverage Initiative for Uninsured Individuals to include the following components:

- The Initiative proposal should not require the state to spend additional General Fund.
  - The Initiative proposal should not obligate, or create an expectation, that the state will continue the program at the end of the waiver period if additional federal funds are not made available.
- We would also recommend that consistent with the Governor's Children's Health Care initiative, the Initiative proposal should be directed towards providing health care to children. One approach might be to create a grant program to assist counties with their County Health Initiative Matching Fund Program.

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**From:** Swan, Pam (DHS-MCS) [mailto:PSwan@dhs.ca.gov]  
**Sent:** Wednesday, October 19, 2005 3:22 PM  
**To:** aapcalifornia@aol.com; alison.breen@dmh.ca.gov; ann\_blackwood@baxter.com; barbara.boehler@ucdmc.ucdavis.edu; Bburdullis@cms.hhs.gov; bcamarena@chw.edu; benton@usc.edu; BettisB@SacCounty.net; Biglieri, Barbara; binghamr@chw.edu; bjohnson@rcmg.com; Bobbritton@maximus.com; bonnie.ko@nems.org; Borgfeldt, Irene@DMH; Bost, Sue; boyle@healthlaw.org; Bracht, Farra@LAO; broder@nilc.org; Brown, Carol@ci.berkeley.ca.us; bruno-r@iehpc.org; Bullick, Ray@tularehhsa.org; caads@caads.org; Calmedtrans@aol.com; carehomefinders@earthlink.net; casra@casra.org; CBonds@mednet.ucla.edu; cbracy@ccha.org; cbrown2@cms.hhs.gov; chbrawne@maxhealth.com; cheryl@cfilc.org; cjb4joy@earthlink.net; dan.brzovic@pai-ca.org; dawn@dbrewerlaw.com; devberger@earthlink.net; diboone1@cox.net; dick.callahan@eds.com; dmbres@aol.com; dsouza@ilrc-trico.org; eforer@ucla.edu; gcamp@co.riverside.ca.us; GNUSOLUTIONS@cs.com; heleneb@ppmcinc.com; hlapkovsky@caloptima.org; hlaplovsky@caloptima.org; info@calact.org; jackb@achd.org; Janya.Bowman@sdcounty.ca.gov; jbirdie@winfirst.com; Jbovee@calhealthplans.com; jbrode@mrmib.ca.gov; jbutler@drcinc.org; joan.boomer@sfgov.org; Johnson, Anne Burns; judymcdoncald@scdd.ca.gov; Kbrooks@Counties.org; Keith2@CMAC.CAHWNet.ca.gov; labradshaw@earthlink.net; laurajcm@yahoo.com; lbelleza@teamgsi.net; lboyd@chia.usc.edu; LBruguera@RavenswoodFHC.org; lbutler@scfhp.com; lizzy01@adelphia.net; lori@childrenshospice.org; lprose@pirs.org; mbeyer@outlook-associates.com; mbiel@oursaviourcenter.org; mbui@healthsmartmso.com; mebyden@adelphia.net; Melinda.Bird@pai-ca.org; merushkleinfing@sbcglobal.net; mhong@altamed.org; mjbetker@msn.com; mlb99@aol.com; monica@lif.org; nancy@lacehh.org; Rbiggar@AltaRegional.org; rboyle@cpca.org; rcampbell@mdxnet.com; rhys.burchill@verizon.net; rich.cancilla@safeway.com; rogerb@netpenny.net; sberzon@altshulerberzon.com; sbfogel@pacbell.net; sbruce@pwwf.org; scampbell@jerichoforjustice.org; scott.f.burns@us.pwc.com; seconddistrict@bos.co.la.ca.us; sinnfein61@yahoo.com; tborsdorf@egact.org; tbrewer@archstone.org; tibbits@lafreeclinic.org; ybice@cvhnclinics.org  
**Subject:** Medi-Cal Hospital /Uninsured Demonstration Healthcare Coverage Initiative

**\*\*\*PLEASE DO NOT REPLY TO THIS EMAIL\*\*\***

Hello interested stakeholder,

10/21/2005

On September 1, 2005, the federal government approved the Medi-Cal Hospital/Uninsured Care Demonstration (hospital financing waiver). One of the requirements under this demonstration is the development of a Healthcare Coverage Initiative for uninsured individuals. The intent of this initiative is to expand coverage. By January 31, 2006, the Department is required to submit a concept paper to the federal Centers for Medicare & Medicaid Services regarding this Coverage Initiative.

Per the Special Terms and Condition, Items 43 and 44, the following are the basic components of the Coverage Initiative:

- There is \$180 million of available federal matching funds for this initiative
- The \$180 million of available federal funds are **annual allotments**, per year, during the last three years of the demonstration (these funds can be paid out in subsequent years to the extent the services were rendered during a prior project year)
- Enrollment is to begin September 1, 2007

In preparation for a larger public stakeholder process which will be held before the end of the year, the Department would like to obtain some initial input from interested stakeholders on the development of the Healthcare Coverage Initiative concept. It is our intent to reach out to a variety of interested individuals to hear directly from them as to what ideas and approaches they believe the state should consider in developing this proposal. Some questions we are asking stakeholders to consider include:

- What is your vision of the coverage initiative, such as:

Who should be covered?

What services should be provided?

What would constitute a "participating provider?"

Should it be implemented statewide or in limited areas (as pilot projects or optional county programs)?

What sources of matching funds are available for this purpose?

We also are interested in obtaining written input from a broad array of stakeholders prior to the larger stakeholder process. This written input should include, at the least, ideas that respond to the above questions. You may submit your feedback electronically via email submission at [MCRedesign@dhs.ca.gov](mailto:MCRedesign@dhs.ca.gov).

Please submit your feedback **no later than Friday, November 4, 2005, close of business**. Given the number of potentially interested stakeholders in this process, **please limit your comments to no longer than two pages**. The initial input we obtain from stakeholders will help inform the ideas, concepts, and approaches on which we will seek input through the public stakeholder process later in the year.

Thank you in advance for your willingness to participate in this effort.

## **Healthcare Coverage Initiative For Uninsured Individuals**

Prepared by: Deane Dana III, Health Care Consultant, 5798 Elvas Ave., Sacramento, Ca. 95819 e-mail [ddgov@surewest.net](mailto:ddgov@surewest.net)

### **Vision of the Coverage Initiative:**

We should not invent what does not exist. A close examination of existing community not for profit providers of service who currently receive community and/or foundation support and have established governing boards should occur to determine their capabilities as initiative participants. Providers who can demonstrate broad community support, provision of community service, fundraising and audit scrutiny should be considered as priority potential providers. The Initiative should incorporate diverse providers which provide human resource assistance such as homeless services, transitional housing, youth shelters, blood banks and senior services. The Initiative would permit these providers to utilize their existing capabilities and expand services to incorporate expanded outreach, provide access to preventive health screening and develop a community health referral system for the uninsured.

### **Coverage:**

Any U.S. citizen of all ages would be eligible for system entrance. Non-resident initial health screen, emergency referral and system entrance. Non-residents should be directed to DSH County Health facilities or Federally Qualified Health Care facilities where available.

### **Services:**

Health and Mental Health assessment, physical screening, RX review, immunization and general counseling on potential health coverage ,co-pays and availability of services locally and regionally. A universal client file should be required and an assessment of potential eligibility for all benefits should occur. All providers should have extensive referral capability and state training on existing urban/rural referral models. Tele-medicine should be incorporated into pilots wherever possible for emergency referrals.

### **Participating Providers:**

Any not-for-profit public service organization that has been in continuous operation for 2 years, operates as a public service corporation, receives at least two non-public grants annually, has recognized community support and has some form of grant review or audit scrutiny performed in the last 2 years. Service provision in any area of health and human services would minimally qualify. Co-partnerships with HMO's, public health foundations, universities, blood centers or other health entities would enhance provider selection priority. Must meet minimal services outlined above and must utilize a community based volunteer program. Public relations/public service announcements and programs must be incorporated into the service plan.

### **Implementation:**

Pilot projects are preferred to insure non-dependence of public funding and utilization of volunteers and co-partners. Optional county programs could be utilized as pilots in high need/no service provision areas. Pilot programs should be emphasized in rural and urban rural areas of the state. Urban projects should be tested in 3 counties. Similar priority should be afforded urban providers who can establish partnerships with FQHC's for non-resident participants.

### **Matching Funds:**

Endowments, religious contributions(Both the Episcopal and Catholic churches are providing grants in rural counties), HMO and University assistance/grants (telemedicine/seasonal immunization provision ) , blood center credits for whole blood, platelet and marrow are all possible sources. Co-pay and insurance reimbursement for health screening should be utilized.

### **Closing Statement:**

Once a provider is selected under the Initiative, that provider or their partners could become priority health referral sources for state and federal health initiatives in that area. Similar to Area Agencies on Aging the Initiative provider would become a local single point of contact for recommendations on incorporating gatekeeper or emergency services from any source in the state or federal government. Any grant involving outreach and referral could require coordination with this uninsured model.

This model intentionally avoids the use of existing county health models and primary health care providers who are dependent on government funding sources and potentially biased in the referral and subsequent provision of needed healthcare services. The proposed Healthcare Initiative for Uninsured Individuals model intends to assess need and then independently make referrals to available resources. It is intended to leverage existing local funding and resources and realistically stay within budget of this demonstration project. The model is designed to reach those persons who do not communicate through government, but who do have confidence in community providers who understand their communities and needs. Most important of all, the proposed model is designed to be implemented quickly, so that emergency provision of services could occur if the need arose.

**Swan, Pam (DHS-MCS)**

**From:** Gonzales, Ramon [RGonzales@hsa.co.merced.ca.us]  
**Sent:** Friday, October 21, 2005 3:19 PM  
**To:** MCRedesign  
**Subject:** Medi-Cal Hospital/Uninsured Demonstration Healthcare Coverage Initiative

What is your vision of the coverage initiative, such as:

I envision a day where healthcare will have no borders. A day when healthcare will not be politicized. A day when we no longer ask if California should have healthcare for everyone but when.

Who should be covered?

I believe this should include universal health care but not a universal health care package. For example, all residents of California should have some type of health coverage (i.e. medical, prescription, dental, vision) but a tiered approach were resident participate in cost sharing, deductibles, co-pays, etc. as coverage increases. The basic universal health care package would be just that, basic. Health coverage options would be offered on a tiered approach.

What services should be provided?

All California Residents should have basic medical, prescription, dental and vision coverage. As coverage increases, so should monetary participation by the enrollee. Continuity of care should be covered for enrollee's with catastrophic illnesses.

What would constitute a "participating provider"?

I feel this is one of the main questions that needs to be explored to make Medi-Cal sustainable and attractive for providers as well as enrollee's. I believe the answer, at least in part, is to administer the Medi-Cal program as you would a regular business, wherein increased competition delivers a better product. The PMPM capitation should be based on, a) coverage; b) utilization; c) quality. Currently, PMPM capitation is based only on coverage.

Break down health care by its three basic components and set compensation accordingly, this way, enrollee's can expect the highest quality of care and providers the best price.

- i. Coverage - Either your covered or your not
- ii. Utilization - If your covered, you either utilize your health insurance or you don't
- iii. Quality - If you utilize your health insurance, you either receive quality care or you don't

I put forth the following for consideration:

- i. Coverage - Providers would continue to receive compensation PMPM (Similar to current system)
- ii. Utilization - Providers would receive additional monies on a quarterly basis ONLY for the members that utilized their healthcare during the quarter, regardless of how many times the member accessed services.

11/22/2005

- iii. **Quality - Members that utilized their health coverage in a given quarter would rate it. Providers would be reimbursed accordingly.**

Should it be implemented statewide or in limited areas (as pilot projects or optional county programs)?

If Medi-Cal is to be administered similar to a business, any business would tell us that they start small and go from there. I would recommend a pilot in 2/3 large counties; 2/3 medium size counties and 2/3 small counties.

What sources of matching funds are available for this purpose?

Foundations, matching federal dollars, TCE, CHCF.

Thank you.

Ramon Gonzales/Medi-Cal Supervisor  
Merced County Human Services Agency  
2115 W. Wardrobe Avenue  
Merced, CA 95341  
(209) 385-3000 x5362

11/22/2005

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**MEMORIALCARE®**  
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November 1, 2005

Kim Belshe  
Secretary  
California Health and Human Services Agency  
1600 Ninth Street  
Sacramento, CA 95814

RE: Medi-Cal Hospital/Uninsured Care Demonstration (hospital financing waiver)

Dear Secretary Belshe:

As President and Chief Executive Officer of MemorialCare Medical Centers, a five-hospital, not-for-profit health care system in Los Angeles and Orange Counties, I am writing to offer recommendations to you as you prepare for the public stakeholder process to better determine implementation of the newly enacted hospital financing waiver. MemorialCare appreciates this opportunity to offer our perspective on the implementation.

The question of services rendered and eligibility for these services have been widely debated. One thing is certain – primary care services must be expanded. California offers more optional benefits in our Medicaid program than all but a few states. Some of these benefits might well be eliminated in favor of increased primary care and increased prevention and education programs. California needs to fully examine all of the benefits offered, and weigh each one against an ever-increasing patient load, and a decreasing pool of funds.

One of the many challenges by the Medi-Cal program and providers alike is physician recruitment and retention. The Medi-Cal physician fee-schedule provides minimum levels of reimbursement that prevent many good physicians from opening their practices to Medi-Cal patients or require such a large volume of patients that care may be compromised. This is a problem from a primary care perspective, but also pushes untreated patients toward specialty care. MemorialCare believes that physicians must be reimbursed fairly. Equitable reimbursement goes beyond the mere numbers of patients seen. High quality care must be held as our collective ultimate goal. The hospital industry believes that physician reimbursement might be reflective of their quality performance. An ever-higher standard must be achieved.

November 1, 2005

Page 2

As the Governor proposed in the early days of his administration, coverage 'tiering' must be carefully examined. However, MemorialCare cautions that if 'tiering' is established, the state must protect all 'medically necessary' treatments and procedures currently in place. For example, thousands of California children who reside in low-income households are helped by California Children's Services. This essential program must be protected – at all costs.

MemorialCare believes that the care provided to the frail and elderly must be protected as well. In many cases, In-Home Supportive Services allows these beneficiaries to remain either in their home, or a small, community based facility. This service affords them the ability to retain much of the independence, which in turn keeps them from needing to reside in higher cost facilities. The state must strengthen its long-range Olmstead plan.

Lastly, the debate over a clear definition of the uninsured needs to be re-examined. There are thousands of uninsured Californians who are legitimately not eligible for Medi-Cal. These patients often present themselves at community based hospital's Emergency Departments. Following state and federal law, these hospitals are required to treat and stabilize all patients entering the Emergency Departments, regardless of their ability to pay. Hundreds of millions of dollars are spent by these hospitals for uncompensated care. To this end, increased access to urgent care services, again allowing for increased prevention and education, will result in fewer uninsured needing emergency services. This particular discussion must include all public health agencies as well as the UC system.

There are no easy solutions to the complex challenges facing California's health care system. MemorialCare applauds the administration for opening a dialogue between government and providers in the hopes of finding solutions to these problems.

If MemorialCare can be of any further assistance, please feel free to contact either myself, or Peter Mackler, Director of Government Relations and Policy.

Sincerely,



Barry S. Arbuckle, PhD  
President and Chief Executive Officer  
MemorialCare Medical Centers

Cc: Sandra Shewry  
Stan Rosenstein



1415 L Street  
Suite 850  
Sacramento, CA 95814

November 4, 2005

Ms. René Mollow  
Associate Director, Health Policy  
Medical Care Services  
MS 4000  
P.O. Box 997413  
Sacramento, CA 95899-7413

Via Email: [rmollow@dhs.ca.gov](mailto:rmollow@dhs.ca.gov)

**RE: Federal Hospital Financing Waiver Healthcare Coverage Initiative**

Dear Ms. Mollow,

On behalf of the California Association of Health Plans (CAHP), thank you for the opportunity to provide input on the development of the Healthcare Coverage Initiative component of the Federal Hospital Financing Waiver. CAHP represents 35 full-service health plans in California. As you know, most of our members are actively engaged in public programs providing coverage for persons who would otherwise be uninsured, and many are engaged in privately funded efforts to expand coverage as well. Although there is not a huge sum of money on the table relative to the magnitude of the uninsured problem in California, if we are thoughtful and deliberate, we have an opportunity to design and implement an initiative that will be valuable to those it serves and lay the groundwork for additional coverage expansions, be they public or private.

Given the limited funding and the short timeframe for design and implementation, we would like to offer a few guiding principles.

- First, the Healthcare Coverage Initiative should relieve the extraordinary burden on safety-net care providers.
- Second, the initiative should build upon existing programs and provide insights to help shape plan designs for the uninsured in the future.
- Third, the initiative should fund medical care in a manner that reduces costs and improves quality through preventive care and care management programs that minimize the need for costly treatments down the road.
- Fourth, given the likelihood of matching dollars being provided by local governments and variations in local needs, flexibility at the local level is also important.

The managed care delivery system is uniquely positioned to achieve these principles and to measure what works and what doesn't work. In addition, there are existing managed care

Ms. René Moliow  
Re: Healthcare Coverage Initiative  
November 4, 2005  
Page 2 of 2

delivery systems in most counties thereby minimizing the need for a large investment in administration and infrastructure. The Administration has repeatedly emphasized its belief that managed care increases access, is cost-efficient, and improves health care outcomes. We concur. Care coordination and preventive care are critical to improving health care outcomes for the uninsured and alleviating the burden on safety-net providers by reducing the costly use of urgent and emergency services for conditions that can be prevented or treated on an outpatient basis.

Please do not hesitate to contact me if you would like to discuss these ideas further. We look forward to working with you and other stakeholders as this effort moves forward. Thank you for your consideration.

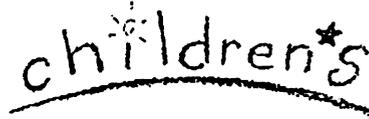
Sincerely,



Christopher Ohman  
President and CEO  
California Association of Health Plans  
(916) 552-1910

cc: Kim Belshe, California Health and Human Services Agency  
Sandra Shewry, California Department of Health Services  
Tom McCaffery, California Department of Health Services  
Stan Rosenstein, California Department of Health Services  
Vanessa Baird, California Department of Health Services  
Toby Douglas, California Department of Health Services  
Leanne Gassaway, California Association of Health Plans  
Ariella Birnbaum, California Association of Health Plans  
Cherie Fields, Local Health Plans of California  
CAHP Member Plans

CALIFORNIA



HOSPITAL ASSOCIATION

November 7, 2005

Ms. Rene Mollow, MSN, RN
Associate Director, Health Policy
Medical Care Services, MS 4000
P.O. Box 997413
Sacramento, CA 95899-8413

SUSAN A. MADDOX
PRESIDENT &
CHIEF EXECUTIVE OFFICER

3914 MURPHY CANYON RD.
SUITE 125
SAN DIEGO, CA 92123

PH 974.1644
FAX 858.974.1629

Dear Ms. Mollow:

The California Children's Hospital Association respectfully submits our ideas on expanded insurance coverage under the hospital refinance waiver to the Department of Health Services. We appreciate the opportunity to work with you and look forward to participating in future stakeholders' meetings.

California's 1.33 million uninsured children under 18 years of age represent 12% of all children and 18% of California's total uninsured population. Most (87.2%) come from full or part-time working families. Last year advocacy groups and several counties sponsored bills to cover more children. Governor Schwarzenegger said in his veto message of two such bills that he wants to expand health care coverage to the state's uninsured and will focus on children without health insurance. The refinance waiver's requirement of expanded coverage in the last three years of the waiver provides access to federal funds to address this agenda. The convergence of financing and political will should produce good results for California's uninsured children.

We recommend the following for covering uninsured children and ensuring their access to needed services:

- Develop a coverage initiative for low-income children ages 0-20 similar to the other 2005 children's health initiatives. CCHA would propose raising the income threshold for the Healthy Family program to 350% FPL, and increasing the allowable income levels of families for financial eligibility in the California Children's Services (CCS) program. This would go a long way to covering uninsured children in working families.
Improve access to outpatient, urgent and preventive care in safety net hospitals by supplementing the Outpatient Disproportionate Share fund (W&I code 14105.97) with waiver funding. This fund targets high volume Medi-Cal safety net providers. It could be further focused on pediatric services to shore up the essential services that would be needed under the expansion of children's coverage and for children who remain uninsured. An alternative funding mechanism would be to develop a pediatric outpatient adjustment payment for Medicaid outpatient services in children's hospitals, similar to that of Illinois Medicaid.

INTEGRATED PEDIATRIC HEALTH SYSTEMS SERVING CALIFORNIA'S CHILDREN

LEOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL • MILLER CHILDREN'S HOSPITAL AT LONG BEACH • CHILDREN'S HOSPITAL LOS ANGELES
CHILDREN'S HOSPITAL CENTRAL CALIFORNIA • CHILDREN'S HOSPITAL AND RESEARCH CENTER AT OAKLAND • CHILDREN'S HOSPITAL IN ORANGE COUNTY
CHILDREN'S HOSPITAL AND HEALTH CENTER SAN DIEGO • MICHELE SARTOR VETERANS CHILDREN'S HOSPITAL OF PLEASANTON

Thank you for the opportunity to participate in developing coverage initiatives under the waiver. We look forward to working with you on these ideas.

Very best regards,



Susan Maddox  
President & CEO



Jan Ouren  
Senior Vice President

cc: Stan Rosenstein, DHS  
Charity Bracy, CCHA Vice President  
CCHA Board

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<sup>1</sup> 2005 California HealthCare Foundation, "Snapshot California's Uninsured 2005", p.12. CCHA, using the Current Population Survey, March 2005 Supplement, found 2 million uninsured children age 0-20, compared to CHCF's 1.333 million children age <18.

<sup>2</sup> Ibid, p.13

<sup>3</sup> California Healthline, October 17, 2005

<sup>4</sup> Illinois' POAP or Pediatric Outpatient Adjustment Payment program was implemented to ensure access for specialized outpatient services at children's hospitals. In order to qualify for this program a facility must be a children's hospital and possess a pediatric outpatient percentage greater than 80 percent during the pediatric outpatient adjustment base period. [http://www.hfs.illinois.gov/annualreport/reimbursing\\_hospital.html](http://www.hfs.illinois.gov/annualreport/reimbursing_hospital.html)



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**Delivered By Email**

**TO:** Rene Mallow  
Toby Douglas

**FROM:** Santiago Muñoz  
Claudine Swartz

**DATE:** November 9, 2005

**SUBJECT:** Medi-Cal Waiver - Coverage Component

Thank you for your leadership on the coverage component of the Medi-Cal waiver. Also, thank you for your patience in allowing us to provide comments. As mentioned at our recent face-to-face meeting, we believe that the coverage component provides us a unique opportunity to measurably demonstrate the importance of healthcare access to low-income uninsured Californians. In an effort to move collaboratively in that direction, this email responds to your request for input and raises a series of practical concerns that we ask you to consider.

As you know the University of California's (UC) five teaching hospitals are a critical component of the state's hospital safety net; they will rely heavily on funds available via the Medi-Cal waiver to ensure hospital care is accessible to Medi-Cal and uninsured patients. At the very core of the waiver are provisions designed to protect the UC and other safety net hospitals. It is within this context that the coverage initiative should be conceptualized and evaluated.

The development of a concept paper for CMS is an ideal opportunity to outline various core principles that support the goal of the hospital waiver. We believe the following principles should be used as the framework for the coverage initiative and drive the content of the forthcoming concept paper.

**Core principles for the healthcare coverage initiative:**

- 1. The initiative must maintain the viability of the safety net hospitals.** The hospital financing waiver was negotiated with the goal of supporting California's fragile network of safety net hospitals – the funding available for the health insurance coverage product must contribute to this overarching objective. The \$540 million earmarked for the coverage initiative has been touted by the state as a critical component of the waiver's Safety Net Care Pool; therefore, the coverage product must support the safety net hospital network and its efforts to ensure healthcare access for the uninsured.
- 2. The initiative must recognize the important role of safety net hospitals that provide costly tertiary and quaternary care to low-income Californians.** While the limited resources available for the coverage product may prompt a focus on primary care, which is

important, it is imperative that we consider protecting access for high-acuity, complex medical and surgical cases. These are often life-threatening cases that require cutting-edge clinical care and continuity of multi-modality care.

3. **The use of public hospital expenditures should continue to be earmarked to fund public hospital payments.** In order to draw the \$540 million in federal funds, the State of California must provide a non-federal share. This could include public hospital CPEs. While the UC is committed to maximizing payments under the waiver, the use of hospital expenses as the non-federal share of the Medicaid payments must remain a source to fund hospital payments. Absent this commitment, the waiver structure is threatened.
4. **The demonstration project must be manageable and efficient, given finite resources.** Assuming that the state can draw \$540 million in federal funding, it must recognize that these resources are not sufficient to create a statewide coverage product. To that end, it is important to focus resources in an efficient manner. As such, the state should consider an initiative that targets payments to providers not towards a more traditional coverage product. Absent such an effort, hospitals such as the UCs may be left caring for high-cost uninsured patients without any of the additional resources made available to help ensure access.
5. **The coverage initiative should help sustain providers that currently serve Medi-Cal and uninsured patients.** With limited resources, the state must help maintain the viability of providers caring for vulnerable low-income patients. It now remains unclear whether safety net hospitals can maintain access to care during Years 3-5 of the waiver. In fact, the safety net hospitals are now working with the state and federal government to limit ambiguity surrounding the funds accessible via the waiver. Rather than funding new providers, the state must maintain, and strengthen, existing provider/patient relationships.

We appreciate that DHS's number one priority right now is resolving issues that ensure federal Medicaid payments flow under the new waiver. These issues are formidable and include the CPE cost finding methodology, the inclusion and certification of certain expenses including physician expenses, intern and resident expenses, and the payment process. DHS has done a fine job of maintaining CMS's focus on these difficult and highly politicized issues. UC urges DHS to continue to place a high priority on such efforts. We hope DHS agrees that it is critical to resolve key issues which hold together the fabric of the waiver before dedicating resources to develop a coverage product beyond a conceptual stage.



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

November 8, 2005

René Mollow  
Associate Director, Health Policy  
Department of Health Services  
Medical Care Services, MS 4000  
1501 Capitol Avenue  
Sacramento, CA 95814

Dear René:

The California Hospital Association (CHA), on behalf of our member hospitals and health systems, including California's public and private safety-net hospitals, is pleased to provide comments on the health coverage demonstration provision (years three through five) of the Medi-Cal Hospital Financing Waiver.

***Background***

Nearly 7 million Californians have no health insurance and another 4 million are inadequately insured. Access to health care services for California's working poor and uninsured populations, including access to highly specialized services such as emergency, trauma and pediatric care, is increasingly jeopardized by the growing number of uninsured and underinsured Californians and by the financial fragility of public and private safety-net, rural and other hospitals.

Every Californian should have equitable access to affordable, medically necessary, high-quality health care. For most Californians, this should be accomplished by providing access to health coverage. Access to hospital services also must be maintained by protecting the health care safety net.

The federal funds allocated to a health coverage demonstration as part of the hospital financing waiver are limited to \$180 million annually for three years. An often-stated goal of the Administration during the Medi-Cal hospital financing waiver negotiations was stabilization for the state's public and private safety-net hospitals to ensure access to care for the patients they serve. Due to fundamental problems inherent in the waiver, coupled with rising costs and increasing numbers of the uninsured, California's safety-net hospitals will be facing more serious fiscal difficulties in year 3 of the waiver, if not sooner. It is critical the funds allocated in the waiver for health care coverage remain with the state's safety-net hospitals. Otherwise, the goal of providing coverage for vulnerable Californians will be compromised.

Funding is essential. The issue of funding raises the question of the non-federal share, whether it will be state General Fund, certified public expenditures or other local or state funds.

***Recommendation***

CHA recommends a proposal to provide access to hospital services to low-income Californians not otherwise eligible for government health programs. The proposal must incorporate the public and private safety-net hospitals into the delivery model. Further, it should build on the CMS/Medi-Cal hospital waiver to ensure access to hospital services.

***Summary***

CHA looks forward to working with the Department and other stakeholders to develop a responsible program that qualifies California to receive the \$180 million in years three through five of the waiver, and meets the goal of a stable and equitable hospital safety net.

Sincerely,

A handwritten signature in cursive script that reads "Sherreta Lane".

Sherreta Lane  
Vice President, Reimbursement & Economic Analysis

SL:mg



# P.E.A.C.H., INC.

Private Essential Access Community Hospitals

December 5, 2005

René Mollow  
Associate Director, Health Policy  
Department of Health Services  
Medical Care Services, MS 4000  
1501 Capitol Avenue  
Sacramento, CA 95814

Dear Ms. Mollow:

Thank you for the opportunity to provide comment regarding the health coverage demonstration project contained in the new Medicaid hospital financing waiver. This component of the new 1115 waiver ties approximately \$180 million of funding, in each of the last three years of waiver, to the State's ability to expand healthcare coverage to the uninsured. We understand that the State is required to submit a paper conceptualizing the initiative by January of 2006 to CMS for review and consideration, and we appreciate the opportunity to provide a few very general comments for consideration as the Department of Health Services develops that concept paper.

The funds that are annually available for the coverage initiative, in years Three – Five of the waiver are an integral component of the overall financing structure for public and private safety net hospitals. Quite specifically, as the state negotiated the total funding request for all DSH hospitals throughout the waiver negotiations, this annual allotment of \$180 million was imbedded in the request. Not until the final weeks of the negotiations did we understand the full nature of the federal government's requirement that the \$180 million would be granted, but only if healthcare coverage to the uninsured was expanded. The principle purpose of the waiver is to deliver current levels of funding to DSH hospitals with adequate growth over the five years as a means to help cover the costs of care provided to the low-income patients we disproportionately treat. The \$540 million total possible funding funds under the Healthcare Coverage Initiative, being imbedded in that overall sum, should therefore be available for payment to all DSH hospitals for the services provided to uninsured patients.

Second, in recognition of the limited funds available for this effort in the last three years of the waiver, it is clear that the coverage initiative funding must (1) utilize an existing delivery network and (2) be targeted to a limited and specific population or effort. PEACH supports an approach that considers the following provisions:

- The State should pursue opportunities to "match" the available \$180 million via existing state programs to generate an annual \$360 million in state/federal funding. The total funding would be a state-driven CPE program.

- The State should develop a program that could be either a basic benefits package for those Californians with the fewest resources and least access to care; a “disease management”-type program, which might cover conditions such as diabetes or asthma; or an expansion of a children’s coverage product.
- In recognition of the cost-efficiencies of utilizing an existing delivery model, the program should be administered through local initiatives as well as County Organized Health Systems in counties in which they are functioning. Administrative costs should be kept to a minimum.
- Choice of safety net providers and continuity of care must be ensured. Primary care patient services should be required to be provided through safety net clinics or physicians with a history of providing care to uninsured and Medi-Cal beneficiaries. These clinics and physicians must have admitting privileges or contracts with both private and public DSH hospitals.
- Reimbursement for care to indigent patients would be paid to the eligible safety net clinic and physician providers or DSH hospitals that deliver the services to the beneficiary, whether public or private.

We hope to continue to partner with the Department of Health Services in the crafting of a proposal to best utilize these limited funds to ensure maximum efficiency. Please do not hesitate to contact me if I can elaborate upon any of the information contained above, or provide any additional information to assist you in your efforts. Once again, thank you for your interest in our views.

Sincerely,



Catherine K. Douglas  
President and Chief Executive Officer  
Private Essential Access Community Hospitals, Inc.

Cc:

Kim Belshé  
David Topp  
Sandra Shewry  
Stan Rosenstein  
Toby Douglas