



COVERING THE MIAs: COUNTIES, FEDERAL REFORM AND A STATE WAIVER

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Who is an MIA? It is typically a low-income working individual or couple with no disabilities and no minor children, living at home and ineligible for public and private coverage. For some it is your young adult children in an entry level job with no health coverage, and for others, it's your older, hard-working or recently laid off mom or dad after all the kids have grown up and moved out.

California currently pays for care to the MIAs (medically indigent adults) through its 58 counties with a mix of state (realignment), county (match) and sometimes federal funds. County programs for the MIAs are poorly funded, facing increasing demands for care with diminishing resources as state realignment funds to counties diminish because sales taxes and vehicle license fees have fallen during our severe recession. In 2006, California's counties reported spending about \$1.8 billion on care to about 1.2 million uninsured persons – roughly \$275 per uninsured Californian (6.5 million total uninsured then, 8.2 million now).

Many but not all the county programs for the uninsured are quite weak in the areas of prevention and primary care, which are essential elements of the federal reform. Others are not good on management of chronic conditions and better at delivering episodic care. This leaves many uninsured dependent on the emergency room for treatment of preventable illnesses. Ten California counties received three-year competitive federal grants to improve primary care, chronic care management and prevention for the MIAs, and most have markedly improved their systems; these grants end at the end of this summer.

The recently enacted federal health reform bill would allow California to get federal matching to pay for Medicaid coverage of its MIAs effective April 1, 2010. On January 1, 2011, a new option for Medicaid enrollees with multiple chronic conditions will provide states up 90% FMAP for care coordination and case management services. Then in 2014, California will receive 100% federal funding for coverage of all MIAs. A number of other states (e.g. states such as Oregon, Arizona, New York, Maine and Massachusetts) already receive federal Medicaid match for this population through a §1115 waiver and are well positioned to benefit immediately from the new match. What about California? Yes, it can. It could do so either as a straightforward state plan amendment (SPA) or through a §1115 waiver request to the federal government that builds on and improves county coverage of the MIAs. This paper looks at blending the waiver and the the recently enacted health reform.

California is seeking to renew a §1115 Medicaid waiver set to expire on August 31, 2010. Medicaid waivers grant states federal funds and flexibility to experiment with their Medicaid programs, in order to make their programs more efficient and effective. California's waiver, known commonly as the hospital financing waiver, governs hospital inpatient reimbursements; it helps strengthen the sustainability of California's safety net with federal funds for hospital care



to the uninsured; this includes hospitals' inpatient rates, hospitals' DSH (Disproportionate Share) payments and the Safety Net Care Pool (SNCP) that can be used for both hospital or ambulatory care to the uninsured. The current waiver also funds coverage expansion for Medically Indigent Adults through ten county health care coverage initiatives (CIs) -- \$180 million annually.

Under a waiver renewal, the state has hoped to strengthen the CIs with federal matches to fund expanded initiatives in the 10 existing county programs and to extend the coverage initiative opportunity to California's other 48 counties. The CIs are limited to uninsured medically indigent adults (MIAs). The waiver in combination with federal reform opportunities signed into law under HR 3590, the Patient Protection and Affordable Care Act, give California the opportunity in the near future to fund better coverage for the MIAs.

Under federal health reform (HR 3590), California could expand Medicaid to the MIAs, using its current county spending on their care to fund the local match. (The counties already do so in a limited fashion under the current waiver for the ten county CIs). This assumes that the current county funds are sufficient in combination with the available federal match to meet the requirements of HR 3590 for coverage of the MIAs—such as provider choice, prevention, primary care and timely geographic access to care.

Alternatively, the state can expand its Medicaid waiver, under which counties could still put up their current funding to draw down matching federal dollars but would maintain some flexibility to transition their current systems to meet federal reform requirements by 2014. For example, a large part of an improved health care system involves strengthening primary care and prevention, integrating the public and private sectors and better managing patients' chronic care.

County Medical Services Program (CMSP) counties could and do meet many of these federal Medicaid requirements already and could readily qualify for the federal match. These are the 34 small, mostly rural counties that band together to pay for MIA care. In 2009, CMSP counties spent \$285 million on care for the uninsured that may have drawn down federal matching funds.

Payor counties like Orange and San Diego cover the MIAs in their counties by reimbursing a broad mix of participating providers for care, but historically they have lacked the prevention and primary care components needed to manage and improve health outcomes for patients with chronic conditions. They began to develop these components under their coverage initiatives. Some payor counties simply block grant their funds to a local hospital and have no county funding for the local primary care network at all. With the enhanced federal funding, Orange and San Diego could contract with their local managed care organizations (MCOs) for an integrated system of care. Fresno and Merced counties could contract with their local community clinics and doctors for a better-balanced delivery system with an infusion of federal funds.

Provider counties, like San Francisco and Los Angeles operate public hospitals and public clinics that provide care to the uninsured, including the MIAs. Some contract with private non-profit community clinics, and some use their local managed care plans to deliver well-integrated and accessible services. These counties would likely be able to meet federal Medicaid standards. Others restrict uninsured patients' access to care to their own hospitals and clinics. Within their networks, some counties stint on primary care, lack geographic accessibility and timely access to



services due to chronic underfunding. Provider counties like Riverside or San Bernardino operate county clinics, but have limited to no contracts with local, non-profit clinics for care to the uninsured; whereas Kern and Ventura began to develop these relationships with local clinics through their coverage initiatives. These counties may be able to upgrade their programs with federal matching funds to meet federal Medicaid standards, but compliance could not be achieved overnight.

In summary, many California counties already do or could readily enact program improvements to meet federal Medicaid standards. Some counties are unprepared to meet federal reform requirements, and still others may be unwilling to transition to a better-balanced and more integrated system even with potential access to federal matching funds. Considering the varying levels of readiness and willingness among counties for reform, California could seek a Medicaid waiver, with a waiver of state-wideness and transitional benchmarks giving the less prepared counties the time and appropriate financial incentives to build their systems in line with federal requirements. In our view the first and highest priorities are to improve primary care and prevention, geographic and timely access, treatment of chronic conditions and a steady shift to managed care. In addition, such a waiver could cap counties financial exposure so that their financial obligations under the waiver do not exceed what they have already voluntarily undertaken. Counties are already struggling with budgetary concerns; this type of waiver would ensure that the access to new federal matching funds neither harms their programs' sustainability, not allows a county to pocket the federal match with no system improvements.

The waiver provides California with the opportunity to create a bridge and stepping stones to federal reform that will allow the state to maximize federal funding both during the interim period and when 100% federal financing is available in 2014. Under a renewed waiver, California counties can enroll MIAs in the years leading up to full reform implementation. With the MIAs already identified in the system, California will be in a strong position to immediately draw down federal funds for these individuals in 2014.

The new federal match begins on April 1, 2010 to expand coverage to the MIAs with incomes below 133% of FPL. What are we waiting for?

California providers will still struggle to finance care to those uninsured that do not qualify due to income or immigration status. In 2014, the Exchanges and federal tax credits will become operational to finance care for the uninsured with incomes above 133% of FPL and the Medicaid expansion will cover those with incomes below that level with 100% federal funds.