REVISED CONSUMER, COMMUNITY AND IMMIGRANT PROPOSAL TO PROVIDE SAFETY-NET CARE TO THE REMAINING UNINSURED

THE ONCE-IN-A-GENERATION OPPORTUNITY TO ENSURE A MEDICAL HOME TO ALL CALIFORNIANS

California has a once-in-a-lifetime opportunity not only to expand health insurance to millions with a successful implementation of the Affordable Care Act, but also to ensure that *every* Californian—including those left uninsured—has basic access to care and coverage.

With existing health care resources, we have the opportunity to ensure at least safety-net care and coverage for *all* Californians, including the remaining uninsured, but only if we safeguard funds for the county safety net, put in place the right incentives, and use our funds efficiently, effectively, with transparency and accountability.

Decisions made in the next few weeks could fulfill this goal and vision, or could lock out our fellow Californians from coverage and let current Low-Income Health Programs expire. We have a once-in-a-generation opportunity this year to get this right, and to continue our commitment to care for all Californians.

We are pleased California is moving forward to expand Medi-Cal. **We oppose programmatic human services realignments** that distract from the work of implementing the Affordable Care Act this year.

In anticipation of potential savings, Governor Brown proposes a formula to claw-back most of $1.4 billion in health realignment dollars currently earmarked for the existing county public hospitals, clinics, safety net and public health programs. **The Governor's proposal takes too much, too soon; and put in place the wrong incentives, caps funding short of meeting the needs of the remaining uninsured**, and allows county low-income health programs to disappear. The Governor's proposal:

- **Takes funds prematurely**, including $300 million in the first six months, $900 million in year two, and $1.3 billion in year three.
- **Imposes a cost cap** that locks counties into recession-era spending and decisions to scale back services and those eligible;
- **Prevents the safety-net's ability to meet future needs**, from changes in health or immigration law, to new ways of providing better care.

In order to have a strong health care system for all Californians, including the remaining uninsured, our organizations propose the following as an alternative solution to similar goals:

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- **Preserve the health realignment dollars that go to county services for the first two years**, when the newly eligible are paid for 100% by the federal government, and when the safety-net providers will face peak demand and an uncertain transition. This also allows counties to get better data on actual enrollment and costs of both the remaining uninsured and the newly covered.

- **After two years, ensure at a minimum that each county preserves a baseline of health realignment dollars for basic public health and indigent health costs.** Preserving a baseline (historically over half) of county realignment dollars associated with public health as a baseline provides counties the certainty to maintain core programs. This funding should be tied to greater transparency requiring counties to report how health realignment dollars are spent on public health & indigent health. Counties should continue to be under maintenance of effort requirements and these funds should be dedicated to health programs.

- **For CMSP and payor counties, additional dollars (up to a quarter of realignment funds) should be available to reimburse counties for enrolling their remaining uninsured in a medical home.** This creates an incentive for counties to keep patients out of the emergency room by providing primary and preventative care, and provides a metric that will vary based on facts on the ground. It helps to reduce the State's costs for emergency Medi-Cal. Funds would be available if their costs go above baseline for enrolling Californians in a medical home, whether a CMISP-type program that provides primary or preventative care and behavioral health, or an extended Low-Income Health Program, or other type of health home.
    - The dollars would only be available for those who are not eligible for Medi-Cal or Exchange subsidies or who do not have an affordable offer of coverage because their employer's coverage is not affordable, Covered California costs too much, they are denied eligibility because of immigration status or they are locked out by closed enrollment periods.
    - Federal funds and state savings should be maximized by screening and enrolling for Medi-Cal and Covered California, and for those left, by first using emergency Medi-Cal funding (but then wrapping primary and preventative services after).
    - This approach gives the state and the counties flexibility to deal with changes in the ACA or immigration reform, where the responsibility for those on a path to citizenship may shift over the time.

*** For public hospitals counties, any formula should <u>not</u> include any cost cap based on historical costs, locking counties into decisions made in a recession, before health and immigration reform.** .

- Public hospitals should get a **formula grounded in actual costs, with a retrospective "true up" to provide savings, that include incentives for medical homes**, and efficient and effective care delivery, to keep people out of emergency rooms as much as possible.
- **Any ACA-related savings (from the county or the state) should be shared between the state and counties, with the county dollars committed to provide a medical home** and coordinated care.. Given that there will still be gaps in the safety-net, we support a portion of state savings going to funding streams to support non-profit community clinics and health centers.

These recommendations don't require any more spending by the state, don't place any new mandate on the counties, but they provide the opportunity for counties to meet the needs in their communities. Using existing resources, **these recommendations provide a framework to finally provide a medical home for *all* Californians.**

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