FEDERAL WAIVER PROPOSAL

Introduction

Since the early 1990s, the Federal government has encouraged states to expand health coverage through use of Medicaid waivers. Waivers allow states to use their Medicaid programs to generate savings through implementation of managed care programs, with reinvestment of savings into expanded coverage. The “budget neutrality” aspect of waivers allow the Federal government to gain greater fiscal certainty of Medicaid costs than afforded under the program’s traditional open-ended entitlement financing.

California has generally used Medicaid waivers to create alternative health care delivery models such as the Medi-Cal Managed Care Plan for the TANF-linked population, but has not broadly employed waivers for coverage expansion like many other states. The exceptions to this are California’s Family PACT waiver and the Healthy Families Parental Coverage waiver.

Oregon, Arizona, New York, Massachusetts and Tennessee already have waivers that focus on coverage expansion for uninsured adults. There remains a major opportunity for California to use a Medicaid waiver, in combination with existing indigent care financing, to extend health coverage to a significant portion of low-income uninsured persons in the State. Existing indigent care funding generally in counties could be used as the non-Federal share to, under a waiver, match Federal funds that combined could provide funding for Medi-Cal coverage for uninsured persons.

Significantly, recent Federally-approved coverage expansions have allowed the benefit levels of the newly covered to be less generous than the mandatory Medicaid populations. Thus, the scope of the new coverage could be tailored to the availability of overall financing. The delivery systems could be existing Medi-Cal managed care structures, like Local Initiatives and County Organized Health Systems.

In 2000-01, counties spent over $1.5 billion in funds (i.e., Prop. 99, Realignment, and county costs) for indigent care which served about 1.5 million persons statewide. Portions of the $1.5 billion are unmatched, and a waiver could generate Federal matching funds that could greatly increase the purchasing power of indigent care funds to extend access to more persons through Medi-Cal coverage. The combined funds could be used to cover uninsured adults such as the 1.14 million under 100% FPL, and potentially a portion of the 1.2 million persons between 100% and 200% FPL.

California could meet the Federal budget neutrality test by a combination of savings under existing waivers, accessing unspent Federal State Children’s Health Insurance Program (SCHIP) funds, and/or consolidating and simplifying coverage and benefits among various programs.
Proposal Elements

1. **Eligibility.** No entitlement. Three groups of uninsured adults age 18-64 are targeted:

   Population 1 – uninsured adults age 18-64 under 100% FPL – estimated 1.14 million persons; and

   Population 2 – uninsured adults age 18-64 between 100% and 200% FPL -- estimated 1.24 million persons; and

   Population 3 - parents of Medi-Cal and Healthy Families children who are slated to be covered under the approved, but delayed SCHIP Parental Coverage Expansion Waiver – estimated 275,000 persons.

2. **Benefit Package.** Participating counties to provide basic minimum scope of services; additional services can be provided as each county deems appropriate.

3. **Financing.** Federal matching obtained via Intergovernmental Transfers (IGT) or Certified Public Expenditures (CPE) using existing non-Federal State and local funds for indigent care. Payments would be made on a per member/per month basis and/or an CPE match. Unspent SCHIP funds are accessed.

4. **Delivery System.** Counties opt in on a voluntary basis and specify defined provider network for enrolled population. For counties with county hospitals, the defined provider network is the county health system and county contracted providers.

5. **Eligibility Administration.** Point-of-service enrollment.

6. **SB 855 and SB 1255 Funds.** Recognize IGTs as an expense for purposes of calculating OBRA '93.

7. **Implementation.** All counties have the option to participate.

8. **Waiver Approach.** Obtain 1115 Waiver to maximize options and flexibility.
CalAccess: County Systems of Care

Proposal for California 1115 Medicaid Waiver

Submitted by the
California Association of Public Hospitals
and Health Systems
and
Los Angeles County Department of Health Services

Working Draft, for Discussion with the State
29 April 2004
CalAccess: County Systems of Care Proposal
Table of Contents

Executive Summary.................................................................3

Need Statement: California’s Health Care Crisis..............................4

An Opportunity for Improvement:
CalAccess: County Systems of Care............................................6

CalAccess Benefits California,
Aligns with State Priorities and Federal Goals..............................7

Background: California’s Indigent Care Programs............................8

Project Description: CalAccess: County Systems of Care.....9-14
  • Developing County Systems of Coordinated Care
  • Program Deliverables
  • Target Population
  • Range of Services
  • Financing Section
    o Funding Overview
    o Structure of Project Payments
    o Role of Medi-Cal DSH Payments
    o Budget Neutrality

Conclusion.................................................................14
Executive Summary

The California Association of Public Hospitals and Health Systems (CAPH) and Los Angeles County Department of Health Services (LAC) have developed a statewide proposal to stabilize health care for the medically indigent, improve quality and access to care, create a more rational and cost-effective mechanism of financing than currently exists, transform public health care providers and build counties’ capacities to serve their communities -- while recognizing the budget realities of the county and State governments. The creative and innovative design of CalAccess: County Systems of Care (CalAccess) will match federal Medicaid dollars to support coordinated systems of county indigent care at no cost to the State.

The CalAccess program stands to benefit the State by creating a new revenue source for public health care for the indigent. A match put up by counties, using money dedicated to indigent health care, would draw down the federal Medicaid funds.

This project can be accomplished using the opportunity afforded by the State’s proposed Medicaid 1115 Demonstration Waiver. Through CalAccess, California could define a set of services for a distinct population that would be eligible for a federal Medicaid match (FFP). This arrangement would not create a new group of Medi-Cal beneficiaries, a new government entitlement program, nor would it spawn a new insurance product. Rather, it would better utilize existing local resources to increase federal Medicaid funding to support the ongoing provision of health care to a population that is closely linked to the Medi-Cal population, from a policy and delivery system perspective. As part of an 1115 waiver demonstration project, the federal government has the authority to share in the burden of caring for the indigent, without expanding Medi-Cal eligibility. The value of the CalAccess program could reach up to $1 billion, infusing the state’s struggling public health care system with badly needed resources to perform critical functions.

Because the counties’ indigent care systems are also the principal providers of care to uninsured and Medi-Cal patients, CalAccess provides an occasion for the State and federal governments to strengthen California’s capacity to serve those populations and to improve quality, access and efficiency of care.

CalAccess would demonstrate that county coordinated systems of care for the indigent benefit all low-income groups, resulting in efficient and cost-effective provision of both indigent and Medi-Cal services.

CalAccess also would help the State tackle several aspects of the current health care crisis. By stabilizing county indigent care systems, including public hospitals, CalAccess could work to ensure the continued availability of the full scope of services that those institutions provide, such as emergency and trauma services. By setting a floor for participation at 100 percent of the Federal Poverty Level (FPL), CalAccess could address
the increasing variability among counties’ approaches to indigent care provision. By
requiring that participating counties create a plan for improving system capacity,
organization of care, and infrastructure improvements, CalAccess could initiate a process
of creating a coordinated, cost-effective, competitive public health care delivery system,
operated locally, led by county decisions and priorities.

From a health policy perspective, the program would improve access and quality of care
in several ways. It would prompt the development of organized county-designed systems
of care that coordinate patient care and improve efficiencies. Among the initiatives these
county systems would implement are targeted services, disease and case management
protocols, health promotion, outreach and enrollment, and system infrastructure
improvement such as management information systems.

CalAccess is a fiscally responsible plan to strengthen the ability of California’s 58
counties to provide health care to the most vulnerable populations. The program fulfills
government priorities of increasing standardization while maintaining local control over
health care decisions and delivery. It also will create incentives for counties and their
public hospitals to design better, more appropriate systems of care for the indigent and
the Medi-Cal program, both of which would be well served with a greater emphasis on
primary care and chronic disease management. By installing a mechanism that ties
federal Medicaid money to improving health care delivery, California can lead a
performance-based transformation in the capacity and quality of its public health care
delivery system.

Need Statement: California’s Health Care Crisis

California’s counties play a vital role in the State’s overall health care delivery system.
At the core of these efforts are the 24 public hospitals Statewide\(^1\) that are central to the
delivery of needed health services to Medi-Cal, indigent and uninsured patients, as well
as to all residents of their counties who benefit from emergency and trauma services and
from the containment of infectious disease and the public hospitals’ central role in bio-
terrorism and disaster preparedness.

Taken together, California’s public hospitals deliver nearly 80 percent of inpatient and
outpatient care to the indigent. These essential institutions, however, are suffering from
structural financial deficiencies that have put them in a position of attempting to meet a
growing demand with a shrinking supply of resources.

The counties’ indigent care systems are also the principal providers of care to the
uninsured and Medi-Cal beneficiaries. CalAccess: County Systems of Care, a proposed
component of the statewide demonstration project, would illustrate that coordinated
systems of care for all low-income groups result in efficient and cost-effective provision
of Medi-Cal services. That by supporting county indigent care systems, access and

\(^1\) 15 counties operate 20 public hospitals; three counties contract with the University of California to
provide that service; Fresno County contracts with a private non-profit hospital for county indigent care
services.
quality of Medi-Cal services also will improve, while strengthening the capacity of counties to deliver health care to the medically indigent for whom they are responsible.

As the medically indigent population continues to increase, public hospitals and county indigent care systems see a larger proportion of patients that do not, and cannot, pay for services. At the same time, budget deficits at the county and State levels result in cuts to public hospitals and to the programs that support their work, such as county indigent funds and the Medi-Cal program. The federal government also has initiated a direction to restrict Medicaid supplemental money, on which public hospitals rely, and to reduce the overall size of the Medicaid program over time. Simultaneously, the cost of delivering health care has risen, as pharmaceutical prices, nursing wages and new technology surpass the average rate of increases in other sectors. Public hospitals, faced with more non-paying patients and less government money to subsidize their care, find themselves struggling to operate within balanced budgets while still providing the level of quality care and the extent of access necessary to serve their communities. If current trends continue, by 2007, the gap between public hospital revenues and expenses will exceed $1 billion. This is not a viable arrangement. Steps need to be taken now to stabilize and reinforce county systems of indigent care.

**Widening Expense-Revenue Gap at California Public Hospitals**

![Chart showing widening gap between expenses and revenues from 2002 to 2007](chart.png)

Source: 2004 CAPH Financial Forecast

Already, fiscal constraints are forcing California’s 58 counties and 24 public hospitals to curtail services, reduce programs, lay off staff and in some cases close entire hospitals, clinics or service lines. These actions quite often lead to increased utilization of emergency rooms – both at public and private hospitals – an expensive, inefficient and sometimes inappropriate way to deliver care. Over the long term, that pattern is
unsustainable, and both the indigent and the institutions that serve them are at risk looking forward.

**An Opportunity for Improvement: CalAccess: County Systems of Care**

The California Association of Public Hospitals and Health Systems (CAPH) and Los Angeles County Department of Health Services (LAC) have developed a proposal to stabilize health care for the medically indigent, improve quality and access to care, create a more rational and cost-effective mechanism of financing than currently exists, transform public health care providers and build counties’ capacities to serve their communities -- while recognizing the budget realities of the county and State governments. The creative and innovative design of CalAccess: County Systems of Care (CalAccess) will bring in federal Medicaid dollars to support coordinated systems of county indigent care at no cost to the State.

Under State law, California’s 58 counties are responsible for the provision of health care to indigent individuals. They fulfill this role through direct operation of health care facilities, including public hospitals, and/or contracts with health care providers using a combination of local funding sources such as property taxes and vehicle license fees. Counties dedicated more than $1.5 billion to serving about 1.5 million medically indigent persons Statewide in 2000-01.

Because the same county indigent care systems provide much of the care to Medi-Cal beneficiaries, the increased funding will promote the development of coordinated systems of care for Medi-Cal beneficiaries as well as the medically indigent and will help ensure continuity of care for individuals whose eligibility status fluctuates.

The recent economic condition of the State has prevented the expansion of health coverage through Medi-Cal and Healthy Families, and also restrained counties from increasing funding of indigent health care despite growing costs and demand. In response, counties have been forced to reduce services and limit eligibility. This has exacerbated the variability among county indigent care programs, increased disparities in access to care, and threatened the viability of local public hospitals and other county-contracted indigent care providers. Pressure brought to bear on counties, public hospitals and other county-designated providers by the growing indigent and uninsured population is a critical element threatening the stability of California’s health care system.

The broad crisis in health care -- in terms of cost, coverage, access and quality – is a multi-faceted national problem with no simple culprits or easy solutions. Clearly, today the public sector is not in a position to expand coverage or create new entitlement programs. At the same time, there are some 6.3 million uninsured Californians in need of primary, specialty and emergency health care, and the medically indigent are a subset of that group. The institutions that treat these most vulnerable and disenfranchised health care consumers are in urgent need of support in order to maintain and improve their essential role in meeting the State’s health care needs.
That can be accomplished using the opportunity afforded by the proposed Statewide Medicaid 1115 Demonstration Waiver. Through CalAccess, the federal government would help meet the cost of a defined set of services for a distinct population. This arrangement would not create a new group of Medi-Cal beneficiaries, a new government entitlement program, nor would it spawn a new insurance product. Rather, it would better utilize existing local resources to increase federal Medicaid funding to support the ongoing provision of health care to a population that is closely linked to the Medi-Cal population, from a policy and delivery system perspective. The value of the CalAccess program could reach up to $1 billion, infusing the State’s struggling public health care system with badly needed resources to perform critical functions.

The CalAccess proposal provides a positive approach that will benefit the population in need and the institutions and entities responsible for them. By recognizing the severity of the circumstances California’s counties and their public hospitals face, and constructing a new model to address them, the State, in cooperation with the federal government, can lead the nation in the realms of public and health care policy.

Further, by correlating the payments to the indigent population, counties would retain local control over the expenditure of the money, though participation would be predicated on the dedication of all CalAccess funds to indigent health care services. Building in flexibility for local government is consistent with State and federal goals and is appropriate in the design of a health care program that must respond to local needs. At the same time, the program could provide a statewide minimum standard for eligibility and services, which would help to ameliorate the growing geographic disparities in indigent care delivery. At the expiration of the demonstration project, there would be no State or county obligation to continue to fund CalAccess.

**CalAccess Benefits California, Aligns with State Priorities and Federal Goals**

The CalAccess program, by relieving pressure on the county systems of indigent care and bolstering the quality and accessibility of care for the indigent and Medi-Cal patients, advances the State in accomplishing many of its current pressing priorities.

From a fiscal perspective, the program stands to benefit the State by creating a new revenue source for county care for the indigent. Using county money already dedicated to indigent health care, the State would obtain federal Medicaid funds. This arrangement would strengthen the counties’ abilities to meet their mandate to provide indigent care, without creating a new requirement, entitlement program or defined population. The Medi-Cal program would not expand, as no new State money would be involved in the program, and the indigent would not become Medi-Cal beneficiaries. The federal money used to support services to the indigent, however, would be delivered in a more rational, direct fashion, clearly indicating its purpose. That would allow the county-designated institutions that serve the indigent to create coordinated systems of care for the indigent and Medi-Cal populations to deliver health care in a more effective, appropriate environment.
Public hospitals cannot decouple the Medi-Cal and indigent populations, as they make up a porous group of patients, all of whom could be better served with an emphasis on primary care and chronic disease management. However, financial limitations and disincentives to develop such clinical strategies have hampered their ability to create these mechanisms. The CalAccess program would diminish those obstacles by creating dedicated federal funding to enhance counties’ contributions to the care for this population. These additional resources would allow better, more cost-effective delivery structures to be installed, relieve pressure within the health care system, and offer opportunities for the State to address other priorities.

From a health policy perspective, the program would improve access and quality of care in several ways. It would prompt the development of organized county-based systems of care that coordinate patient care and improve efficiencies. Among the initiatives these systems would implement are targeted services, disease and case management protocols, health promotion, outreach and enrollment, and system infrastructure improvement such as management information systems.

Increasing the resources attributed to indigent care will achieve a more stable delivery system and provide crucial ballast to county public hospitals. These institutions’ contribution to the State’s overall health care system cannot be underestimated, and ensuring their survival is key to successful health policy. Their central role providing care to the indigent, uninsured, immigrants, Medi-Cal beneficiaries, delivering ER and trauma care to all residents, training doctors, and leveraging federal Medicaid funds that help to subsidize private safety net hospitals and keep the State’s Medi-Cal rates low is essential to California’s medical and fiscal health. The CalAccess program would create a more stable, viable and competitive public hospital system, ensuring the availability of quality care for the indigent and Medi-Cal patients and ER and trauma services for all Californians.

The CalAccess proposal brings creative thinking to a long-standing problem, and is well poised for incorporation in the overall Medicaid waiver that California plans to seek from the federal government. If approved, the CalAccess program would assist the State in better delivering needed health services, while preserving and enhancing the county systems of care that treat the indigent, uninsured and Medi-Cal patients.

Many states have used demonstration projects to reform health care delivery systems, such as the California’s Medicaid Demonstration Project for Los Angeles County, the New York Partnership Plan, and Missouri’s demonstration project to transform the public hospital in St.Louis.

**Background: California’s Indigent Care Programs**

California’s indigent care programs are configured through two basic models -- the County Medical Services Program (CMSP) and the Medically Indigent Services Program (MISP). Both models provide a basic range of county health services to medically indigent Californians who are uninsured and ineligible for Medi-Cal, Healthy Families, and Medicare. These services include inpatient and outpatient care, prescription drugs,
and laboratory and ancillary services. Significantly, there is no minimum level of eligibility and benefits required of CMSP and MISP counties. Because there is no relationship between how many medically indigent persons reside in a county and how much a county spends, there is wide variation in county indigent programs. Additionally, how county indigent programs relate to other providers serving low-income populations is variable, with some counties playing only a payer role while other counties take a central role in providing care to low-income persons.

Under CMSP, 34 small counties pool their local indigent care funds into a common program of eligibility and benefits administered by the State. CMSP is led by a Governing Board comprised of representatives from participating counties who determine eligibility and benefits levels, and the delivery system. CMSP’s delivery system is comprised of eligible providers (with the exception of pharmacy) under the State’s Medi-Cal program. CMSP is budgeted to expend $238 million for medically indigent clients in FY 2003-04.

Under the MISP model, comprised of larger counties, eligibility, benefits and the delivery system are configured on a county-by-county basis. MISP counties either directly operate public hospitals and clinics or contract with private providers, or a mixture of both. In general, MISP programs are oriented around a core set of public hospitals that are either county-operated or run by the University of California. These institutions are often major providers of care to Medi-Cal beneficiaries, and serve essential roles in assuring public health services such as communicable disease control, and regional emergency and trauma care networks. According to the most recent available data, MISP counties expended $1.4 billion in FY 2000-01.

**Project Description: CalAccess: County Systems of Care**

The CalAccess Program would transform the financing and delivery of health care to indigent Californians. New federal Medicaid funds -- obtained by matching existing county spending on indigent health care -- would be used to pay for care of indigent patients provided by public hospitals and other county-contracted indigent care facilities. Building on the strengths of counties and public hospitals and with the opportunity for additional federal funds, county systems of coordinated care for indigent and Medi-Cal patients would be developed, reducing the burden of disease on the patient population, reducing inappropriate emergency room usage and preventable hospitalizations and better managing costs of care for the population.

This section provides an overview of the CalAccess Program:

- Developing County Systems of Coordinated Care
- Program Deliverables
- Target Population
- Range of Services
- Financing
  - Budget Neutrality
Developing County Systems of Coordinated Care

A principal component of the proposed CalAccess demonstration project is re-orientation of the current county indigent care arrangements to organized systems of coordinated care. Counties have in place the building blocks to deliver high quality, cost-effective care to indigent and Medi-Cal patients, but fundamental changes are needed to reorganize and stabilize the components to develop systems of care that better promote access, manage chronic disease, improve quality and service and manage costs. Establishment of county coordinated care systems will improve patient care, help make public hospitals and other county-contracted providers more stable, cost-effective and competitive and provide a foundation for long-term cost management and savings related to care of the indigent and the Medi-Cal program.

CalAccess aims to strengthen county indigent care programs, improve their effectiveness, and initiate progress toward standardizing eligibility and services provided among counties. This would be accomplished statewide via an “opt-in” by CMSP and individual MISP counties. As conditions of participation counties would: 1) maintain their current level of indigent care funding during the project, 2) provide a minimum set of services for medically indigent persons whose incomes are at least 100 percent of the Federal Poverty Level (FPL), and 3) provide a plan for county system capacity and infrastructure improvements.

In developing the plan, counties will focus on four key areas of coordinated care.

*Establish a Medical Home:* A “medical home” will be identified for patients served by the county indigent care system. This term connotes a systematic connection to a provider who oversees and coordinates the care for a particular patient. For some patients this may be a primary care provider. For other patients with highly complex medical needs, a specialist may more appropriately serve in that role. Establishment of a medical home is considered a critical factor in coordinating a patient’s care and reducing fragmentation and duplication in care delivery.

*Coordinate Health Care Needs:* Due to the medical complexity of indigent patients, the existence of multiple health conditions and the wide array of medical and mental health services frequently required, greater coordination of care amongst providers within the county indigent care system—including coordination between primary care, outpatient specialty care, emergency room, lab and other diagnostic services and inpatient care—is critical to improving care of patients.

*Chronic Care Management:* Many indigent patients have chronic diseases such as diabetes, asthma and high blood pressure in addition to other medical conditions. Effectively managing these diseases and the associated co-morbidities is critical in helping stabilize patients’ health status and avoiding preventable hospitalizations.
Strengthen Linkages Across County Systems of Care:
Public hospitals in particular among county indigent care providers are connected organizationally at the local level to county mental health, substance abuse and public health services, as well as county social and human services, which offers the structure to address patients’ full range of health, behavioral and social needs. Given the complexity and range of services essential to serve the health care needs of indigent patients effectively, strengthening linkages within the county structure is highly important in improving care.

Program Deliverables
Each participating county will construct a plan to better coordinate systems of indigent care, using the following five categories as areas in which to pursue improvement:

- Access
- Managing Disease
- Delivery System Infrastructure
- Quality and Service Improvement
- Management Information Systems

Based upon consideration of county-specific situations, needs of the patient population and current status and challenges of the local county indigent care system, counties will identify appropriate program activities. The accompanying box listing a menu of potential options offers a sample of the types of services and improvements that counties may choose to consider.

Target Population
Indigent persons eligible for CalAccess will meet income and other program criteria. Counties that opt to participate in CalAccess will set an income eligibility threshold for the program no lower than a Statewide standard of at least 100 percent of the Federal Poverty Level (FPL). Indigent persons who are not otherwise eligible for any other health care coverage, such as Medi-Cal, Medicare, Healthy Families or employer-sponsored health plans, and who have satisfactory immigration status, could be included.
Indigent persons will enroll in CalAccess through a point-of-service enrollment system.

**Range of Services**

CalAccess provides access to care, not coverage or insurance. Counties that participate will provide medically necessary services to indigent residents through a county designated system of care (“system”), to the extent that resources are available. The system will include public hospitals and other contracted community providers that operate within the county’s system of indigent care. For counties without public hospitals, the county will determine the delivery system.

Services that will be provided include inpatient hospital, outpatient hospital, and physician services; and prescription drugs as deemed necessary by the physician and filled at system facilities. A primary component of the program will be increased coordination of care as described above. Family planning services will continue to be available to this population through the Family PACT waiver. Counties may choose to include other services under this program, as resources allow. Emergency services to enrollees will not be reimbursed if provided at hospitals outside the county determined delivery system. Indigent persons without satisfactory immigration status will be excluded from the program, and only emergency services will be available to them, as dictated by current law.

**Financing of CalAccess**

**Funding Overview**

By recognizing current county health care expenditures for the indigent as Medicaid expenditures, this project would secure federal matching funds to help stabilize county indigent care systems. As part of a demonstration project under Section 1115 of the Social Security Act, the federal government has the authority to share in the burden of caring for the indigent, without expanding Medi-Cal eligibility. These local and federal funds together will assist the counties in transforming their public systems to become more cost effective and efficient. Because the same county indigent care systems provide much of the care to Medi-Cal beneficiaries, the increased funding will promote the development of coordinated systems of care for Medi-Cal beneficiaries as well as the medically indigent and will help ensure continuity of care for individuals whose eligibility status fluctuates.

**Structure of Project Payments**

Each county will have the option, under an appropriate State statutory amendment, to redirect a portion of its local indigent care subsidies to fund the nonfederal share of the Medicaid indigent care payments. The payments under this proposal will be for services rendered to indigent populations (excluding those without satisfactory immigration status). In order to promote stability and predictability in payments, the number of indigent patients to be served by each locality and the maximum payment amounts under
the project will be prospectively determined. The proposal envisions that payments will be made to local governments in the form of capitated payments that will incentivize the development and maintenance of coordinated systems of care. In addition to the capitated systems, the financial structure may include “incentive” payments to be earmarked for particular requirements such as small-scale capital purchases, technology, and other investments necessary to maintain and operate the county indigent care system.

Various factors including the waiver budget neutrality analysis, the willingness of local governments to redirect voluntarily a portion of the local indigent care subsidies to fund the State share of the Medicaid indigent care payments, and the current volume, mix and intensity of services provided to indigent patients are effective limits on the aggregate total of project payments. Notwithstanding these practical limitations, the current analysis indicates that the project could generate as much as $1 billion in federal Medicaid funding. These resources would enhance the ability of each county indigent care system to reduce its ongoing structural deficit, to concentrate on improving and coordinating the health care delivery system and to make necessary investments in its infrastructure.

**Role of Medi-Cal DSH Payments**

In order to stabilize financially and transform the service delivery structure of the county indigent care systems, payments under the project are designed to be in addition to current levels of Medicaid supplemental funding. More specifically, public hospitals must be guaranteed their current level of Medi-Cal SB 855 DSH payments. These payments, together with the payments under this proposal, will help ensure a comprehensive approach to the financing and delivery of services to the medically indigent. Further, the proposal would effectively eliminate the financial disincentive in the DSH program to investing in ambulatory care expansion and disease management interventions. The proposal would not impact the current flow of DSH payments to private hospitals, and the public hospitals would continue to fund the entire State share of the DSH payments in a manner currently authorized by law.

**Budget Neutrality**

To obtain federal approval of its statewide Medicaid Demonstration Project under Section 1115 of the Social Security Act, the State will be required to demonstrate that, over the term of the project, the State will not receive more in federal Medicaid funding than it would have received in the absence of the project. Centers for Medicare and Medicaid Services (CMS) policy generally requires that the State determine what total federal expenditures would be without the project. This total projected amount, referred to as the “Budget Neutrality Limit,” represents a cap on total federal expenditures under the approved Statewide project. It is anticipated that the federal Medicaid funds paid to the counties under this proposal will be taken into account in establishing compliance with the Budget Neutrality Limit.
In determining the Budget Neutrality Limit, CMS should consider the federal savings that flow from the statewide Medicaid Demonstration Project, as well as from other California waiver programs. For example, CMS should take into account savings that arise from the phase-down of the Los Angeles County demonstration project, as well as the State’s managed care and other Medicaid waivers. Savings from the unspent Statewide allotment of the State Child Health Insurance Program (S-CHIP) should also be considered. In addition, the trend factor applied in determining the Budget Neutrality Limit should incorporate the fact that the State has been among the lowest in per capita Medicaid spending for many years. As a result, substantial increases in expenditures would be expected in the absence of the statewide redesign program.

Taken together, these factors should result in a Budget Neutrality Limit that is high enough to accommodate the anticipated expenditures for indigent care. In addition, because each county would designate the amount of local funds available each year, there would be a predetermined annual cap on total expenditures in each county, assuring the State’s ability to monitor and assure compliance with the Budget Neutrality Limit.

**Conclusion**

CalAccess is a fiscally responsible plan to strengthen the ability of California’s 58 counties to provide health care to the most vulnerable populations. The program fulfills government priorities of increasing standardization while maintaining local control over health care decisions and delivery. At no cost to the state, it will create incentives for counties and their public hospitals to design better, more appropriate systems of care for the indigent and the Medi-Cal program, both of which would be well served with a greater emphasis on primary care and chronic disease management. By installing a mechanism that ties federal Medicaid money to improving health care delivery, California can lead a performance-based transformation in the capacity and quality of its public health care delivery system.