LOS ANGELES COUNTY
HEALTH AGENCY

Los Angeles County Board of Supervisors

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Second District

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Third District

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Mitchell H. Katz, M.D.
Director, Health Agency

Jonathan E. Sherin, M.D, Ph.D.
Director, Department of Mental Health

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director, Department of Public Health

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

August 11, 2017

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Mitchell H. Katz, M.D.
Director

SUBJECT: **IMPACT OF THE AFFORDABLE CARE ACT AND FEDERAL REPEAL/REPLACE EFFORTS ON LOS ANGELES COUNTY (ITEM #2 FROM THE FEBRUARY 21, 2017 BOARD AGENDA)**

On February 21, 2017, the Board directed the Director of the Health Agency, in collaboration with the Chief Executive Officer (CEO), to develop options of how health insurance coverage could be maintained and/or extended within Los Angeles County and the State.

The Healthy Agency's most recent memo to the Board on health reform, "Impact of the Affordable Care Act and Senate Repeal/Replace Efforts on Los Angeles County," dated July 14, 2017, provided a summary of the impact of the Affordable Care Act (ACA) on the County, a summary of Senate Bill 75, and an overview of efforts to repeal the ACA. Since the last report to the Board, the Health Agency collaborated with the CEO, County Counsel, Auditor-Controller (A-C), and the Department of Public Social Services (DPSS) to provide the following update.

LEGISLATIVE STATUS

In recent months, the House of Representatives and the Senate have considered legislation to repeal and replace significant portions of the ACA. On May 4, 2017, the House passed H.R. 1628, the American Health Care Act (AHCA) by a vote of 217 to 213.

On June 22, 2017, the Senate released its draft bill, the Better Care Reconciliation Act (BCRA) of 2017, a "discussion draft" of legislation to repeal and replace the ACA. In the weeks following the release of BCRA, the Senate Republican leaders modified several of provisions of this measure to garner sufficient votes to ensure its passage off the Senate Floor. On July 25, 2017, the Senate began a days-long floor

debate on ACA repeal and replace legislation. On July 28, 2017, despite intense pressure from the Administration and Senate Republican leadership, the Senate failed to pass alternative "skinny" legislation that would repeal the ACA's individual and employer mandates and temporarily repeal the medical device tax by a vote of 49 to 51.

Congress has adjourned for its summer recess and will reconvene on September 5, 2017 at which time it may again take up legislation to repeal and replace the ACA. The Senate Health, Education, Labor and Pension Committee (HELP) is working on a bi-partisan effort to shore up the ACA insurance markets and is expected to hold hearings on this issue the first week of September 2017 and is expected to take up this legislation sometime thereafter. There are also bi-partisan discussions in the House on this issue. No committee hearings are scheduled.

Even if the Republican-led Congress is unsuccessful in their attempts to repeal and replace the ACA, the Administration is able to make major modifications to the health care marketplace and the Medicaid program specifically through their administrative and regulatory functions. These actions may include stopping the cost-sharing reduction subsidies to compensate health insurers for reducing deductibles and co-payments for low and moderate income market place enrollees. This action could increase health care premiums for consumers and cause some health insurers to withdraw from the marketplace. Senators from both sides of the aisle have urged the Administration to make these subsidy payments. The Administration is also considering approving Medicaid demonstration waivers that would allow states to opt out of certain ACA provisions, such as those that would have prohibited work requirements as a condition for Medicaid eligibility. The Health Agency expects that the coming months will see major proposals that could impact Medicaid through CMS rule-making activities. Congress' efforts at overhauling the tax system could also present opportunities for further potentially deleterious effects on Medicaid.

The County's Washington, D.C. advocates continue to advocate in strong opposition to legislation that would repeal major provisions of the ACA and enact significant changes to the Medicaid program.

PROPOSED CHANGES TO THE HEALTH CARE LAW

County Counsel prepared the attached analysis of recent Federal legislative efforts to repeal and/or replace the ACA (Attachment I). The analysis includes the AHCA, BCRA, and an Amendment to the AHCA (known as the "skinny" repeal). The analysis also includes a summary of other potential efforts that the Administration may pursue that may not require Congressional action. County Counsel will continue to update this analysis as needed.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT CUTS UPDATE

The July 14, 2017 report included the anticipated impact of the BCRA Senate Bill on the ACA. Since that time, the Centers for Medicare and Medicaid Services (CMS) has released a proposed rule implementing the ACA's Medicaid Disproportionate Share Hospital (DSH) payment cuts for federal fiscal years (FY) 2018 thought 2025. CMS published the proposed rule in the Federal Register on July 28, 2017. Comments are due August 28, 2017 and DHS will be submitting comments regarding the rule as it relates to both the integrity of the source of data being utilized and the formula's weighting factors. We'll report on any updates or changes to the rule in a future report.

POTENTIAL IMPACT OF ANY REPEAL/REPLACE CHANGES

The County's health care system, both public and private, continues to face many challenges in our efforts to deliver effective, high quality, patient centered care. The impacted departments continue to evaluate the potential impact of the propose AHCA and BCRA changes on their operations. Of particular concern are the potential changes Congress may make to current health care law and the impact these changes may have on the progress we have made, and intend to continue to make, to integrate, expand and modernize our system of care.

With this in mind, it is critical that the County moves forward with a coordinated effort to assess any proposed changes in health care law, the potential impact of any changes, and evaluate strategies for Board consideration. To achieve these goals the CEO established a Health Care Reform Workgroup consisting of key departments impacted as well as other departments that provide essential support and advisory services. The Workgroup includes the CEO, the Health Agency, DPSS, County Counsel, and the A-C. The Workgroup held its first meeting on August 2nd and will continue to meet monthly, or more frequently if needed, to evaluate strategies for the Board's consideration, as well as look at other operational changes that might be necessary in order to address the possibility that either benefits and/or eligible beneficiaries are reduced.

The following is a recap of the potential impacts for departments that have not previously been reported to the Board in prior memos:

Mental Health Impact Assessment

According to the Department of Mental Health (DMH), in FY 2015-16, approximately 44,000 consumers covered under the Medi-Cal Expansion (MCE) received Specialty Mental Health services from both directly operated and contracted agencies. Based on approved claims for these services, the total gross cost was $177.9 million, of which $144.7 million was for direct services provided by our network of directly operated (40% of the total services and claims) and contracted programs (41% of the total services and claims) and $33.2 million for acute psychiatric inpatient and outpatient services provided by our Fee-For-Service (FFS) Medi-Cal Network (19% of the total services and claims). In order to accommodate the additional MCE workload, DMH expanded some staffing

for DMH directly operated programs where additional capacity was needed due to increased numbers of MCE aided consumers and for specific programs that targeted communities with large MCE enrollments.

The fiscal impact of any repeal/replace changes would vary in magnitude based on the type of services needed by the consumer and the funding source for those services. For example, using FY 2015-16 claims data, approximately $100 million (69%) of the cost to serve MCE consumers in our directly operated and contracted programs (non-FFS Medi-Cal) are eligible for Mental Health Service Act (MHSA) funding. If the federal funding match is reduced as indicated under the proposed AHCA and BCRA bills, and the State did not fund the loss of federal revenue, MHSA would have to absorb these costs and could do so only to the level where funding is available. The remaining $44.7 million (31%) of the cost of services, currently funded by non-MHSA sources, would require additional local, state or federal funds, as would the estimated $33.2 million in services provided by the FFS Medi-Cal Network since these services are ineligible for MHSA funding.

In order to deal with these potential changes, DMH would do a thorough assessment and implement a plan that will minimize disruption of services to DMH's consumers and workforce. The plan would have to consider reallocation and reduction of funding and services in both directly operated and contracted programs. There are no other ACA revenues received by DMH, however, the analysis above does not include related revenue to offset administrative costs and other indirect costs and which could be subject to reduction because of the proposed ACA changes due to lower overall Medi-Cal revenue claims.

Substance Abuse Prevention and Control (SAPC) Impact Assessment

The proposed ACA repeal and replace legislation would phase out a significant portion of the federal financing for the MCE, which is the clearest threat to SAPC funding. The per-capita cap for federal Medicaid funding could also pose a substantial threat. However, the specific effects of this policy change would depend on the State's reaction to this broader reduction in federal financing.

SAPC projects that 45.5% (or 23,815) of patients will be covered through the MCE. Based on the 95% FMAP for Medi-Cal-reimbursable services in 2017, the proposed legislative changes to the ACA could significantly impact the estimated MCEO revenue of $210.9 million, relative to $521.7 million in total projected program spending (the total program spending includes certain program costs that are not covered by Drug Medi-Cal (DMC), such as room and board, recovery bridge housing, My Health LA, and criminal justice programs' extended residential stays). Changes to Medi-Cal eligibility and financing would also impact access to substance use disorder (SUD) services for other County departments' clients (e.g., DPSS) who are required to receive SUD treatment as a condition of participation in certain assistance or criminal justice programs.

Most MCE service expansion has occurred at the contracted provider level since SAPC only has one directly operated facility – Antelope Valley Rehabilitation Centers (AVRC). Changes to eligibility and federal financing for the MCE population would likely result in a marked decrease in persons served and would strongly impact contract providers, who have added new staff and facilities due to the ACA and DMC-ODS waiver expansions.

Currently, DHS and DMH do not have DMC-certified locations. Therefore, SAPC provides very limited financing to either department, approximately $1.7 million for DHS medical services at AVRC and $918,000 for various DMH programs (e.g., Lamp, Dual Diagnosis Program, AB 2034 Housing Homeless, services at Social Model Recovery and Behavioral Health Services, and the annual Integrated Care Conference).

In-Home Supportive Services (IHSS) Program Impact Assessment

The proposed ACA changes could potentially impact over 16,000 IHSS recipients that are not receiving SSI payments and are covered by Medi-Cal under the expansion (individuals between 19-64). Many would be moved to the residually uninsured population. Due to the IHSS funding structure between the counties and the State, DPSS is unable to determine the fiscal impact of this potential move at this time.

DPSS Impact Assessment

The Medi-Cal enrollment counts for LA County increased by over 1.2 million individuals, or approximately 632,000 cases due to the MCE. The expanded population would be the largest population impacted by the proposed ACA changes, and would impact DPSS' administrative funding. The State, counties and the County Welfare Directors Association of California are in the initial stages of developing a new county administrative budget methodology, to be implemented during FY 2017-18. The fiscal impact of changes to the ACA on DPSS's administrative funding cannot be determined at this time. The County currently receives $176.5 million in Medi-Cal funding to administer the ACA. This funding is used by DPSS to cover the cost of approximately 1,027 Eligibility Workers and 128 Eligibility Supervisors, along with the corresponding overhead.

Additionally, the proposed ACA changes would significantly impact federal funding for General Relief recipients who were enrolled in Medi-Cal as part of the MCE.

Finally, the proposed changes in the eligibility redetermination period from 12 months down to six months for the expanded population would be an added workload to the department, since staff would be required to process case renewals more often; DPSS expects a higher rate of discontinuances. Historically, 27% to 30% of beneficiaries lose their coverage each month during renewal, this number may double for the expanded population as they would be required to submit an additional renewal.

WORKING GROUP ON STATE STRATEGIES

As previously reported to the Board, a working group of stakeholders was assembled to develop strategies on how California could deal with the potential ACA repeal/replace changes and serve to maintain and extend the gains made under the ACA. The working group held the fourth and final meeting of the first set of stakeholder meetings on July 14, 2017. Participants reviewed the "strawperson" scenarios and the extensive comments that were made by stakeholders prior to the meeting (Attachment II). The meeting went well. Several participants commented that it was one of the best planning processes that they had participated in. Although there was no consensus reached yet on what the next best steps for a California health plan would be, there was consensus on continuing the process.

The group agreed that it would be most productive to split into two groups. One group will focus on the next steps if the ACA is significantly repealed. This group will look into the feasibility of establishing a California state individual mandate, a state employer mandate, a state requirement for minimum insurance benefits, and potential revenue streams to replace lost funding. The second group will look at ways to extend coverage to the residually uninsured by focusing on ways to improve care while also decreasing costs such that the saved money can be used to extend coverage.

We are currently discussing with several health philanthropy organizations regarding funding ongoing facilitation of the meetings and the extensive technical work necessary to determine the feasibility of the different ideas that were raised in the stakeholder process. Additional meetings of the two groups are scheduled for September.

We will continue to provide regular updates to the Board as the ACA repeal/replace efforts continue to evolve. If you have any questions or would like to discuss further, please contact me anytime at (213) 240-8101.

Attachments

c: Executive Office, Board of Supervisors
Auditor-Controller
Chief Executive Office
County Counsel
Health Services
Mental Health
Public Health
Social Services

COUNTY COUNSEL
LOS ANGELES COUNTY

ACA REFORM LEGISLATION

August 2017

As a component of the report back to the Board of Supervisors, County Counsel prepared the following analysis of recent Federal legislative efforts to repeal and/or replace the Affordable Care Act. The analysis includes the American Health Care Act, the Better Care Reconciliation Act of 2017 and an Amendment to the American Health Care Act (known as the "skinny" repeal).

It is expected that when Congress resumes on September 5, 2017, many if not all of the components included in the earlier proposed legislation and set forth below will again be raised in some form as part of any continuing repeal and/or replace effort of the Affordable Care Act. County Counsel will continue to update this analysis as needed.

The analysis also includes a summary of other potential efforts that the Presidential Administration may pursue that may not require Congressional action.

ANALYSIS

1. Medicaid Expansion ("MCE")

POTENTIAL CHANGE	PROJECTED IMPACT
MCE Category • Gradual phase-out of Federal match from 90% Federal Financial Participation (FFP) to 50% in 2024.	• Options to account for reduced Federal match: -- Reduce coverage -- Restrict eligibility -- State/local share must increase. $15 billion annually needed in 2024.
Reductions in DSH Funding Under ACA, DSH cuts are planned to offset increased revenue from MCE. • DSH cuts to take effect *only* in states that expanded Medicaid coverage (MCE). • States that did not expand coverage may get additional DSH payments.	• CA receives approximately 9% of nationwide DSH funding, or around $1.1 billion (LACo receives $360 million). • Applying the 9% to the scheduled cuts, DSH cuts would be $180 million in 2018 to $720 million in 2025. • CMS published the methodology for DSH allocations among the states on 7/28/17. Pending review.

2. Restructuring of Medicaid

PROPOSED CHANGE	PROJECTED IMPACT
FFP Cost Limits • Per Capita Cap. Establishes a per capita Federal spending limit (based on historical expenses), effective 2020. • CPI Adjustment. Increases annually by a CPI factor. • Block Grant Option. States can opt to receive block grant funding (based on the per capita cap and enrollment), and have design flexibility. State would have a lower MOE than its current share of cost.	• Medicaid inflation will outpace the CPI. • Estimated that CA state/local share would increase by $680 million in 2020 to $5.3 billion by 2027. • States may reduce eligibility, coverage, or payment to offset cost increase. • Cap on new federal funds will hinder ability of state to support public hospitals.
Hospital Presumptive Eligibility ("HPE") • Eliminated in 2020.	• 25,000 individuals per month in CA get HPE coverage. Medicaid reimbursement would not be available for these services until a full Medicaid application is processed.
Retroactive Medicaid Eligibility • Medicaid coverage to three months prior to submission of application reduced to the month of submission (except for SPDs under S.B.).	• Hospitals would no longer receive Medicaid reimbursement for this coverage period.

3. Health Exchanges and Private Insurance Market

PROPOSED CHANGE	PROJECTED IMPACT
Insurance and Employer Mandates • Eliminates insurance mandates for individuals and employers. • Increase Health Savings Accounts (HSA) contributions in 2020 under Skinny Repeal.	• The U.S. Congressional Budget Office (CBO) estimates that 7 million fewer people under the BCRA will have individual insurance by 2026, likely because they will opt not to buy it • County's cost to cover indigent care increases.
10 Essential Health Benefits • States can opt out of essential health benefits • Insurers can offer skinnier coverage so long as they sell one plan with essential health benefits (SB only). • Insurers can charge higher premiums based on age.	• Healthier individuals will likely buy the low coverage plans. •Sicker individuals will buy full coverage plans which will increase the cos.t

SUMMARY OF POTENTIAL

PRESIDENTIAL ADMINISTRATIVE EFFORTS

- **Insurance Mandate.** Per Executive Order (13765), IRS will not ask taxpayers whether they have insurance coverage.

- **Cost Sharing Reductions Subsidies (CSRs).**
  - Estimated $7 billion paid to insurers in 2016.

  - In litigation. US House of Representatives v. Thomas Price.
    The House filed suit against the Obama Administration claiming that the CSRs were not authorized by the ACA or Congress. The court ruled in favor of the House but the matter is on appeal. Recently, the appeals court ruled that States Attorney General may intervene in the case, so the case cannot be dismissed even if the Trump Administration elects to withdraw.

- **ACA Premium Tax Credits.**
  - Estimated $32 billion to insurers or individuals in 2016.
  - Elimination would require change in ACA.

- **Congressional Tax Subsidies.**
  - Employer contribution "carryover" from previous Federal health benefits to ACA.
  - Applies to Congress and its staff.
  - Elimination would require change in Federal Regulation.

- **Outreach and Enrollment Efforts.**
  - e.g. Administration canceled $5 million in ads for healthcare.gov.
  - Possible change in enrollment applications/ processes, eligibility re-determination, etc.

Section of Proposal	Organization	Comment
PARAGRAPH ONE What the goal this group is solving? What is the overall purpose of the document Is this a consensus process?	Charles Bacchi California Association of Health Plans	Are we solving for the couple million uninsured due to churn/immigration status? costs are moderate; federal hurdles are significant; solutions are not radical Are we planning a response to loss in coverage and affordability due to federal changes? Unclear cuts until 2020 Are we trying to end the current way we cover low and moderate income Californians through managed care and reinventing the entire delivery system? I don't really get it. Our Medi-Cal program is in the tail end of a massive expansion into managed care. Health plans are in the midst of complying with changing federal and state rules including network, quality, and data enhancements. We all agree the program needs more state funding to draw down more federal dollars. That doesn't take a massive reorganization of the program it takes a commitment from California government to dedicate more general fund dollars to Medi-Cal.
	Erica Murray CAPH	CAPH strongly supports the broad goals of coverage expansion, health equity, and cost reduction. It would be helpful to have a set of principles as a guide for what we are trying to accomplish (maybe this is related more to the problem statement or goal). • One such principle should be that in a state with a third of all residents living at or below 200% FPL, it is imperative that California protect and support a strong, robust health care safety net that can provide access to high quality care to all those who need it. Such protection includes ensuring that safety net providers have adequate rates and other payments to provide this access. • Another principle could be that the State should invest more directly in the Medi-Cal program.

Section of Proposal	Organization	Comment
	Louise McCarthy CCLAC	Purpose of Document**:** Is this document meant to sum up and build upon the various recommendations the group has considered, or is it a stand-alone document with additional recommendations, beyond those already discussed? If it is meant as a summary of the work, why are some prior recommendations included and others not? If it is not a summary, how will recommendations from other groups come forward for consideration?
	Louise McCarthy CCLAC	No Consensus**:** • To date no consensus has been achieved nor sought on any proposal discussed at the stakeholder convenings. The group has merely reviewed options and discussed some concepts at a very high level. • CCALAC has not taken a formal position on any of the proposals discussed in this document or any other. We would need to seek input and a formal vote from our full membership before taking a position on any recommendations from this body.
PARAGRAPH 2: We are committed to expanding coverage under both scenarios by increasing revenues and reducing unnecessary care and administrative costs.	California + Advocates/CPCA	Where are the additional revenues coming from?
	Brianna Lierman Local Health Plans of CA	What are the key administrative simplifications and decreases in unnecessary care being targeted to generate the savings needed to fund Golden State Care?
PARAGRAPH 3: Harmonize Medi-Cal, Covered California and the county-run managed care mental health and substance use treatment systems	Louise McCarthy CCLAC	Is this the overall goal of the proposal? Does harmonize mean merge? Does this include enrollment, payment, and managed care functions? In the scenarios that follow there is little information on how this harmonization would look.
	Charles Bacchi California Association of Health Plans	This recommendation is concerning. There are currently five different models for Medi-Cal Managed Care and nearly 20 different health plans contracting with DHCS to administer the program. We operate the COHS, Two-Plan, Regional, GMC and two other county based managed care options. If this group is proposing to wipe out Medi-Cal Managed Care plans and their unique models and replacing

Section of Proposal	Organization	Comment
		with a single statewide plan we would be opposed. This would lose the value of local health plans aligned with county governments and public hospitals, competition between public and commercial/non-profit plans, and choice for enrollees in the GMC counties. This proposal also raises governance issues since DHCS and Covered California are governed under different statutes and have different federal frameworks for providing coverage. For example, Covered California's core duty is to pair federal subsidies to enrollees paying out of pocket for some premium and out of pocket costs. Medi-Cal has no premiums- no subsidies- and no out of pocket costs. Instead it is governed through federal waivers that stipulate how funding can be spent. Federal subsidies are only available through exchanges at this time. Federal requirements for QHP's differ from federal requirements on Medi-Cal plans. There are however some standards and requirements that could be aligned between the two systems and a more constructive approach would be to focus on those differences and seek to standardize where appropriate.
	Barbara Ferrer LA Dept Public Health	Is this a place holder for a public option as opposed to a proposal that allows for multiple health plans that all are required to offer the same integrated set of services?
	Stuart Bussey Union of American Physicians and Dentists	The integration of Medi-Cal, Covered California, and county managed care systems is a noble goal, but will take many years to effectuate. Matching EHR systems would be the first step down this road.
	Anthony Wright Health Access	HARMONIZATION: The biggest new concept in the paper, and something only tangentially discussed in this process, is the overall vision to "harmonize Medi-Cal, Covered California, and the county-run managed care mental health and substance abuse treatment systems into a better coordinated and eventually a single universal managed care health plan for low-to-moderate income Californians."

Section of Proposal	Organization	Comment
		This sounds like an important goal, and raises some questions: What does "harmonizing" mean? Is this proposing a full merger of these programs? Under Medi-Cal, Covered California, Counties, or a new entity? • Without more details, it's hard to tell if we are levelling up or levelling down the care provided. Medi-Cal is a better benefit/cost-sharing structure for low-income patients with many needs and has a network of providers focused on those specific needs, including public hospitals and clinics. Medi-Cal patients shouldn't want to give that up; Nor would private Covered California patients want to be scaled back to just Medi-Cal providers or some of the hassles Medi-Cal patients put up with. We could get the best of both worlds, or the worst of both worlds for patients. • The feasibility issue is that versions of this proposal would involve a lot of dislocation and potentially a lot of money (say, to raise Medi-Cal rates), so we need to have clear, articulated goals for what we want at the end of it for that level of investment and turmoil. • Doing a major reorganization during a hostile federal Administration raises concerns—even if the ACA remains, we will have uncertainly hanging over the programs for the next few years, and we are not sure California wants to contribute to that. • The idea of harmonizing multiple programs, including Medi-Cal, Covered California and others, evokes many of the Sacramento conversations at the beginning of ACA implementation to create a brighter line of "public health care" and then a "private market" above that. It was part of the rationale to roll Healthy Families into Medi-Cal, and also seemed to be something during the debate over a Basic Health Plan—which raised similar questions. California explicitly chose not to go down the path of the Basic Health Plan, for a variety of reasons, including the potential impact it would have on the individual and small group markets as well as the state general fund exposure. We recognize that wherever we draw the line (100%, 138%, 200%, etc), there will be churn above and below, so we are not sure if it's a huge difference where that line is, and if it is worth the disruption.

Section of Proposal	Organization	Comment
		• We note that harmonization between Medi-Cal and Covered California is important, but so is harmonization between Covered California and the private marketplace. Almost 70% of those who leave Covered CA go to private coverage and most of that is ESI. Only 16% go to Medi-Cal. (About 15% become uninsured) (See slide 1 of 2015 survey: http://hbex.coveredca.com/data-research/library/Active-Membership-Slides.pdf) There are policies that we would support under a "harmonize" agenda: • Health Access has already been pursuing an agenda of harmonizing the regulation of private and Medicaid managed care plans—on timely access, language access, the recent network adequacy surveys, and the DMHC complaint hotline. We have sought DMHC regulation of COHS for exactly this purpose. What else is there to do on this agenda, where we expect the same protections across markets (Medi-Cal, Covered California, private, etc)? • Just harmonizing services (health, mental health, human services, housing, etc) within the county would be a major effort. We are just starting with whole-person care pilot projects, and other efforts. What is the agenda to further encourage counties to make those connections? We would be interested in exploring integration efforts within county services. • Health Access supports efforts (that have had varying degrees of success) of bringing safety-net providers and plans more into the private market. Helping the Local Initiatives to participate in Covered California (both under the vision of "public option" and just for the practical benefit of more competition and alignment/potentially less churn), has involved steps from allowing Covered California to collect premiums to facilitating the ability to offer a regional network. We have also supported efforts to make it easier for safety-net providers to be able to contract with private plans and be in those networks, as "essential community providers."

Section of Proposal	Organization	Comment
PARAGRAPH 4: The plan would include coverage for undocumented residents, emphasize health equity and eventually provide a single integrated benefit of physical health, mental health and substance treatment services with a single network of providers. The plan would no longer be called Medi-Cal – but would instead be given a name evocative of our state such as Golden State Care.	Charles Bacchi California Association of Health Plans	Is this the state direct contracting with providers? If so, we would have concerns over the lack of expertise and bandwidth the state has to accomplish this- not to mention the role that the DMHC plays in ensuring that health plans provide consumer protections. Thousands of provider contracts would have to be administered by the state compared to the 20 or so managed care contracts. Speaking of which, is this a return to a fee for service model that unwinds all the advances of managed care payment reforms? That would be unwise.
	California + Advocates/CPCA	What is a "single network of providers"? Who runs Golden State Care? Covered CA? DHCS?
	Erica Murray CAPH	The specific concept of Golden State Care needs more vetting and details before we can agree that it is the ultimate goal of this group process. For example (not an exhaustive list): • How would the programs merge? Would Medi-Cal continue to be state administered? Would one program be "in charge?" • What would the impact of such integration be on the health care safety net? • Are there potential alternatives for us to consider that would improve integration and coordination without total programmatic integration? It would be helpful to consider alternatives before selecting one approach.
	Brianna Lierman Local Health Plans of CA	Would Golden State Care be administered by a single state agency? Would the agency contract with health plans, similar to how Medi-Cal managed care works today? How would payments to providers be set and flow under the Golden State Care delivery system? What benefits would/not Golden State Care cover?

Section of Proposal	Organization	Comment
		How would member/provider grievance and appeals systems be administered in Golden State Care? What financing/funding mechanisms are being considered to support Golden State Care? What key tasks need to be accomplished to achieve effective coordination of mental health services contemplated under Golden State Care?
	Anthony Wright Health Access	BRANDING: The other big, new idea is about rebranding the system "Golden State Care" or something like that. Given how much we are truly dependent on Medicaid dollars: does it help or hurt politically to have our own branding? Haven't we found that it is a problem that people don't recognize that a cut to Medicaid nationally that we are campaigning against is actually a cut to beloved local programs that they rely on? At least Medi-Cal and Medicaid sound related with a CA twist (which is about right), but if the brand was completely different, that would make our work harder to make the connection with the public about cuts to the program. In this debate, we have found out how much we are dependent on the federal government—if anything, this experience would argue to keep Medi-Cal, if not revert the name back to Medicaid.
SCENARIO #1 COMMENTS #2) Institute a broad employment mandate to increase the number of people who have employment based insurance.	California + Advocates/CPCA	How do we institute a broader employer mandate?
#3) Develop new revenues specific to maintaining existing	Charles Bacchi California Association of Health Plans	This is the 800 lb gorilla in the room. Knowing how much you have to raise in order to keep the status quo is likely a back breaker before you even start to contemplate expanding coverage. All the other proposals have to take a back seat

Section of Proposal	Organization	Comment
health insurance benefits.		until we know how much revenue it takes to keep what we have- that should be step one.
	Stuart Bussey Union of American Physicians and Dentists	As for the primary equation of generating revenues I agree that legislation and/ or referendums on "sin taxes" -sugary sodas, tobacco, oil extraction, etc should be pursued ,especially if ACA is repealed VLF tax increase is another possibility The other suggestion I made at an earlier meeting is soliciting money and grants from private corporations Tax deductions and credits from private corporations and foundations (Colorado , Hawaii) have generated moneys for physician recruitment. Why not reach out in some way to fund --healthcare for all As for the state and employer mandates to help fund this universal access , care should be taken to clearly label them as taxes and avoid the arguments that beleaguered the Feds with the ACA . of course these mandates should be graduated accdg to individual income and business size
#4) Implement decreased administrative burdens and reduce unnecessary care to save money compared to current system.	California + Advocates/CPCA	What is the role of DHCS, DPH, Covered CA in this? Are we talking about c-sections? What else?
#5) Continue to fund current Medi-Cal beneficiaries at current coverage levels, through combination of new revenues as well as decreased administrative	California + Advocates/CPCA	What are we thinking about with IPAs? “middle men” organizations? Do we need regulatory standards for IPAs?
	Stuart Bussey Union of American Physicians and Dentists	As for reduction of admin costs Medicare has the best track record and should be our benchmark along with the low overhead ofLA care Reducing unnecessary healthcare costs can occur through a tight utilization review process on one level ,

Section of Proposal	Organization	Comment
costs and reduced unnecessary care.		and the creation of a panel of overarching HC experts including mds rns ethics personnel social workers....Similar to the Board suggested in SB 562.
	Erica Murray CAPH	What evidence do we have that there are/would be sufficient funds achieved through decreased administrative costs and reduced unnecessary care to pay for salvaging Medi-Cal expansion? How would these savings be calculated?
#6) Retain subsidies in Covered California for low and moderate-income Californians purchasing insurance on the exchange.	California + Advocates/CPCA	Does Medi-Cal become one of many plan products on the Exchange?
#7) If there were no longer exchanges or if subsides dramatically decreased, propose a public option including a buy-in to Medi-Cal supported by state and county dollars.	Charles Bacchi California Association of Health Plans	This concept is very sketchy. There is a multitude of issues that need to be fleshed out before it should be recommended as a legitimate option. Lets not forget that provider payment rates differ between Medi-Cal and the exchange. Is this proposal based on reducing provider payments to Medi-Cal levels? Remaining federal subsidies could not easily be transferred to Medi-Cal. Medi-cal is not designed to have cost sharing. How would premiums be set for those who "buy in" to Medi-Cal? Who would administer collection of premiums and collection of subsidies?
	Wendy Schiffer LA Care	Would the public option be a Medi-Cal buy-in or could it be public plans competing on the exchange? Could regional partnerships among public plans be developed?
	Stuart Bussey Union of American Physicians and Dentists	I agree that a public option would be an effective tool for lower income people .If not legislated how about a referendum?
#8) Enhance county level coverage models for the residually uninsured	California + Advocates/CPCA	Do the County health programs and local health plans also become plans/programs of Covered CA?
#9) Focus on provision of primary care homes	Stuart Bussey	Primary care homes, care pathways and economical and realistic formularies should be an important part of the plan Since the mouth is the "gateway " to many

Section of Proposal	Organization	Comment
	Union of American Physicians and Dentists	diseases some preventive dental care and education should be provided to all who are eligible
#11) Incentivize integrated care models (e.g., inpatient, outpatient, home care).	California + Advocates/CPCA	How does HIT fit in? Transparency needed through an all-payer claims database? Start with single payer claims database Do we need a statewide HIE?
	Stuart Bussey Union of American Physicians and Dentists	incentivized integrated care should be fairly monitored for providers in the form of P4P For patients there should be incentive subsidies or reduction in costs or copayment for those participating in tobacco or weight reduction programs "Rewards" for achieving milestones in weight reduction or smoking cessation should be considered
	Brianna Lierman Local Health Plans of CA	How do the proposal's concepts such as care pathways, integrated care models, primary care homes, alternative payment models, and population health interventions for high utilizers differ from, build upon, or replace what plans already do today?
	Wendy Schiffer LA Care	Many of the provisions are already being implemented (e.g. primary care homes, integrated care, population health interventions) but probably not universally. Would this plan mandate, incentivize, and how?
#13) Use alternative payment models in place of fee-for-service	California + Advocates/CPCA	In what cases will we need CMS approval? What are we assuming here as it relates to CMS willingness to engage? How are we accounting for federal protections like PPS? DSRIP is through waiver? DSH payments? CAH payments? How does 1115 waiver play into this? Are there risks to opening the waiver right now? Would we need a 1332 waiver too? How do we think through process and provider buy in? FQHCs started APM conversation in 2011 and in 2017 still no APM.

Section of Proposal	Organization	Comment
	Stuart Bussey Union of American Physicians and Dentists	Alternative pay models such as capitation, bundled payments etc should be on the table Health savings plans for healthier patients should be considered
#14) Provide palliative care on an outpatient and inpatient basis.	California + Advocates/CPCA	Do we add it to the essential health benefits?
	Stuart Bussey Union of American Physicians and Dentists	Palliative and hospice care should have clear criteria as far as when to institute
#15) Encourage use of patient portal and texting patients to exchange information	Stuart Bussey Union of American Physicians and Dentists	Pt - Provider communication through emails ,texts , and E consults are a good idea
#16) Bid drug, medical device, and durable medical equipment (DME) prices for the entire state (this program plus State jail system). Bid process would result in a single recommended drug/device/DME in each category, giving drug companies an incentive to lower their cost to become the recommended drug.	Charles Bacchi California Association of Health Plans	Drug prices are a real problem in our health care system so we appreciate the focus on new ideas to lower them. It is important to remember that drug rebates exist already. How much lower would they really be under this proposal? Other states (Texas) tried to create a statewide formulary to accomplish this goal and actually saw drug prices increase. I believe California's health agency spent several years working on this issue- perhaps they could help inform this concept. A place to start may be looking at the state's fee for service Medi-Cal drug purchasing and those of corrections/general services/etc before trying to tackle Medi-Cal managed care where in most cases drugs are carved into rates.
	California + Advocates/CPCA	How is 340B implicated or not? Should it be? What about state eligible drug rebates?
	Brianna Lierman Local Health Plans of CA	If the state were to bid and purchase drug, medical device and DME for all health care programs, how would those health care services and benefits then be administered? By the State under a fee-for-service delivery system? What would the impact be to other programs such as 340b? What would the impact be, if any, to dispensing fees?

Section of Proposal	Organization	Comment
	Wendy Schiffer LA Care	Short of a single plan (Golden State Care), would a single negotiator for drugs, etc. that would be used/paid for by multiple plans be allowable?
	Anthony Wright Health Access	BULK PURCHASING: The unified bargaining for drugs and medical devices with a unified formulary is something that has already been explored, but more policy work is needed. While the benefits are clear, taking away over 20% of care from the management of the plan raises a question about managed care—at least in theory if not in practice, a plan should be monitoring and adjusting their preferred practices between medications vs. counseling or other interventions. Even having one unified formulary under, say, Covered California, or even Medi-Cal, would be a big deal—maybe that would be a place to start, as part of the model contract.
#17) A single expert panel, including patients and/or patient advocates, will determine those quality, population health and equity measures that will be used by all providers. At least 80% of the measures will be those required of providers for federal quality initiatives. Plans will not be allowed to impose additional quality indicators	Charles Bacchi California Association of Health Plans	The concept here is a noble one. Health plans have to manage a multitude of different quality measures. Cal-PERS, covered California, Medi-Cal, large group purchasers, Medicare, CMS, etc, all have different quality indicators. Looking for easy areas to align those measures could be a valuable exercise. This recommendation however is too specific. By limiting quality measures (80%) to federal quality measures pre-determines an outcome that may actually not advance quality in a meaningful way. The panel's charge should be focused more on aligning public purchasers quality measures and on what measures actually measure quality and less on defaulting to federal measures. This shouldn't be a race to the bottom.
	Brianna Lierman Local Health Plans of CA	HEDIS is an existing quality measurement tool that consists of 81 quality measures across 5 domains of care. More than 90% of plans use it today. Why was HEDIS rejected and instead the new single expert panel for development of measures preferred? How would the new system for developing quality, population health and equity measures impact current P4P programs?
	Erica Murray CAPH	While we agree with the principle of parsimony, unless and until such a set of agreed-upon metrics is developed and implemented, public health care systems are reliant on the multiple pay-for-performance programs that help us drive

Section of Proposal	Organization	Comment
		transformation and receive supplemental payments needed to keep the lights on. The byproduct of these multiple P4P programs is a wide array of performance metrics we must measure and report. Not ideal, but at the moment necessary. Therefore, if this recommendation were to be implemented, it must be accompanied with a commitment to adequate safety net financing and meaningful incentives for transformation.
	Barbara Ferrer LA Dept Public Health	Is there an opportunity to include language here that requires that the measures capture the experiences of sub-populations at higher risk for poor health outcomes.
	Larissa Estes and Manal Aboelata Prevention Institute	Add more specificity to the composition of the expert panel that will identify quality, population health, and equity measures to be used by all providers. It should be: • representative of California's diversity, • inclusive of groups impacted by the healthcare system, including residents, • reflective of subject matter expertise in non-clinical, community & population wide approaches, as well, • focused, in part, on measures that identify how health outcomes are produced at the community level and how health equity can be achieved by addressing the determinants of health. • See for example: *Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health*
	Wendy Schiffer LA Care	What is the scope of the single, expert panel? How would panel members be selected and what constituencies would be represented? Why are plans being precluded from imposing quality indicators and if so, will they be represented on the panel?
	California + Advocates/CPCA	Are we starting over? Is there anything we can do with IHA? Can we learn from their process? How do we build in social determinants of health?

Section of Proposal	Organization	Comment
#18) Enable local public Medicaid plans (COHS and Local Initiatives) to cover those patients currently in Covered California and to provide service in areas that do not already have a public option.	Charles Bacchi California Association of Health Plans	Public plans can (and some do) offer coverage through covered California. It is an expensive and burdensome process to become a qhp- thanks to federal and state requirements. Many public plans decided not to participate in covered California. Unclear on what you mean by "enabling." Obviously we support participation in the exchange but are leery of mandates to do so. Not all plans are eager to collect premiums- create new provider networks- manage cost sharing- etc. Also, does this recommendation envision public plans offering commercial coverage outside of their geographic service areas?
	Wendy Schiffer LA Care	local public Medicaid plans can currently choose to offer a Covered California plan but only L.A. Care has chosen to do so. Is the goal to get more public plans offering plans on Covered California, or is the goal for them to serve the Covered California population in their Medi-Cal plans (e.g. a Medi-Cal buy-in)?
#20) Effectively coordinate county mental health and substance abuse services with medical services.	California + Advocates/CPCA	Should we consider better enforcement of parity? Now requirements are only on county plans. Should DMHC regulatory schedule should be used as model? Should we try to secure transparency in the MOUs between plans and counties? How do we think about the data exchange? What is needed? How do we manage benefits for commercial and/or exchange products related to mental health?
SCENARIO #1 BENEFITS		
Would eliminate churn of patients from Medicaid to the Exchange and the Exchange to Medicaid. When beneficiary income increases or decreases, the only change would	Charles Bacchi California Association of Health Plans	Not sure this is as easy as it sounds. QHPs and Medi-Cal plans don't always overlap neatly. How do you handle a region where five plans offer commercial coverage through covered California but there is only one Medi-Cal managed care plan?

Section of Proposal	Organization	Comment
be what they would have to pay.		
Patients would no longer need to change providers when going between Medicaid and the Exchange	Charles Bacchi California Association of Health Plans	See comment above. If the proposal is to wipe out all public plans and consumer choice in the exchange by wiping out QHPs and replace with a single plan- we would be strongly opposed.
SCENARIO #2 COMMENTS	Liz Forer Venice Family Clinic	The key to #2 will be determining what remains of ACA funding and how best to use it and then to build the rest of the system around it. The tricky part with both #1 and #2 is that many of the things that are so simple to write down take huge amounts of work to accomplish. So we would need to be somewhat realistic as to what we could accomplish. Therefore, trying to prioritize what is most important and must come first will be critical. I would hope that we could speed up payment reform as that would really help the shift to many of the cost saving items and help make them happen more rapidly. If we can provide the right rewards than the system will shift more quickly.
The cost of the care of the undocumented would be covered through: 1) money the state currently spends on the undocumented through specific state only programs such as limited scope Medical; 2) funds that the counties spend on the care of the undocumented;	Erica Murray CAPH	Is the suggestion that counties would provide all funding related to care for the uninsured? What issues arise when using DSH for coverage? What would counties need in return for the use of these funds? I will ask our Policy and Technical Advisory Committee (PTAC) to consider financing issues.

Section of Proposal	Organization	Comment
3) savings from the administrative simplifications, decreases in unnecessary care, and drug cost reduction in this plan.		
Dedicate funding to population health programs that have shown the ability to lower the cost of care and reduce health disparities.	Barbara Ferrer LA Dept Public Health	Since the evidence is compelling that such programming saves money, I think this item should be included in both scenarios. The funding stream could initially come from one time assessments on large health insurance plans and large hospitals (that can count towards community benefit obligations); subsequent funds can come from a percent of 'savings' realized from implementation of prevention efforts.
SCENARIO #2 NEXT STEPS We also need an analysis of the workforce needs and how we will achieve them.	California + Advocates/CPCA	Need to discuss our goals for workforce What are we doing about Pipeline? Do we need to consider a major investment in Residency? GME? Need principles of what is our ultimate vision to guide. How do we want to build in Promotoras and community health workers?
	Larissa Estes Manal Aboelata Prevention Institute	Workforce development needs to be inclusive of K-12 improvements to support higher education and the healthcare / public health career pipeline.
SCENARIO #1 AND #2 COMMENTS	Louise McCarthy CCLAC	Recommendations/Features**:** The features described in the document are a mixture of both broad principles and specific policies, along with some existing features of our current system. There's very little detail explaining how some of the policies would be funded, while others are very specific. Actual policy

Section of Proposal	Organization	Comment
		recommendations should be separated from principles, and should be fleshed out with more detail. Further, status quo elements need not be called out explicitly.
	Erica Murray CAPH	Are the features considered a package? Or independent from one another? Are they iterative? Piecemeal? Are there some that are contingent on others? For example, under Scenario 1, Features 7 and 8? Similarly, how should the features be prioritized? Based on available funding? How "big" should we go for each? How should we determine what funding stream is connected with what feature? Eg paying for Exchange subsidies versus salvaging Medi-Cal expansion.
	Louise McCarthy CCLAC	Are there any recommendations in either scenario to improve Denti-Cal? In the Med-iCal proposal our group recommended that LA and Sacramento Counties return to Denti-Cal Fee for Service, like the rest of the state.
	Larissa Estes and Manal Aboelata Prevention Institute	Where possible, include language emphasizing the important role that determinants of health play and include opportunities for financing population level interventions: • Data suggests that health outcomes are largely driven by social and economic factors (40%), health behaviors (30%), and the physical environment (10%) and much less by clinical care (20%)1 • Systems and providers should increasingly be incentivized to engage in intentional community and cross-sectoral partnerships that directly shape the social and economic factors and the physical environment. • Providing flexibility to implement such innovative payment models has the potential to greatly improve population health beyond what traditional medical care can do alone. • See, for example https://www.cdc.gov/policy/hst/hi5/index.html: "The Health Impact in 5 Years (HI-5) initiative highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier."

Section of Proposal	Organization	Comment
		Include strategies that would invest some cost savings into agencies, infrastructure, and approaches that work to prevent illness and injury in the first place. • Look to learn from successes and challenges of models from across the country that have relevance, such as Massachusetts, Vermont, Richmond, CA, etc. • Identify a portfolio of financing mechanisms, some of which will help to capture and reinvest in primary prevention (to reduce some sources of underlying demand on the system and break cycles of high-utilization). Add language that would enable / incentivize practitioners and systems to partner with community collaboratives to address the community conditions that contribute to producing medical high utilization such as housing, employment, education, and social connectivity. • Current strategies that focus on reacting to immediate needs and coordinating care, are critical for the 5% of the population representing 50% of total healthcare costs, and there is even more to be gained through interventions that prevent illness and injury in the first place—it's a key to long term success. • For more, see: Disrupting the Pathway - A Prevention Approach to Medical High Utilization
	Fred Leaf	It appears the aspirational goals are on point based on the discussions during the three meetings we have had to date. A number of the features of the scenarios are at least cost neutral and, in some cases, will generate cost savings. The "monster" in the room is the funding required to cover potential lost federal revenue and/or the costs of program expansion (e.g. residually uninsured). The two primary sources of funding are additional revenues and cost savings, primarily through new taxes and program efficiencies.

Section of Proposal	Organization	Comment
	Anthony Wright Health Access	The long lists compiled include many familiar ideas, including ones that Health Access and our consumer advocacy coalition has supported, if not sponsored and championed, over the years: coverage expansions in Medi-Cal, affordability subsidies for private coverage and the tax revenues to pay for them, employer mandates, incentives for improved and expanded county-based programs, inclusivity of the undocumented, bulk purchasing and bargaining, greater accountability on access, quality, and cost, greater focus on preventive and primary care, and more. Some of these campaigns are active, ongoing efforts as we speak in the Capitol and around the state. We presented on some of these topics, and we welcome the conversation to bring additional support to these efforts. Yet even on these ideas, we would need much more detail to say we support a particular proposal, much less to agree that we have consensus. It is critical to know how they cost out; how they relate to one another; what their relative priority is; and what obstacles are involved. We have critiqued other proposals, at the state and federal levels, that lack the details needed to give consumers comfort about their access to care. On all these items, there is a two-part analysis: 1) whether we all support the idea, both the concept and the down-and-dirty details, and 2) the feasibility, and whether the "juice is worth the squeeze" in terms of the potential costs, dislocations, and political obstacles, weighed against the tangible benefit to consumers.
OTHER COMMENTS	Stuart Bussey Union of American Physicians and Dentists	Reaching out to the California Bar may result in some needed legal and malpractice Reform (health courts, no fault insurance) as legal fear and defensive medicine is a major driver of medical cost For those providers who deliver the services mentioned above --the encouragement of hiring employees who can collectively bargain and the discouragement of hiring more expensive contracted employees would save money and improve care in the long run.

Section of Proposal	Organization	Comment
		UAPD stands ready to help make these plans a reality!
	California + Advocates/CPCA	We are supportive of the larger goal to improve the whole system…but cannot fully endorse Golden State Care at this point in time.
	California + Advocates/CPCA	1. Are we ready for the political process and introducing a bill in January? 2. How does this relate to SB 562 (Lara/Atkins)? 3. Can we think through easy first steps before taking on the full idea? 4. What are some policies that we think are politically doable for an initial, early win for this coalition? We need to build up a track record for working as a coalition and build up trust among the coalition. 5. Should we develop principles? Are we just consolidating what we have now? We would like to see the entire system shift towards a heavy investment in primary care. How else can we build in patient/consumer agency? 6. If we shift towards primary care, how can we be assured that hospitals are still excellent and strong and viable? 7. Is there anyone else we need to invite to the table? 8. What do we see as the commitment each organization will need to contribute to achieving our goal? ACA took decades to build. 9. Is there going to be funding for staff to commit resources to researching and lobbying these system-wide ideas?
PROCESS COMMENTS	Brianna Lierman Local Health Plans of CA	Given the uncertainty at the national level, we still do not yet know whether we are facing Scenario #1 (repeal) or Scenario #2 (no repeal) outlined in the proposals. But the scenarios are vastly different. Regardless, in either one, the task before us is too important and complicated to conclude the conversation in one meeting on July 14. Local health plans are committed to being a productive part of the vision for the future. To that end, we look forward to continuing to work with you and our State Strategy colleagues in the coming months as we make our way through this unprecedented time together
	Erica Murray CAPH	Before a state planning workgroup is developed to identify policy proposals and revenue sources, there is more work that this body should conduct in order to

Section of Proposal	Organization	Comment
		ensure that there is actual consensus. Thus far we have scratched the surface of policy concepts, but would need to better understand how each concept would be actualized. For example, the group agreed on reducing unnecessary care – but we have not yet considered potential policy/regulatory requirements for reduced care, calculating the savings based on those reductions, and using those savings for accomplishing an alternative policy goal. Once we understand the "how" – or, more accurately, potential choices of "how" – we could convert those choices into legislation. The scenarios are vastly different from one another: we either have an opportunity to build on our great achievements, and consider improvements that had previously been impossible with such high levels of uninsured and uncompensated care. Or, we will have to consider how to salvage the coverage gains we've made, with likely less money than we will need for a complete restoration, and all the choices that will accompany such an effort. Because those scenarios are so different, and because the task before us to draft legislation is a big one, I recommend we wait to proceed with next steps until mid August in order to have greater clarity on our charge.

Proposal for a California State Strategy

Draft – For Discussion Only – June 29, 2017

Depending on whether the Affordable Care Act is repealed or not, we have a unique opportunity to advance the healthcare system in California. Our proposal is based on the strong alignment that we have seen in a wide group of health care stakeholders who have participated in a consensus process, including health care advocates, health care providers, union leaders, clinics and hospitals in both the public and non-profit sectors, insurers, organized physician groups, public health advocates, philanthropists, and government officials.

This proposal and its two scenarios are intended to stimulate discussion at our July 14 State Strategy session. We are committed to expanding coverage under both scenarios by increasing revenues and reducing unnecessary care and administrative costs. The basic difference is that in Scenario #1 savings are used to replace a portion of the lost ACA dollars. In Scenario #2 savings they are used to expand coverage to the residually uninsured (primarily the undocumented).

To the fullest extent allowed by law, we propose, in both scenarios, to harmonize Medi-Cal, the California Health Exchange (Covered California) and the county-run managed care mental health and substance use treatment systems into a better coordinated and eventually a single universal managed care health plan for low-to-moderate income Californians. The plan would include coverage for undocumented residents, emphasize health equity and eventually provide a single integrated benefit of physical health, mental health and substance treatment services with a single network of providers. The plan would no longer be called Medi-Cal – but would instead be given a name evocative of our state such as Golden State Care.

Scenario #1: Assumes repeal of most components of ACA and/or substantial decreases in Medicaid funding

FEATURES OF SCENARIO #1

1. Institute a state individual mandate with appropriate affordability provisions to stabilize the private insurance market.
2. Institute a broad employment mandate to increase the number of people who have employment based insurance.
3. Develop new revenues specific to maintaining existing health insurance benefits.
4. Implement decreased administrative burdens and reduce unnecessary care to save money compared to current system.
5. Continue to fund current Medi-Cal beneficiaries at current coverage levels, through combination of new revenues as well as decreased administrative costs and reduced unnecessary care.

6. Retain subsidies in Covered California for low and moderate-income Californians purchasing insurance on the exchange.
7. If there were no longer exchanges or if subsides dramatically decreased, propose a public option including a buy-in to Medi-Cal supported by state and county dollars.
8. Enhance county level coverage models for the residually uninsured.
9. Focus on provision of primary care homes.
10. Use care pathways (expected practices, guidelines) to reduce unnecessary care.
11. Incentivize integrated care models (e.g., inpatient, outpatient, home care).
12. Use population health interventions to care for patients with high utilization of services.
13. Use alternative payment models in place of fee-for-service.
14. Provide palliative care on an outpatient and inpatient basis.
15. Encourage use of patient portal and texting patients to exchange information.
16. Bid drug, medical device, and durable medical equipment (DME) prices for the entire state (this program plus State jail system). Bid process would result in a single recommended drug/device/DME in each category, giving drug companies an incentive to lower their cost to become the recommended drug.
17. A single expert panel, including patients and/or patient advocates, will determine those quality, population health and equity measures that will be used by all providers. At least 80% of the measures will be those required of providers for federal quality initiatives. Plans will not be allowed to impose additional quality indicators.
18. Enable local public Medicaid plans (COHS and Local Initiatives) to cover those patients currently in Covered California and to provide service in areas that do not already have a public option.
19. Commercial health plans will continue to function in the same manner.
20. Effectively coordinate county mental health and substance abuse services with medical services.
21. Protect full scope of reproductive health services and Planned Parenthood services covered under Medi-Cal and FamilyPACT.
22. Reimburse for home and community-based care and/or home adaptation for Medi-Cal patients who have been in a nursing home more than 60 days and do not need that level of care.

BENEFITS OF SCENARIO #1

1. Would build toward universal, affordable coverage for all California residents
2. Would eliminate churn of patients from Medicaid to the Exchange and the Exchange to Medicaid. When beneficiary income increases or decreases, the only change would be what they would have to pay.
3. Patients would no longer need to change providers when going between Medicaid and the Exchange.
4. Mental health benefits would be provided without an initial determination of whether the person has a mild mental illness or a serious mental illness. (In

current system, the county is required to pay if the person has a serious mental illness but the health plan is required to pay if the patient has a mild mental health illness).

5. Providers would no longer have to prescribe different drugs for the same condition simply because a patient was in a different plan.

LIMITATIONS OF SCENARIO #1

- Would require state revenue sources to make up for federal dollars lost through ACA repeal.
- Healthcare expansion would be postponed until a new administration is installed or additional dollars are available.

NEXT STEPS FOR SCENARIO #1

1. Work with state planning workgroup and legislative leaders to identify policy proposals and revenue sources that can be employed to preserve current Medicaid expansion funding and Covered California subsidies. (including extending Medicare tax to incomes above $170K; soda tax; DMV fee; etc.)
2. Outside body to score costs of covering those who are eliminated from ACA coverage, projected savings from features of program, and analysis of legislative, waiver, and or votes of the people necessary to bring forth vision.

Scenario #2: ACA is not repealed and decreases in Medicaid are minimal at least initially

FEATURES OF SCENARIO #2

1. Focus on provision of primary care homes.
2. Use care pathways (expected practices, guidelines) to reduce unnecessary care.
3. Incentivize integrated care models (e.g., inpatient, outpatient, home care).
4. Use population health interventions to care for patients with high utilization of services.
5. Use alternative payment models in place of fee-for-service.
6. Provide palliative care on an outpatient and inpatient basis.
7. Encourage use of patient portal and texting patients to exchange information.
8. Bid drug, medical device, and durable medical equipment (DME) prices for the entire state (this program plus State jail system). Bid process would result in a single recommended drug/device/DME in each category, giving drug companies an incentive to lower their cost to become the recommended drug.
9. A single expert panel, including patients and/or patient advocates, will determine those quality, population health and equity measures that will be used by all providers. At least 80% of the measures will be those required of providers for

federal quality initiatives. Plans will not be allowed to impose additional quality indicators.

10. Enable local public Medicaid plans (COHS and Local Initiatives) to cover those patients currently in Covered California and to provide service in areas that do not already have a public option.
11. Commercial health plans will continue to function in the same manner.
12. Effectively coordinate county mental health and substance abuse services with medical services.
13. Protect full scope of reproductive health services and Planned Parenthood services covered under Medi-Cal and FamilyPACT.
14. Reimburse for home and community-based care and/or home adaptation for Medi-Cal patients who have been in a nursing home more than 60 days and do not need that level of care.
15. Dedicate funding to population health programs that have shown the ability to lower the cost of care and reduce health disparities.
16. The cost of the care of the undocumented would be covered through:
    1) money the state currently spends on the undocumented through specific state only programs such as limited scope Medical;
    2) funds that the counties spend on the care of the undocumented;
    3) savings from the administrative simplifications, decreases in unnecessary care, and drug cost reduction in this plan.

BENEFITS OF SCENARIO #2

1. Would eliminate churn of patients from Medicaid to the Exchange and the Exchange to Medicaid. When beneficiary income increases or decreases, the only change would be what they would have to pay.
2. Patients would no longer need to change providers when going between Medicaid and the Exchange.
3. Mental health benefits would be provided without an initial determination of whether the person has a mild mental illness or a serious mental illness. (In current system, the county is required to pay if the person has a serious mental illness but the health plan is required to pay if the patient has a mild mental health illness).
4. Decrease in administrative expenses due to running a separate mental health plan.
5. Providers would no longer have to prescribe different drugs for the same condition simply because a patient was in a different plan.

LIMITATIONS OF SCENARIO #2

- There are unlikely to be sufficient funds to cover dental services or long-term care for those who are not eligible for Medicaid.

QUESTIONS FOR SCENARIO #2

1. Assuming the ACA stays in place, would there be value in extending the individual or employer mandate beyond what they are currently?

2. Is there enough money from savings to decrease copays for persons above the poverty level?
3. What changes are needed at state level to make Medi-Cal enrollment more user friendly for patients and for workers?
4. What legislative actions, federal waivers, and/or votes of the people would be required to create the California plan?

NEXT STEPS FOR SCENARIO #2

1. Outside body to score costs of covering the undocumented, projected savings from features of program, and analysis of legislative, waiver, and or votes of the people necessary to bring forth vision.
2. We also need an analysis of the workforce needs and how we will achieve them.