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Los Angeles Times; 9-23-95

Clinton Offers L.A. Aid Plan Based on Community Care

■ **Finances:** In announcing \$364-million health package, President praises proposal to move away from hospitals. Supervisor Molina says action saves lives, jobs.

By JEFFREY L. RABIN, JOSH MEYER and JACK CHEEVERS
TIMES STAFF WRITERS

A grateful Los Angeles County supervisors looked on, President Clinton on Friday announced a \$364-million rescue package designed to fundamentally restructure the county's teetering health care system as it rescues the vast network from collapse.

On the tarmac at Santa Monica Airport with a presidential helicopter as a backdrop, Clinton hailed the plan to move the county's vast public health system from a reliance on expensive hospital treatment to less costly preventive care at health centers and community clinics.

"It would have been criminal to permit these clinics to close and all of this crisis to develop not just because of the very poorest people in the county, but because of the working families on very limited incomes who don't have insurance," Clinton said.

"And that is a national issue. It's not a Los Angeles County issue. If it can be solved here with the restructuring, a lot of people all over America will be learning a lot from what you are doing. And the working families of America will be better served by it."

On behalf of the jubilant supervisors, who represent the nation's most populous county, board chairwoman Gloria Molina thanked Clinton for his assistance in the county's worst hour of financial distress. "Your announcement today has literally saved countless lives and certainly many jobs."

Yet the president's mid-morning announcement, broadcast live on local television, only served to underscore the amount of work still facing the supervisors. The county's elected leaders must still make tough decisions in the coming days and weeks to solve the fiscal crisis that drove the county to the brink of bankruptcy and the health system to the edge of collapse.

While the rescue package, with
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its one-time shot of federal dollars, will avert the threatened closure Oct. 1 of the county's six comprehensive health centers, most of the 28 community clinics and many outpatient services at county hospitals. It is not a cure-all for the ills that face the nation's second largest public health system. Officials said Friday they could not specify how many of the 5,200 layoffs and demotions that had been expected Oct. 1 now can be averted.

"There are a significant number of jobs that cannot be restored," said Burt Margolin, the county's health czar. "There clearly will be significant services that cannot be funded under any scenario."

The supervisors returned to their chambers at the Hall of Administration Downtown and decided they did not have enough information on the details of the deal to take any action on Friday.

By postponing any decisions until they meet again Tuesday, the supervisors rejected the demand of the biggest union representing county workers that they halt the layoff and demotion of thousands of health workers scheduled to take effect at the end of next week.

Gilbert Cedillo, general manager of the Service Employees International Union, Local 860, urged the board to rehire county employees who have received pink slips. "I call upon you to rescind the layoff notices immediately," he said. "Let's bring some stability. . . . We have been given a golden opportunity by the President to do this with sobriety, in a thoughtful way."

While the board decided to wait to make a decision, Supervisor Zev Yaroslavsky thanked Cedillo for the union's lobbying of Clinton. "It's clear you've had an impact on this decision, and this spirit of cooperation works much better than the alternative," he said.

With the aid package less than a day old and county health officials planning to work through the weekend to analyze its effects, there was no indication of how many of the pink slips will be withdrawn.

And the county, pressured by the federal and state government, was put on notice that it must

CLINTON:

Aid Plan Based on Community Care

dramatically change the way it delivers health services to millions of county residents who are poor or lack health insurance.

"In order to remold steel, you have to turn the heat up on that steel," Yaroslavsky said to Clinton at the airport. "Hot enough so that it is pliable. The heat has been turned up on the Los Angeles County health care system, now to the point where it can be remolded, remolded in a more effective, more efficient, cost-effective way that better serves our public."

It will not be easy.

David Langness, spokesman for the Healthcare Assn. of Southern California, which represents private hospitals, said the aid package is not salvation.

"I just hope that nobody thinks that the crisis is over. It's not," Langness said. "We've got a major crisis in health care in Los Angeles County and it's not going away."

The aid package merely buys time, he said.

"It's not a bailout. It's just a finger in the dike. It gives us a little bit of breathing room to reconfigure, redesign and retool Los Angeles County's health care system, which is a huge, huge task."

The county health system, he said, is "so complex and such a culture of dependency on in-patient care. It'll take a big change in the power structure of county government and the Department of Health Services to move away from a hospital centered [system] and toward an outpatient one."

With Congress on the verge of slashing Medicaid and Medicare funds, the county could have another \$600 million shortfall in next year's budget. "No short term bailout can fix them," he said.

Dr. Brian Johnston, an emergency-room specialist and president-elect of the Los Angeles County Medical Assn., said the federal aid was "wonderful news" and that county supervisors should now move to drastically reform the much-criticized Health Services Department.

He said the supervisors should set up a county Health Authority, as recommended by Margolin. Separate from the health department, the authority would be composed of medical experts who would carry out broad health care policies approved by the supervisors.

The \$364-million federal bailout provides an upfront infusion of money to stabilize the county's health system and prevent the closure of the nation's biggest public hospital, County-USC Medical Center.

However, over five years, the county must reduce its health care costs substantially by moving firmly toward preventive care at community health centers and clinics rather than in expensive hospital bills.

To provide care to the needy and the working poor, Supervisor Mike Antonovich said the county must still move in the direction of privatizing some of its clinics and health centers "in innovative and cost effective partnerships" with private hospitals and medical groups.

The board is expected to consider contracts with private providers next week before the Oct. 1 deadline.

Margolin, a former state assemblyman with a long record on health care reform, joined in thanking Clinton for his leadership in moving two days of intense talks in Washington toward an agreement.

"There is absolutely no way in the world that we would have been able to develop this package if the President of the United States hadn't taken some of the most creative thinkers in the area of health service delivery, ordered us essentially to go into a room in Washington, D.C., and literally lock that door until we came out with a solution."

Health care workers were cautious in the wake of Clinton's announcement.

Nurses and union leaders demonstrated all day at County-USC, saying they would continue their demonstrations and sickouts until they were sure that the jobs of all county health workers were being protected.

"We need to hear that the layoffs are going to stop, that there is going to be worker protection, that these members are going to have jobs Oct. 1," said Cedillo, whose local represents nurses and other health workers.

The sickouts continued Friday, with all 16 of the registered nurses assigned to the operating room

taking the day off. As a result hospital officials suspended all non-emergency and elective surgeries, and reserved the operating rooms only for trauma and other emergency cases, according to hospital spokesman Harvey Kern.

Nurses and other workers in the medical center's family planning clinic also stayed off the job, causing a shut-down of the clinic.

Kern said half the nurses in the medical center's pediatrics clinic stayed off the job Friday as well, forcing managers and other replacement health workers to fill in. He said the pediatrics clinic was continuing to see patients.

"We have to figure out how we are going to go about reversing this," Kern said. "Emotions are heavy. It is going to take a while to get over all this, even if we are over the crisis."

One of the operating-room nurses who didn't show, Pattie Sugerman, turned up at the hospital nonetheless to participate in the daylong series of demonstrations and news conferences outside the hospital.

"I feel some hope," Sugerman said after Clinton's announcement.

Beth Ostheimer, a senior attorney for a San Fernando Valley legal aid group that sued the county in an attempt to block clinic closures and other cuts, said her group would withdraw its suit if the county used the federal money to avert the cuts and maintain existing medical services for the poor.

uninsured.

At the airport, Los Angeles county's five supervisors were visibly jubilant about the federal bailout, shaking hands and smiling on the in front of Marine One, the helicopter that was to take Clinton to campaign-style events in Orange County and San Diego.

There was even time for joking. Supervisor Mike Antonovich likened the county's situation in recent months to that of a country-western song by Tom Lehrer, titled "Sliding Slowly Down the Razor Blade of Life."

Contributing to this story were Times staff writers Douglas P. Shult and Timothy Williams in Los Angeles and Robert A. Rosenblatt and Faye Fiere in Washington.

Los Angeles Times; 9-23-95

Clinton Sees Windfall in His Gift-Giving to State

By JOHN M. BRODER
TIMES STAFF WRITER

SAN DIEGO—To Californians, fires, floods, earthquakes, riots and recession are personal or economic disasters; to President Clinton, they offer dramatic opportunities to impress the most populous state with his powers of purse and office.

As he amply demonstrated this week, an incumbent President can deliver folding money—and lots of it.

Indeed, Clinton's promise Friday of \$364 million in accelerated federal Medicaid reimbursement funds to rescue Los Angeles County's near-bankrupt public health care system is just the latest example of his use of the White House to

deliver federal largesse to a state that is central to his reelection hopes.

It was also a chance for Clinton to make a stark visual statement to the voters of California.

As local television broadcast the event live, the President stood on the Tarmac at Santa Monica Air-

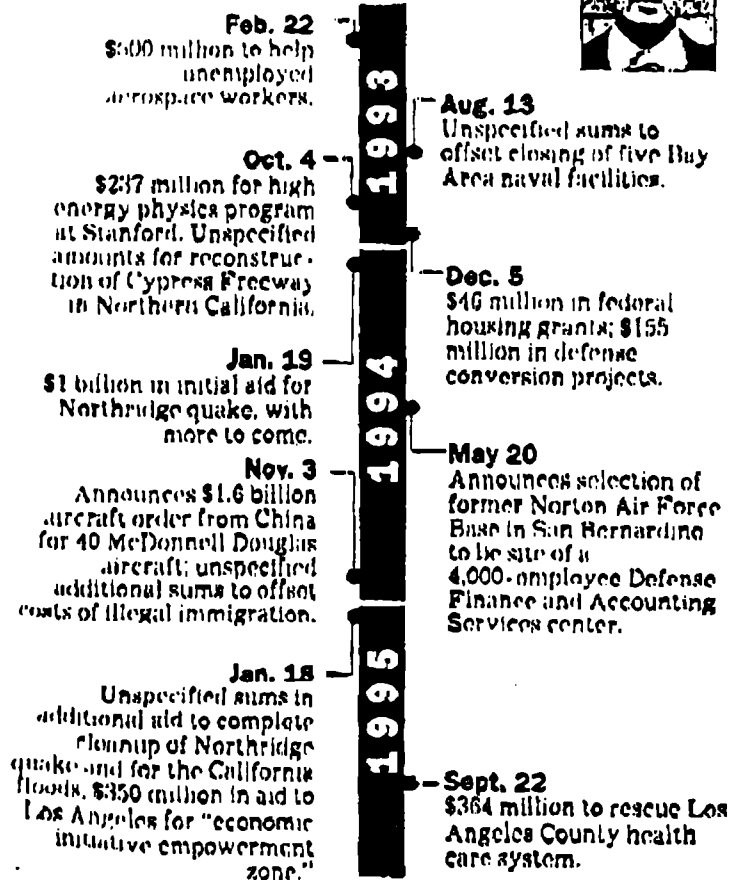
NEWS ANALYSIS

port on Friday morning with the five Los Angeles County supervisors, county health czar Burt Margolin and Mayor Richard Riordan—and without the noticeably absent Gov. Pete Wilson.

Wilson was in New Hampshire on Friday, trying to revive his
Please see CLINTON, A24

Stream of Aid

President Clinton has made these pledges of federal assistance during his 20 visits to California:



CLINTON: Seeking a Political Windfall in Aid for L.A.

Continued from A1
falling quest for the Republican presidential nomination. The White House was not shy about making political hay out of the President's role in helping resolve the county health crisis while Wilson was a continent away, pursuing his bid to take Clinton's job.

"Where is the governor today?" White House spokesman Mike McCurry asked facetiously, knowing full well where Wilson was.

"For two days we've been here solving problems in the state," McCurry said. "It took the leadership of the President to make it happen. That might provide a contrast with the contribution of the governor."

Wilson, interviewed while touring the downtown of Keene, N.H., scoffed at the suggestion that he was shirking his responsibilities. He called McCurry's comments "a clumsy effort by a frightened White House to make [Clinton] look good at my expense."

Focusing on one of his central campaign themes, Wilson added, the health care bailout notwithstanding, that the federal government is draining hundreds of millions of dollars from California by not properly enforcing immigration laws.

"Even if [the bailout money] were an outright gift, it is far less than what they impose on the

county . . . for the costs of illegal immigrants."

Clinton has now visited California 20 times since his 1992 election and virtually every visit has two overlapping purposes—to tap into the state's large and generous Democratic base for campaign contributions and to spread around federal money to alleviate disasters or soften the blow of the closing of dozens of military bases.

The catalogue of Clinton's California goodies is impressive for their size and variety. February, 1993, \$500 million to help retrain laid-off defense industry workers; December, 1993, \$200 million for housing assistance and defense conversion programs; January, 1994, \$1 billion for Northridge earthquake relief, and January, 1995, \$350 million for a new "economic empowerment zone" in Los Angeles.

The list also speaks to the state's political importance for Clinton. With its 54 electoral votes—one-fifth of the 270 needed to win the White House—carrying California is crucial under any circumstances. But given Clinton's current political troubles in Southern and border states, California has assumed "must win" status for him.

Political scientists say that there is no substantial evidence that delivering economic benefits to a state or congressional district di-

rectly affects voting patterns. But, said John Petrocik, professor of political science at UCLA, it can't hurt.

"Some have found a correlation between New Deal expenditures on public works and how well Franklin Roosevelt did in certain states. He appeared to spend money in states where he was weakest and there was some evidence of improvement," Petrocik said.

"It's probably going to help Clinton, too, by giving people in California something good to say about him and remove some reasons to be unhappy," he added.

Clinton and his top aides clearly believe that the gifts he has bestowed on California have been money well spent. Clinton reportedly ordered senior federal officials to work around the clock to draft the county rescue package in time for him to announce it before he left Los Angeles on Friday.

Senior aides were elated by the resulting accord. John Emerson, who ran Clinton's California campaign in 1992 and works full time on state issues at the White House, pumped the air with his fist like a victorious quarterback after the President announced the deal.

Another top White House official said that it gave Clinton a welcome opportunity to talk about issues that he considers strengths—health care, education and federal-state partner-

ships—and avoid divisive issues that could cut into his support in California, particularly immigration and affirmative action.

Herbert Alexander, director of the Citizens Research Foundation at USC and an expert on money and politics, said Clinton obviously believes that he cannot win reelection without California and that his generosity with federal funds is designed to improve his prospects here.

Alexander noted that the county health care aid "puts the Clinton Administration in a favorable light" particularly in Southern California, where 60% of the state's voters live.

In 1992, Clinton carried Los Angeles County by more than 700,000 votes over George Bush, more than enough to counteract Republican majorities elsewhere.

"That's a big mass of potential voters and Democrats can exploit that," Alexander said. "It's certainly better to be in a position to be able to help than to say that because of the federal budget deficit we can't do it."

But one question that remains, Alexander added, is "how much of [the favorable political capital] rubs off a year from now?"

Times staff writer Marc Lacey contributed to this story from New Hampshire.

CLINTON: Seeking a Political Windfall in Aid for L.A.

Continued from A1

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Times staff writer Marc Lacey contributed to this story from New Hampshire.

Los Angeles Times; 9-23-95

Nurses, Doctors Elated but Leery of Quick Fixes

By DOUGLAS P. SHUIT
and STEPHANIE SIMON
TIMES STAFF WRITERS

From the crowded wards at County-USC Medical Center to neighborhood clinics in South-Central Los Angeles, patients, doctors and nurses celebrated the presidential bailout of the county's troubled health care system Friday—but said their lingering anger and distrust make them wary of quick fixes.

The county's massive medical network has been shaken so badly that even a bundle of money could not boost the sagging morale or heal the pain employees say they have felt over the past weeks.

Because of the tumult, some doctors predicted that talented, experienced employees, some of whom have already found other jobs, will continue to flee the shaky county health system. And they worried that the county will have trouble regaining employee trust and recruiting a front-line medical team to replace those who leave.

With few details of the rescue plan available, nurses and doctors remained confused, and sometimes pessimistic, about their jobs and their patients' options.

Please see REACTION, A23

Health Crisis Chronology

The health care crisis in Los Angeles County was a long time in the making. It resulted from decreased revenues due to a stubborn recession, cuts in state and federal funding, a huge shift of property taxes from local governments to the state, increased scrutiny of county fiscal practices by financial institutions, and the county's inability to adapt to changes in patient population and health care delivery systems. Here is a brief chronology of key events:

■ September, 1992 Gov. Pete Wilson signs \$57.4-billion state budget, including a shift of \$1.3 billion in property tax revenues away from local governments, reflecting a 45% decrease in the state's contribution to county coffers.

■ July, 1993 State budget of \$52.1 billion passed; \$2.6 billion shifted from local governments to the state.

■ May 24, 1995 Robert C. Gates, head of the county Department of Health Services, announces his resignation, to become effective Nov. 1.

■ June 15 As part of a county budget balancing plan, Chief Administrative Officer Sally Reed recommends closing County-USC Medical Center.

■ June 26 Five-member Health Crisis Task Force, appointed by the Board of Supervisors, meets for first time to address the looming health care crisis.

■ July 14 Gates reveals that the department's deficit is \$90 million worse than the \$655 million previously estimated.

■ July 24 Health Crisis Task Force calls for appointment of health czar and urges closing 34 of 45 clinics in lieu of closing county hospitals.

■ July 25 Health Crisis Task Force issues report warning that entire county health system is in danger of collapse.

■ Aug. 1 Board of Supervisors adopts \$12-billion budget calling for sweeping health care cuts. Burt Margolin, a former state lawmaker who is an expert in health care issues and chairman of the Health Crisis Task Force, is named "health czar" by supervisors.

■ Sept. 1 Official deadline for county facilities to stop accepting new patients. Patient traffic in private hospital emergency rooms climbs 11% the week ending Sept. 2.

■ Sept. 15 Layoff notices are delivered to 4,166 county health care workers. Demotion notices given to 1,034; 1,500 notified they will be transferred when closures begin Oct. 1.

■ Sept. 16 State legislators approve an unprecedented shift of \$150 million from the Metropolitan Transportation Authority to the county treasury to help avert worse cuts in the health care network than already planned. But the Legislature fails to adopt \$135 million in additional aid that the county had been counting on.

■ Sept. 18 Emergency room nurses at County-USC Medical Center stage a sickout to protest pending layoffs, briefly forcing the closure of the emergency room and trauma unit at the nation's largest public hospital.

■ Sept. 22 President Clinton announces a \$364-million rescue package to bail out the county's crippled health care system for the present and requires local officials to implement much needed reforms.

—NONA YATES

Source: Times files

REACTION: Joy, but Fear Lingers

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"I think the hospital is safe, but only for the moment," said Holly Boyd, a nurse who conducts AIDS research at the County-USC Medical Center, which has become a symbol of the county's cash-starved health system. "This is not a permanent solution."

Dr. Ronald L. Kaufman, the medical center's chief of staff, agreed: "It gives us reason to hope. It doesn't say this couldn't happen again."

Last Friday, in tense, emotional conferences with their supervisors, 5,200 county health workers were given notices that they would be laid off or demoted Oct. 1. The unprecedented health crisis also forced the county to announce that 34 of 45 clinics and health centers would be shut down, along with most hospital outpatient services.

The somber mood lasted through this Friday, when President Clinton announced his rescue package. At County-USC, some jubilant nurses cheered, sang songs and snake-danced around the tent city they erected in a protest this week. Ambulance drivers passed by honking horns and waving in support.

But lingering tension and fear crept into the celebration and few were willing to proclaim total victory. Dozens of nurses continued to protest the county cuts by staging sickouts that shut down parts of the hospital. And speakers, although pleased by the bailout, remained guarded about the future and suspicious about the political climate.

Weeks of turmoil have left many health care workers shaken and embittered. The presidential bailout, while welcome, will do little to prop up the crumbling morale or console laid-off employees who feel betrayed.

Emerging from a job-hunting workshop at the H. Claude Hudson Health Center Friday, Violet Williams said no amount of presidential largesse could bring back the security she felt before a pink slip landed on her desk last week. Even if she gets back her job as an urgent care nurse, she said, she is going to make sure she puts in time at a private-sector company at least a few days a week.

"I'm going to have a backup from now on," Williams said. "I'm never going to depend on the county again."

Echoing that distrust, union leaders Friday vowed to keep demonstrating and staging sick-

outs until county supervisors come up with a detailed plan to spend the money—a plan they said must include rehiring all who lost their jobs.

All 16 of the registered nurses assigned to the County-USC operating room called in sick Friday to keep the pressure on county supervisors. The job action forced hospital officials to suspend all non-emergency and elective surgeries, spokesman Harvey Kern said.

Workers in the hospital's family planning clinic also stayed home. And half the nurses in the pediatric division refused to report to their scheduled shifts, forcing managers and other replacement workers to fill in.

"We need to hear that the lay offs are going to stop, that there is going to be worker protection, that these members are going to have jobs Oct. 1," said Gilbert Cedillo, the general manager of Local 860 of the Service Employees International Union, which represents nurses and other health workers.

Some patients even joined in the protest.

The threat of losing a nurse who has long cared for him alarmed 35-year-old Neal Pouliot, who is being treated for AIDS. In the high-profile AIDS clinic, four nurses were scheduled to be laid off and six others demoted and possibly transferred. Being cut off from his favorite nurse would feel "like you are taking me away from my family," Pouliot said. "I am going to be out here until I learn that my nurse will be back."

To underscore their resolve to keep fighting for patients like Pouliot, demonstrators at the rally held up signs saying, "The pawns are still angry." And nurse Ghislaine N. Nash hoisted a placard warning, "These cuts won't heal."

Indeed, many health care workers predicted that fallout from the long-running crisis will continue to haunt the county for years.

On a personal level, many employees said they felt tremendous stress. The County-USC staff has dealt with earthquakes, a riot and shootings in the emergency room, but many said the recent crisis—marked by the layoffs, transfers and demotions announced a week ago—was worse than anything they have ever faced.

"Everyone around here feels like they've been hit in the head by a 2-by-4," Kaufman said.

The system in general has also

beer. frayed Because of the budget uncertainty, the county hospital has lost several nurses who moved onto other jobs, Kaufman said. And he predicted that the county might have trouble finding talented replacements.

Dr. J. A. Asensio, a nationally prominent trauma surgeon who was recruited to County-USC from Philadelphia, joined the noontime rally to warn that the ongoing uncertainty might prompt many on the staff to seek new work.

Until President Clinton's announcement, he expected the hospital to lose half its emergency-room nurses, 30% of its operating room nurses and eight critical care nurses. Those experienced nurses will probably be offered their jobs back—but might not be so willing to accept. "A lot of private institutions would love to raid our system because we have a great bunch of people who are highly qualified," said Asensio, who had been on duty for 42 hours.

Recognizing that the crisis had soured employee morale, hospital spokesman Kern said: "We have to figure out how we are going to go about reversing this. Emotions are heavy. It is going to take a while to get over all this, even if we are over the crisis."

Workers at some clinics were not even sure if the crisis was actually over.

Grim memos still covered bulletin boards and countertops at the El Claude Hudson Health Center: lists of employee hot lines, reminders about outplacement counseling, explanations of budget crisis. Even the employee services center had been transformed, with a hand-scrawled sign tacked on the door announcing Career Transition Room.

With these doomday bulletins surrounding them, employees still felt wary and anxious—and far too unsettled to celebrate.

"I have my layoff notice, and that's what I'm going on," said Renata Burris, a registered nurse.

Clerk Rosundra Golden, who received a layoff notice last week after seven years with the county, agreed: "Do I trust the county after what happened to me? No way. . . . It sounds good now—they're almost saying what we want to hear—but it's not good enough for me."

Ironically, the bailout alarmed some nurses precisely because of its bounty.

Fearing that county supervisors would grab the money and rebuild the old system, without taking time

to draft reforms, they predicted another crash just a few years down the road.

"Sure, we're happy, but for how long?" asked nurse Zenaida Argonza, who listened to Clinton's speech broadcast over the public address system at the Hudson clinic. "How long can they assure our jobs?"

Looking up glumly from the newspaper, Dr. Bobby Harris fretted: "You never know how they're going to use the money."

Similar concerns haunted Dr. Jack Kent, a primary care doctor at an Eastside clinic who was laid off last week. Kent remains hopeful that Clinton's rescue package will save his job. But nerves, and distrust, mute his optimism.

"We really can't trust the politicians who ran it down to the wire and then at the last minute they bail us out," Kent said. "We are going to have to remain vigilant."

While they clamored for reform—such as cuts in the bureaucracy—some health care workers also called for the county to retain control over the clinics, rather than turning them over to the profit-conscious private sector.

"We do what's necessary here. We're not concerned about saving

money at the patient's expense and we don't want to see that change," nurse Williams said.

Unsure about their jobs, nurses said they felt even more queasy about what to tell their patients. After reading about the president's rescue plan, many relieved patients called up to make appointments only to be told that, officially, the Hudson clinic will still close at the end of next week.

Administrators continued to send out packets explaining the closure. And doctors continued to compile patient records to turn over when the clinic shuts down.

"We're just abandoning our patients," nurse Connie Alamdari said. "We're still telling them we close Oct. 1, and we say they just have to watch the news to see. We're still at our jobs, but emotionally, we're not. We're disoriented."

That disorientation came through most clearly at the nurses' farewell picnic on the grassy lawn of the Hudson clinic. Clutching copies of a keep-smiling poem that promised, "The sun will shine again soon and you'll see," nurses rolled barbecued chicken in floppy tortillas and tried to figure out whether they should be mourning or celebrating.

San Francisco Chronicle; 9-23-95

Clinton Gives L.A. \$364 Million Bailout

Battered county health system won't have to shut

By Susan Yonchum
Chronicle Political Editor

Santa Ana

Like a rich uncle who never arrives without gifts, President Clinton returned to Southern California yesterday with a \$364 million bailout for Los Angeles County's desperately struggling health care system.

Many details of the bailout re-

INSIDE

The eleven-hour rescue of Los Angeles' health system is another triumph for a county adept at threatening its own suicide.

PAGE A6

ally disastrous, because one of Clinton's would-be GOP presidential opponents, Governor Wilson, must agree to it. But high-level Wilson administration officials have been involved in the negotiations, and the "can-do, bipartisan" spirit is what the president hopes will propel him — against current odds — back to the White House.

main to be worked out, but Clinton said that the six county-run hospitals and most of the 39 clinics will not have to be closed.

The deal is financially complicated and potentially politi-



BY ASSOCIATED PRESS

'Blues brothers' President Clinton, Vice President Al Gore and actor James Belushi (left) on stage at Hollywood's House of Blues

"This is the example of the kind of teamwork we need to solve the many kinds of transitional problems plaguing the United States as we move into a different kind of economy and a different kind of world," he said, as he was flanked by Republicans as well as Democrats. "They (the problems) don't necessarily have a partisan tinge."

In California, the state he must win to have any chance in the 1996 election, Clinton has been laying a foundation for nearly three years that has included sometimes lavish but occasionally harsh treatment

for the nation's largest state. Although the state's defense-dependent economy has been clobbered by base closings, Clinton has followed up by offering defense conversion plans and money.

He has visited the state more than two dozen times, sometimes speaking out on divisive social issues such as affirmative action and illegal immigration.

On this two-day swing through the land of 54 electoral votes, Clinton stuck to bread-and-butter themes: education and technology

CLINTON: Page A 13 Col. 4

CLINTON: \$364 Million Bailout for L.A.

From Page 1

in San Francisco, health care financing in Los Angeles County, crime and law enforcement in Santa Ana in conservative Orange County and education once again in Wilson's stronghold of San Diego.

The change in strategy was deliberate.

"These two days in California gave him a new opportunity to talk about education, to talk about investments in our health care system, as well as how to protect kids from drugs," presidential press secretary Mike McCurry said in an interview. "These are mainstream issues we intend to focus on."

Despite the serious purpose of the California swing (which also netted the president nearly \$2 million for his re-election bid), there were lighter moments as well, such as when the president, his half-brother Roger Clinton, Vice President Al Gore and actor Jim

Belushi commanded the stage at the House of Blues in Hollywood.

At the crime-prevention event in Santa Ana, which was staged to present a \$1 million gift to a boys' and girls' club, the setting somewhat resembled a Taco Bell commercial — complete with banners and new company spokesman and basketball star Shaquille O'Neal, who was savvy enough not to challenge the much shorter president to a game of one-on-one.

"I can see the headlines tomorrow," Clinton joked. "Shaq visits Santa Ana — President Clinton Also Shows Up."

While the president discussed the need to keep kids away from gangs and drugs, presidential aides were ready to talk politics.

John Emerson, the president's deputy director of intergovernmental affairs and Clinton's policy point man for California, said in an interview that Clinton's appeal in the critical electoral state depends

on the way "people understand what has happened to this state — and why — and how the president has a vision of how we lead this state and lead this nation."

In addition, Emerson asserted that "culturally, Bill Clinton is like a Californian: energetic, youthful. He's a good connect with Californians."

Emerson, who ran the president's successful campaign in California in 1992 and is expected to engineer the effort in 1996, said that Clinton's re-election message in 1996 "will not be what I've done for you in the past — but for what I can get done for you in the future."

One thing that Emerson said the president's re-election team learned from watching Wilson defeat Democrat Kathleen Brown in a landslide is that "if you allow the other side to define the framework for the campaign, you will lose — and we don't intend to do that."

A6 San Francisco Chronicle *****

NATION

SATURDAY, SEPTEMBER 23, 1995

L.A. Gambit Won Health Bailout

Strategy was to put vital services on the chopping block

By Sabin Russell

Chronicle Staff Writer

With its sprawling public health care system at the edge of financial collapse, Los Angeles County won a \$364 million reprieve yesterday from President Clinton that will shave off huge layoffs and give the region a respite before the next wave of federal medical cuts.

As such, the eleventh-hour rescue is another triumph for political brinkmanship by a county adept at threatening its own suicide.

On September 15, more than 5,200 health care workers were notified that they would probably lose their jobs next week because the county had run out of money to operate its six public hospitals and 45 health care clinics.

NEWS ANALYSIS

The debate initially centered on which form of poison to take: close Los Angeles County-USC Medical Center, the nation's busiest public hospital, or shutter four of five other city hospitals that serve outlying areas.

Faced with a \$655 million budget gap, the prospects of a truly catastrophic meltdown of the public health system appeared imminent.

Burt Margolin, the gifted former state assembly Health Committee chairman and unsuccessful candidate for state Insurance Commissioner in the Democratic primary last year, took on the seemingly impossible task of drafting a solution. It turned out to be equally Draconian: close down 35 of 45 neighborhood health clinics and regional surgery centers.

In the end, just about any solution was revolting, with the predictable result that the Clinton administration would open the purse strings and hash out an agreement to forestall the crisis.

"Brinkmanship has worked again," marveled Drew Altman, president of the Kaiser Family Foundation, who served as a health care bureaucrat during the Carter administration when Los Angeles was faced with a public health disaster.

"The strategy this time was to put on the chopping block the thing they wanted least to cut on the theory that in the end everyone would blink," Altman said.

County health care czar Margolin shrewdly placed the survival of the community clinics in play because virtually all health policy experts agree that the future of public health programs depends on the provision of basic medical services from such clinics rather than reliance on expensive central hospitals.

Details of the bailout plan are scarce, but it appears that the county will be able to carry out in five years the restructuring that would have had to occur overnight if a deal was not cut by October 1. Margolin flew to Washington this week and huddled with Medicaid and California health officials to find an alternative.

Two years ago, Los Angeles' tendency to place all its health care eggs in one basket paid off handsomely. The city bet its budget on a plan to wrest millions of federal Medicaid dollars by exploiting a little-used formula that

gives extra money to hospitals serving a "disproportionate share" of poor residents. Result: California secured an extra \$500 million, with Los Angeles collecting about half the total.

Earlier this year, the county tried once again to tap the Medicaid trough, this time by claiming \$300 million through rules that compensate counties for administration costs. It was only when the Health Care Financing Administration refused to go along with it that Los Angeles' financial crisis grew to its present proportions.

The Clinton plan will force Los Angeles to reshape its health care system in a hurry, but the Margolin coup has bought the county time.

A still bigger problem remains, however. The Republican-controlled Congress is serving up a \$182 billion cut in projected Medicaid spending over the next seven years. The effect of that may dwarf Los Angeles' current financial problems.

"What has been going on in Los Angeles is a meltdown," said Dr. Sandra Hernandez, San Francisco director of Public Health. "The scary thing is it was a meltdown even before the federal cuts."

DRAFT**Los Angeles County Health System Financing Components****Primary components**

- **Section 1115 waiver.** The waiver baseline would include \$116 million in spending authority for fiscal 1996, generated by the increase in the uncompensated care trend factor in fiscal 1995. The waiver would be budget neutral over five years as a result of program savings in the outyears. Because of the concern over the need to reserve potentially recoupable costs, none of the \$105 million resulting from the higher trend factor in fiscal 1995 is counted as a benefit to the County.

Immediate benefit to the County..... \$116 million

- **Quarterly payment adjustment.** The County pays the State \$550 million annually to generate Federal match for uncompensated care. The State could allow the County to push back the payment date for one quarter of that payment, or \$138 million, which the County can spend on health services and draw a match from the Medicaid program.

Immediate benefit to the County..... \$275 million

- **Public health service grants.** The County will be eligible for \$50 million in PHS grants.

Immediate benefit to the County..... \$50 million

- **Outpatient rate adjustment.** The State may increase the MediCal rates for outpatient visits in LA County, without incurring additional State costs. The County would pay and receive Federal match for the higher rates.

Immediate benefit to the County..... \$50 million

- **Total immediate benefit to the County is \$491 million.**

Additional benefits

- **Section 1115 waiver.** The second year of the waiver (fiscal 1997) could include \$128 million, generated by the higher trend factor. The waiver would be budget neutral over five years as a result of program savings in the outyears.
- **Higher trend factor.** Upon reconciliation to actual costs in the third year of the waiver (fiscal 1998), HCFA may find that part or all of the \$105 million resulting from the higher trend factor is allowable. If all of the \$105 million were allowable, the benefit to the County over the life of the waiver could be as high as \$700 million.

Burst
Feds did
cash flow
adjust

441

DRAFT*Additional policy option*

- The County now generates its Federal disproportionate share match through the State, which reallocates part of the Federal payment to non-County expenses. The Federal government could, as a condition of this package, require the State to reduce the amount it reallocates, thus increasing the Federal match dollars going to the County on an annual and continuing basis.

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LA COUNTY ISSUES FOR RESOLUTION**State Plan Amendment (SPA)**

- Request (1):** Do not reconcile the Urban Hospital and Related Services trend factor to actual costs for SFY '94-'95.
- Recommendation:** OBRA '93 requires that actual DSH expenditures be reconciled.
- Request (2):** Approve the Urban Hospital and Related Services trend factor for all fiscal years.
- Recommendation:** Limit the Urban trend rate statewide to '94-'95, and for LA County to '95-'96 under the waiver.
- Request (3):** Use a different cost report other than the Medicare reasonable cost principles (OSHDP).
- Recommendation:** Costs incurred should be calculated on Medicare reasonable cost principles. The State estimates that OSHDP costs are 10% higher than Medicare allowable costs.

1115 Waiver

- Request (4):** Drop the OBRA '93 DSH cap "reconciliation" component for all Fiscal Years, instead of for Fiscal Year 1995-96 only.
- Recommendation:** Limit the trend rate for LA County to '95-'96 under the waiver with reconciliation as part of budget neutrality.
- Request (5):** Permit development of the restructuring plan to occur during the demonstration program.
- Recommendation:** At a minimum, the framework for restructuring must be developed prior to approval of the demonstration, with milestones that would be finalized during the demonstration.
- Request (6):** Pay FFP for the aggregate instead of on a per individual basis.
- Recommendation:** Under the demonstration, it may be possible to develop a method that would allow the State to report costs in the aggregate instead of on a per individual basis. (See attached.)
- Request (7):** Pay actual costs for uncompensated care instead of the MediCal payment rates.
- Recommendation:** It may be possible to recognize the cost of services in excess of what MediCal payment rates are as CPE under the demonstration. A method similar to this is in place in Tennessee.

Other Issues

Request (8): Limit recognition of DSH revenues in the County's OBRA '93 computation to those which are associated with County-provided services, as opposed to those related to private sector and other State-administered Medi-Cal services. (The net effect of this proposal is the same as allowing the county to count intergovernmental transfers as costs.)

Recommendation: Include all revenues (County-provided services, private sector services, and other State-administered Medi-Cal services) in the County's DSH OBRA '93 computations and encourage the State and the County to work on reaching an agreement that would ensure that the County receive an adequate level of funding for the public facilities.

Request (8): Allow the State to accept components of the proposal rather than the whole package (i.e., only the State plan or only the 1115).

Recommendation: The 1115 demonstration waiver could be approved without the 1994 -95 state plan amendment. If the urban trend factor for 1995-96 were included in the waiver, it should be reconciled separately.

Request (9): Explore the possibility of securing Kaiser Family Foundation money for the County.

Recommendation:

Request (10): Approve the use of funds secured from a foundation currently being established by the Blue Cross and Blue Shield Plan of California as State match.

Recommendation: The Medicaid Bureau will work closely with the State and County to ensure that the funds can be used as State match without violating any of the tax and donation laws.

SEP-19-95 TUE 11:55

HCFA ORD

FAX NO. 4107885515

OPTION A**The Expenditure Based Model**

The expenditure based model is a formula based upon a combination of cost and volume in Los Angeles county's clinic system. The following is a methodology which uses several variables to determine an aggregate amount:

- o Calculate the cost per visit at county clinics;
- o Establish the relationship of cost per clinic visit to the current Medi-Cal payment levels;
- o Determine the number of individuals who would be covered under the waiver who are not currently recipients of Medi-Cal using:
 - The total number of individuals who are receiving clinic services;
 - An estimate of the number of Medi-Cal eligibles within the group;
 - An estimate of individuals to be excluded based on the provisions of section 1903(v).

The result of this formulation will equal the baseline expenditures that would qualify for Federal Financial Participation under the waiver.

OPTION B

The second proposal is a very simplified methodology for making eligibility determinations. This is to apply the approach used in determining presumptive eligibility of pregnant women to anyone receiving care in a community health clinic. The idea of presumptive eligibility is that based on "preliminary information" about family income, an individual is considered likely to meet the applicable income eligibility requirements and can, therefore, receive services. With the goal of keeping any administrative burden to a minimum, the few essential elements of this eligibility methodology include:

- o The applicant's name and address;
- o Place of employment, if any;
- o Other source of health insurance;
- o Income -- No more specific than "How much income do you have in your family?";
- o Social Security Number;
- o Assignment of rights and agreement of cooperation; and
- o Signature -- Information is correct to the best of their knowledge

Note: Applications of this methodology are subject to the provisions of section 1903(v) of the Social Security Act, or some alternate State or local policy.

DRAFT**LA COUNTY WAIVER OPTIONS PACKAGE****September 19, 1995**

This package reflects three options for construction of the without waiver baseline for L.A. County, including the option offered to the County last week. The range of options, in the aggregate, would infuse federal funding between \$86 and \$715 million dollars over five years. This is separate from the immediate infusion of an additional \$105 million dollars upon HCFA approval of the uncompensated care trend rate increase. The numbers are based on County figures and are subject to change.

Several policy issues need to be discussed at the 3 pm meeting:

- Treatment of \$105 million in without waiver baseline
- Calculation of growth path using a negotiated trend factor
- Illegal Immigrant Eligibility
- OBRA 93 DSH caps (e.g., hospital affiliation of clinics)

Attachment 1:	Explanation of Without Waiver (WOW) Baseline
Attachment 2:	Summary and Detail behind 3 WOW baseline options
Attachment 3:	Breakout of L.A. County FY 1996 budgeted Federal funds

DRAFT**Attachment 1****General Comments (see Attachment 2)**

- In each baseline, the initial \$105 million increase from the augmented trend factor is assumed to be recouped separate from budget neutrality. HCFA GC believes the \$105 million from FY 1994-95, if disallowed, could not be paid through "savings" off of the without waiver baseline.
- There are essentially three options. The options vary the length of time the \$105 million is trended in the without waiver baseline. Each option has been reflected at two aggregate growth rates: 8.9% (county requested) and 10.5% (national growth in Medicaid acute care).
- All baselines leave out DSH, projected at \$474 million annually, trended forward at zero growth.
- The 5-year total is the without waiver baseline. Column 3 reflects any amount in the baseline generated from the \$105 million, and Column 4 is the true baseline.
- Column 6 reflects the WOW baseline options without the \$105 million increase minus what the county projects it will spend under the waiver.

Option 1

- Options 1A and 1B include the \$105 million over the 5 years of the waiver. Assuming the entire \$105 million is disallowed, the figures in Column 3 must be generated to reach budget neutrality across all 5 years.

Option 2

- Options 2A and 2B reflect the offer we made to the State, with corresponding numbers in Column 3 to reflect the decrease in \$105 million trended for two years. Similar to Option 1, these options would allow savings to be made up over the five years of the waiver.

Option 3

- Options 3A and 3B allow a portion of the \$105 million to be included in the baseline in years one and two, and none of the \$105 million to be included in the remaining years of the waiver. Again, savings from any over spending in the first two years of the waiver can be generated over the life of the waiver.

Other Issues

- The County submitted numbers that reflect their projected spending under a waiver that includes clinic care for non-alien indigent and the hospital costs required to comply with OBRA 93. This totals \$3.7 billion over the five years of the waiver (the with-waiver baseline).

DRAFT**Attachment 1**

- The County believes that they have two constraints on their spending: OBRA 93 hospital specific caps for DSH and the without waiver baseline. OBRA 93 caps are more restrictive than most of the WOW baseline options.
- None of the options take into account any infusion of Public Health Funds. HHS/ASMB is working on finding such funds for L.A. County.

The County Budget

- Attachment 3 shows federal funds that are budgeted in the County's FY 1996 budget and the amount the County expects to get through the waiver.
- The County has already budgeted expected funds from the Medicare market basket for FY 1995 only and from both the Medicare market basket and urban trends for FY 1996 only. This translates into \$179 million already budgeted, and dependant upon HCFA's approval of the state plan amendment.
- We expect that the \$100 million request from the County corresponds to the added \$105 million from the uncompensated care trend factor.

**Attachment 2
Summary**

Los Angeles County Options

Column

1

2

3

4

5

6

**Growth
Rate**

**5-Year
Total**

**Increase in WOW
from \$105 M**

**WOW baseline
excluding \$105M**

**County
w/walver spending**

**WOW excluding \$105M -
County w/walver**

Options

Likely Baselines

1A	Disallow at Yr. 6 @8.9%	8.90%	\$4,325	\$683	\$3,642	\$3,716	(\$74)
1B	Disallow at Yr. 6 @10.5%	10.50%	\$4,531	\$715	\$3,816	\$3,716	\$100
2A	Adjust Base in Yr. 3 (8.9%)	8.90%	\$3,881	\$239	\$3,642	\$3,716	(\$74)
2B	Adjust Base in Yr. 3 (10.5%)	10.50%	\$4,060	\$244	\$3,816	\$3,716	\$100
3A	50-25-0 (percent of \$105)	8.90%	\$3,728	\$86	\$3,642	\$3,716	(\$74)
3B	50-25-0 (percent of \$105)	10.50%	\$3,903	\$87	\$3,816	\$3,716	\$100

Baselines without \$105 in base

No \$105 in base @8.9%	8.90%	\$3,642
No \$105 in base @10.5%	10.50%	\$3,816
Benefit from using 10.5%		\$173

**County w/walver projected spending
(with OBRA 93 DSH caps)**

**Total
\$3,716**

DRAFT

Attachment 2

Los Angeles County Options

Options	Likely Baselines	Growth Rate	Base Year	Proposed 1115 Waiver Period					Total
			FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	
1A	Disallow at Yr. 6 @8.9%	8.90%	\$665	\$724	\$789	\$859	\$935	\$1,019	\$4,325
1B	Disallow at Yr. 6 @10.5%	10.50%	\$665	\$735	\$812	\$897	\$991	\$1,096	\$4,531
2A	Adjust Base in Yr. 3 (8.9%)	8.90%	\$665	\$724	\$789	\$723	\$788	\$858	\$3,881
2B	Adjust Base in Yr. 3 (10.5%)	10.50%	\$665	\$735	\$812	\$756	\$835	\$923	\$4,060
3A	50-25-0 (percent of \$105)	8.90%	\$665	\$667	\$693	\$723	\$788	\$858	\$3,728
3B	50-25-0 (percent of \$105)	10.50%	\$665	\$677	\$713	\$758	\$835	\$923	\$3,803

Baselines (excl. DSH)	Growth Rate	Base Year	Proposed 1115 Waiver Period					Total
		FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	
No \$105 in base @8.9%	8.90%	\$560	\$610	\$664	\$723	\$788	\$858	\$3,642
No \$105 in base @10.5%	10.50%	\$560	\$619	\$684	\$756	\$835	\$923	\$3,816
\$105 in base @8.9%	8.90%	\$665	\$724	\$789	\$859	\$935	\$1,019	\$4,325
\$105 in base @10.5%	10.50%	\$665	\$735	\$812	\$897	\$991	\$1,096	\$4,531
DSH @0%	0.00%	\$474	\$474	\$474	\$474	\$474	\$474	\$2,370

County Projected Spending (with OBRA 93 DSH caps)	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total
	896	705	705	705	705	\$3,716

<u>Savings Needed</u>		<u>FY 1995</u>	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>Total</u>
Recoup at Yr. 6 (taken from savings)-8.9%	8.90%	\$105	\$114	\$125	\$136	\$148	\$161	\$683
Recoup at Yr. 6 -10.5%	10.50%	\$105	\$118	\$128	\$142	\$157	\$173	\$715
Adjust Base in Yr. 3	8.90%	\$105	\$114	\$125	\$0	\$0	\$0	\$239
Adjust Base in Yr. 3	10.50%	\$105	\$116	\$128	\$0	\$0	\$0	\$244
50-25-0	8.90%	\$105	\$57	\$29	\$0	\$0	\$0	\$86
50-25-0	10.50%	\$105	\$58	\$29	\$0	\$0	\$0	\$87

DRAFT

Exp - Rev = DSH

Attachment 3

DRAFT**Federal Money Expected to L.A. County (Millions)****County figures**

	<u>FY 94-95</u>	<u>FY 95-96</u>	<u>Sum of Retrospective and Prospective Increase</u>
Medicare Market Basket	\$32	\$50	\$82
Additional \$\$ from Trend increase	\$105	\$97	\$202
Total With SPA-Immediate Influx	\$137	\$147	\$284
 Federal Money in FY 1996 Budget 1/			\$179
Money Expected from Negotiations			\$105
Total			\$284 2/

1/ Bold number represents what County has budgeted in FY 1996

2/ Receipt of the \$284 million is contingent upon HCFA approval of the state plan amendment

CALIFORNIA (LA COUNTY)
DISCUSSION OVERVIEW

* CRN ~~ACF~~

I. OBRA 1993 TRANSITION PLAN

- A. 1994-1995 Trend Factor
 - o Hospital and Related Services For All Urban Consumers CPI
 - o The immediate impact of using the higher urban trend rate is \$105 million (based on State numbers).
- B. Reconciliation and Recoupment
- C. SB1255 Rate Augmentation

II. 1115 WAIVER

- A. 1995 - 1996 Urban Trend Factor
 - o The impact of using the urban trend rate in State Fiscal Year 96 would allow expenditures of an additional \$97 million.
- B. Non-DSH Expenditures Trend Rates In The Without Waiver Baseline
 - o Base Year - Incorporating the additional SFY 95 spending into the 1115 baseline for the first two years of the demonstration results in additional spending authority.
 - o National Medicaid Baseline Trend Rate
- C. DSH Expenditure Trend Rates
- D. Coverage of Indigent Care in Clinics
 - o Under the demonstration, it is estimated that there will be an additional \$50 million in FFP annually for care provided in freestanding out-patient clinics for certain indigent populations not currently eligible for Medicaid.
 - o Eligibility Process (Attachment A)
- E. Health System Restructuring (Attachment B)
 - o Milestones

IV. NEXT STEPS

See smt? -

- Goal Technical
 - Tuesday
 - SEIU
 - PHS

Groundwater

JL → HW: Can they make loan/recompait w/ w/ acuity

TM → BM:

EV → BM: Mtg

Why re-compant?

Callahan

PHS - HRSA

SYMHA

CO

\$18m

+10 this yr.

\$2-3m

+ 3.9m Northridge earthquake

JL: PHS has ~~help~~ w/ lg precedent

JL: Assume 25-50% of TF?

* Non aff. mtg

* Illegals - pols 187

ben pro go illegal
 ely. i.
 (Angell)

* Talk to Warnath

Emerson → ~~East~~ / Rev
 Monahan →
 (Pres - special deal
 during master - state)
 Meet 2

Gary/Burt - today
 11st official
 3pm Tues

PHS - \$50? by COB?

KB - Overall TF

Sally Keel - rec'd
 perm

yaroslav, burke were thank you
molina wanted timeline: spa by Oct 1; waiver by Oct 31
reed: this is tough

staff:
never told us re reconciliation and recoupment (had said by end
of end of waiver vaguely)
will owe
couple hundred million every year!!; year 1 OK?
Gary Wells, Jerry Reuss: why take risk if pay it back
Grantland, Kathy, Lu, Lasowski
will note disallows take a long time

To do:
fallback if supervisors?
layoff notices out Monday assuming current budget (which we think
we can beat)
(SEIU: told each supervisor were contacted; we care; Yaroslavsky
said they don't care re health care)

Xan/Molina — Emerson
LA Times → Mon

Marg - disapp - not as much \$

Penalty

$$\text{DSH cap} = \text{Cost} - \text{revenue}$$

Henry/Karen - can't waive receipt; OBRA '93
diff recorp + bn
Front load

overabundance of revenues
talked to Kathy K.

3³⁰ tomorrow -

* What is legal basis for recoupment?

GAP - hv to disclose

5 year → TF
18 mos.
deliberate further closures
falls off - marginal move →

Maynard - ^{HEFA} made no effort to contact county officials

No calls over few weeks

Mad wanted to brief supervisors

- no ref to their proposal
- it's a go; assumed worked out w/ staff
- effort to bamboozle

wants middle gts

will blow up if card

Know can't cover under
But card people? less structured
on screening eligibility

Chronic money

50-60m → 10-15m; has Pres decided to go after undocumented

THE NATION

women

ed the
which
no oth-
on.Colley,
7-year-
pt. 14,had par-
Donald
and fourCrumi-
least 25
entenced**Orange County Aid Package Approved**

■ SACRAMENTO, Calif.—The California legislature passed the final portion of an Orange County recovery package, allowing the county to raise the money it needs to repay its noteholders and emerge from bankruptcy.

Orange County declared bankruptcy Dec. 6 after suffering investment losses estimated at \$1.69 billion. One official predicted the legislation would allow the county, if its plans are approved, to emerge from bankruptcy by the end of the 1996 fiscal year.

The measures now advance to Gov. Pete Wilson (R), whose office said he would sign the legislation as part of a package of bills that includes an estimated \$200 million in relief for Los Angeles County, which on Friday sent layoff notices to thousands of county health care workers as it prepared to close all six of the county's comprehensive care centers and 28 of 39 commu-

nity clinics. The money should allow the county to rescind those layoffs, demotions and transfers.

Addenda

■ National Urban League President Hugh Price said his organization this week will request that a presidential commission study police violence and create police guidelines to protect citizens' constitutional rights. "There are instances cropping up all over the country of outright police abuse of the U.S. Constitution," including subjecting blacks to unwarranted searches, Price told a gathering Friday in Fort Wayne, Ind.

■ The Texas judge who ordered a bilingual woman to speak English to her 5-year-old daughter because ignorance of the language doomed the girl to life as a maid, rescinded the order after the girl's divorced parents agreed that English proficiency would be in her best interest, according to a spokeswoman for Judge Sam Kiser.

From news services

PHOTOCOPY
PRESERVATION

THE WHITE HOUSE

WASHINGTON

September 19, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco *CH R/DF*
SUBJECT: Background on Los Angeles County Fiscal Problems

The Los Angeles Times may ask you about the fiscal crisis in Los Angeles County, particularly in health services, and about the status of a proposed Federal Medicaid demonstration waiver intended to ease the crisis. I understand that John Emerson has separately forwarded a Q&A on this subject.

HHS and OMB are working to structure a waiver that would provide relief to the county, but have not yet succeeded.

Origins of the Problem: The public health system in L.A. County is the major provider of care to the county's large indigent population, many of whom are illegal aliens. In recent years, L.A. County balanced its budget using a variety of one-time revenues and unreliable assumptions. For the fiscal year that began last July 1, county officials were counting on a huge retroactive claim for Medicaid administrative costs, based on a new, aggressive methodology. HHS rejected the methodology in March.

Gloria Molina, Chair of the L.A. County Board of Supervisors, believes she has a commitment from us to find approximately \$250 million in alternative Federal relief. We have continually told county officials that we will do all we can to identify an appropriate source of such relief. However, it is difficult to identify significant Federal funds with no strings attached without the help of the state, and without setting precedents for other state to request the same assistance. A plan to increase Medicaid rates fell through when the state refused to cooperate (even though it was structured to cost the state nothing). Attached is an article from Monday's New York Times describing the state's failure to assist the county.

Current Budget Status: To balance the budget, the county's administrative officer recommended closing hospitals, including the huge L.A. County/U.S.C. Hospital, the largest hospital west of the Mississippi. In an effort to avoid this draconian measure, the Board of Supervisors passed a budget in July that closed or privatized all six of the county's comprehensive health centers, 28 of the county's 39 clinics and kept the hospitals open for now. (This solution was brokered by former state legislator Burt Margolin, whom the supervisors appointed to serve as "health czar.")

The supervisors also assumed approximately \$180 million in Federal aid, and set themselves a deadline of October 1 to determine whether the Federal aid is really forthcoming. If not, they are committed to taking more stringent action, which probably means closing hospitals. Layoff notices started going out last week and will be needed even assuming the \$180 million in Federal aid. Emergency room nurses at L.A. County/ U.S.C. Hospital staged a sick-out strike earlier this week over the layoff notices.

Federal Options: Since July, HHS and the county have been working on a Medicaid demonstration waiver that would increase Medicaid eligibility in the clinics, but would still be budget neutral over the five years of the waiver. Last week, HHS officials traveled to L.A. to present an option to the county, but serious problems with the plan emerged. As a result, the L.A. press reported serious problems with the Federal aid plan.

The two major points of contention are whether and when to recoup any Federal overpayments during the waiver, and how to exclude illegal aliens from the eligibility expansion without checking each patient's identification.

HHS and OMB officials plan to meet with county officials here in Washington on Wednesday until an agreement is reached or it is determined that none can be reached.

cc: Leon Panetta
John Emerson
Alice Rivlin
Abner Mikva

California Refuses to Bail Out Los Angeles

By SETH MYDANS

LOS ANGELES, Sept. 17 — The State Legislature acted this weekend to rescue Orange County from its fiscal crisis but left neighboring Los Angeles County facing a huge budget gap that officials said would mean thousands of layoffs and the immediate closure of dozens of health clinics.

In a contentious session that lasted until dawn on Saturday, the Legislature voted to allow both counties to reallocate hundreds of millions of dollars earmarked for transportation. But it defeated a package of additional measures that Los Angeles County officials said were crucial to its continued operations.

Most actions taken by the Legislature involved shifting county funds rather than paying out state money.

While Orange County officials, floundering in bankruptcy, rejoiced at their rescue, officials in Los Angeles braced for further cuts in services and predicted a health care crisis.

"This is the best news we've received," said an Orange County supervisor, Marian Bergeson. A Los Angeles County supervisor, Yvonne Braithwaite Burke, said, "This is very grim news."

The Legislature, which previously had resisted helping well-to-do Orange County out of its self-inflicted financial crisis, voted to allow the county to transfer \$810 million from special accounts over the next 20 years. More than two-thirds of this would come from money previously allocated by county voters for transportation programs.

The county declared bankruptcy in December in the face of a \$1.7 billion loss from risky investments. In June, voters overwhelmingly rejected bailing out their government with a half-cent increase in the county's 7.75-cent sales tax.

The refusal by the voters in a conservative, anti-tax bastion to shoulder their own burdens appeared to have paid off.

"This is going to tell a lot of people that they made the right decision, which is so very irresponsible and totally ironic," said Sherry Bebitch-Jeffe, a political scientist at the

Claremont Graduate School. "This basically takes care of their problems. They've got a lot of breathing room."

In Los Angeles County, where a \$1.6 billion budget shortfall was the result of years of accumulated debt and increased borrowing as well as a sluggish economy, the cuts had already begun in the hours before the Legislature acted.

On Friday, 5,200 health workers in the county's huge health care network received notices of termination or demotion in the largest payroll reduction in the county's history. Plans are under way to close 5 small hospitals known as comprehensive health centers and 28 neighborhood clinics as of Oct. 1.

The county had been hoping for both additional state and Federal aid to avert the layoffs and closures, but the actions by the Legislature this

Orange County gets breathing room with new flexibility.

weekend dashed those hopes and meant that additional cuts in county services might also be needed.

"We're back to the drawing boards with very little time left," Sally Reed, the county's chief administrative officer, said on Saturday.

In the all-night session, the Legislature approved a transfer of \$50 million in transit funds into the general fund and told the county it could borrow \$100 million from the Metropolitan Transportation Authority. But it voted down a package of other measures that officials said could have totaled as much as \$135 million.

And some officials said the county might refuse to exercise the authorization to borrow \$100 million in transportation funds, which they said would merely add to an accumulated debt burden and postpone difficult cuts.

"Already the county is heavily leveraged by using its property as collateral or privatizing its properties,"

Ms. Bebitch-Jeffe said. "They are in hock up to their ears already."

The county is also awaiting action by the Federal Government to free at least \$178 million in additional money for the health care system. If this does not happen, Supervisor Mike Antonovich said the survival of the Los Angeles County-University of Southern California Hospital, one of the largest in the nation, could be threatened.

The layoffs and clinic closures are sending Los Angeles County into a crisis that doctors and officials say is certain to cause chaos, overcrowding and the spread of disease. Although the cuts directly affect services to the poor, they say, their effects will quickly spread through the middle class and the wealthy of the county.

Hundreds of thousands of poor people, with no other medical care available, are expected to besiege the emergency rooms of public and private hospitals, which are required to treat all patients. Because routine care will be harder to obtain, many of these patients will be seriously ill, having allowed routine illnesses to become life-threatening.

Left untreated among many poor people, infectious diseases like tuberculosis are expected to become a greater threat to the population at large.

The flood of patients who cannot pay their bills is expected to force some emergency rooms to close, particularly in smaller private hospitals. That is likely to make ambulances have to travel farther, lengthening response times for everybody, regardless of socio-economic status.

The county has been struggling through the summer to find ways to keep its huge health care system functioning, seeking to restructure and streamline its delivery systems and form partnerships with private hospitals.

But stopgap measures will not be enough, said Burt Margolin, the county's health-crisis manager. "The health care system is losing in this one budget year 50 percent of its budget," he said recently. "We are facing the meltdown, or complete collapse, of its ability to rationally deliver services."

10.5% nat'l growth rate $\rightarrow$ total $\$ >$ LA Ctz
But don't flow enough in 1st yr.

Get srvg path?

Also, can they use it? generate match?

un: Reconcile other yrs DSH cap?

$\$ 50_{\text{transit}}$; $\$ 100_{\text{m loan transit}}$

$$\begin{array}{r} \$116 \text{ on-yr1} \\ + 50 \\ \hline 166 \\ + 50 \text{ OP} \\ \hline 216 \end{array} \quad \left. \begin{array}{l} \\ \\ \end{array} \right\} \text{payback}$$

$$\begin{array}{r} \rightarrow 530 \div 4 = \\ 130 \text{ W Edtride} \\ 50 \text{ PHS} \\ \hline 180 \end{array}$$

LA - POTVS Thursday
WCA to Announce

DRAFT

Los Angeles County Health System Financing Components

Primary components

- **Section 1115 waiver.** The waiver baseline would include \$116 million in spending authority for fiscal 1996, generated by the increase in the uncompensated care trend factor in fiscal 1995. The waiver would be budget neutral over five years as a result of program savings in the outyears. Because of the concern over the need to reserve potentially recoupable costs, none of the \$105 million resulting from the higher trend factor in fiscal 1995 is counted as a benefit to the County.

Immediate benefit to the County..... \$116 million

- **Quarterly payment adjustment.** The County pays the State \$550 million annually to generate Federal match for uncompensated care. The State could allow the County to push back the payment date for one quarter of that payment, or \$138 million, which the County can spend on health services and draw a match from the Medicaid program.

Immediate benefit to the County..... \$275 million

- **Public health service grants.** The County will be eligible for \$50 million in PHS grants.

Immediate benefit to the County..... \$50 million

- **Outpatient rate adjustment.** The State may increase the MediCal rates for outpatient visits in LA County, without incurring additional State costs. The County would pay and receive Federal match for the higher rates.

Immediate benefit to the County..... \$50 million

- **Total immediate benefit to the County is \$491 million.**

Additional benefits

- **Section 1115 waiver.** The second year of the waiver (fiscal 1997) could include \$128 million, generated by the higher trend factor. The waiver would be budget neutral over five years as a result of program savings in the outyears.
- **Higher trend factor.** Upon reconciliation to actual costs in the third year of the waiver (fiscal 1998), HCFA may find that part or all of the \$105 million resulting from the higher trend factor is allowable. If all of the \$105 million were allowable, the benefit to the County over the life of the waiver could be as high as \$700 million.

DRAFT

Additional policy option

- The County now generates its Federal disproportionate share match through the State, which reallocates part of the Federal payment to non-County expenses. The Federal government could, as a condition of this package, require the State to reduce the amount it reallocates, thus increasing the Federal match dollars going to the County on an annual and continuing basis.

Have you heard the Bd of S
is voting Thursday on closing
hosp?

175	budget
75	Chairs open - all?
250	

STATE / COUNTY ISSUES

- State Plan Amendment (SPA)

- Not reconciling the trend factor to actual costs for SFY 94-95. *\$105 (x32) SW; 2/3 to LA*
- Using a different cost report than the Medicare reasonable cost principles (the County estimates costs 10 percent higher if their cost report were used);

- 1115 Waiver

- Allowing the urban trend rate under all 5 years of the demonstration without reconciliation to actual costs;
- Permitting development of the restructuring plan to occur during the demonstration program; *??*
- Indigent Care in Outpatient Clinics
 - Paying FFP in the aggregate instead of on a per individual basis; *3*
 - Paying actual costs for uncompensated care instead of the MediCal payment rates;

- Other Issues

- Allowing the State to accept components of the proposal rather than the whole package (i.e., *?* only the State plan or only the 1115).
- Exploring the possibility of securing Kaiser Family Foundation money for the County; and *?*
- Approving the use of funds secured from a foundation currently being established by the Blue Cross and Blue Shield Plan of California as state match. *?*

Put back in waiver - TR?

Swartz 9/6

\$179: 95-96 allowable: \$147m, with \$30-odd for higher mkt bskt; ?
\$32m 94-95 higher market basket

Not in:
\$105 backcasting

\$60m for increasing eligibility in clinics - *could be less*

From: THOMAS COUPAR
 To: BALT2.CO2(LZawistowich,SRichardson,WLasowski,GCLEM...
 Date: Thursday, August 31, 1995 10:38 am
 Subject: LACO Critical Dates

A couple of days ago, Allan Wecker called and wanted to make sure that we knew the critical dates facing LACO decision makers. Since I wasn't sure that our leadership knew those dates, I volunteered to advise the HCFA world. He then noted that he would have Lucien Wulsin call me. Mr. Wulsin is a long time close associate of Burt Margolin. Mr. Wulsin called me this morning. He noted that Margolin faces critical dates in three major areas: OP, IP, and CMAC. OP--29 clinics and 75% of the hospital ambulatory visits are to close 10/1/95 unless the Board of Supervisors has a firm funding commitment by 9/19. Starting on or about 9/1/95 LACO DHS will begin the layoff / bumping notice process to be effective 10/1/95. He noted that they have received 191 responses to the recent RFP to have private organizations operate public facilities. But it didn't sound as if there was much interest in the provision that free care be provided to indigents. IP -- Tomorrow, Margolin will report to the Board his group's recommendations on which hospital's should be closed on 12/1/95. The public announcement will be made on Tuesday, 9/5/95. Wulsin understands that IP closures require a 60-day notice. Hence, the IP process would need to begin on or about 10/1/95. CMAC -- The CMAC Board meets on 9/12/95 and again on 9/26/95. LACO is on both agendas so CMAC can deal with the "DSH trend factor" matter. Wulsin understands that CMAC must give 10-days notice to hold Board meetings, even though such meetings are held in Executive session. And there is some talk that any September CMAC meeting dealing with LACO would be open.

9/1/95 - OP notification to workers begins
 9/1/95 - Margolin recommends which hospitals to close at 12/1/95
 9/5/95 - LACO Board announces which hospitals to close
 9/12/95 - CMAC Board Meeting - LACO SB1255 \$ on agenda
 9/15/95 - Layoff notices to OP workers
 9/19/95 - LACO Board meeting - Last reasonable time to halt layoffs
 9/26/95 - CMAC Board Meeting - LACO SB 1255 \$ on agenda
 9/26/95 - LACO Board Meeting
 10/1/95 - Close clinics
 10/1/95 - Begin process to close certain hospitals at 12/1/95

CC:

WPPROFS.HCFASFO(GM41) 95-96TF, but not backcast
 or freestg clinics

SWhte
 9/6

Notices by 9/15 - assumes Fed \$.
 could save 50-75% OP cuts

Approved budget: Oct 1 - 28 clinics
 6 CHC's

Worse if no \$

Downsize Radio, Dent, mch,
 op hosp

Today @ 2, mtg

Proposed Design Concept for the L.A. County Waiver

Structure of the Without Waiver Baseline

1. The without waiver baseline would be trended from SFY 1995. The waiver window is from SFY 1996 - 2000.
2. The base year of the waiver will include the following:
 - \$105 million from retrospectively increasing the uncompensated trend factor through the State Plan Amendment (SPA)
 - Relevant County Medicaid spending under the waiver.
3. The expected \$97 million increase for the increased SFY 95-96 uncompensated care trend factor, to be routed to the County immediately through SB 1255, will be part of the waiver instead of a state plan amendment. This limits the statewide nature of the SFY 96 increase to waiver counties only.
4. Conceptually, there are 2 without waiver baselines: a higher 5-year growth path trended off of the SFY 1995 base, which includes the \$105 million for the increased uncompensated care trend factor from the SPA (which implicitly allows room for increased uncompensated care factors in future years); and a lower 5-year growth path which does not include the trend factor increase in the base.
5. In the first 2 years of the waiver, the higher without waiver baseline will be used to determine budget neutrality.
6. At year 3 of the waiver, HCFA will determine whether part or all of the increase from the uncompensated care trend factors (from both the SPA and under the waiver) are allowable¹. At that point, the without waiver baseline for years 3, 4 and 5 will be adjusted to reflect the actual allowable costs in the base. In all likelihood, the resulting without waiver will fall somewhere in-between the two baselines above.
7. Starting in year 3, the State will have to adjust its waiver spending to meet 5-year budget neutrality against the revised without waiver baseline. The County must realize additional savings to make up for disallowed spending in years 1 and 2.

¹It is unclear whether HCFA will recoup on both increases in uncompensated care costs--from the State Plan Amendment and under the waiver. It is also unclear whether the recoupment under the waiver will include recoupment on any "unallowable" increase in the baseline due to a higher trend rate for uncompensated care.

Monitoring

8. In addition to the 5-year budget neutrality enforcement, there will be annual monitoring of County expenditures. For monitoring purposes, the County's waiver expenditures would be measured against the both without-waiver baselines.
9. If the County's expenditures exceed annual benchmarks designed to achieve budget neutrality by a given percentage, the County would be required to provide HCFA with a plan of how they would change their program to achieve the expenditure reductions necessary to achieve budget neutrality within the most conservative baseline. This plan would include specifics of both financial payback and program restructuring.

THE WHITE HOUSE

WASHINGTON

August 23, 1995

MEMORANDUM FOR LEON PANETTA

FROM: Diana Fortuna 
SUBJECT: Update on L.A. County Medicaid

Attached is an update on L.A. County Medicaid.

You will recall that HHS went to California in July with a demonstration waiver proposal. On August 3, the county and the state responded to HHS's proposals with some revisions. HHS has now developed a revised plan and had told the county they would travel to California later this week with a response.

However, OMB indicates that they cannot sign off on the proposal until early next week, when Jack Lew returns. At a meeting yesterday, OMB staff also raised the possibility that Public Health Service grants might be available to help L.A. County, but based on HHS's and my own experience in this area, that would be difficult given the categorical nature of PHS grants.

Whenever they present their new plan to the county, HHS staff feels it would be helpful if we reinforced with county officials that they should look carefully at the plan.

cc: Carol Rasco
Abner Mikva
Steve Neuwirth
John Emerson
Jack Lew
Martha Foley

L.A. COUNTY MEDICAID

HHS Proposal in July: \$296 – \$346 million

1. Use a higher trend factor (inflation factor) to calculate the limit on disproportionate share hospital payments. If actual costs are lower than this projection, the state/county would have to repay the money on a flexible schedule. **\$146 million**
2. Rate increase for freestanding outpatient clinics. **\$50 million**
3. Waiver to extend Medicaid eligibility to those using county freestanding clinics; increased Federal costs in the first year to be offset by managed care savings and reduced hospital use in the outyears: **\$100–150 million**, based on rough data from county

Since that time:

- o Rate increase (#2) dead, according to county, and savings from #3 determined to be no more than \$50 million. This reduces value of package above to a maximum of **\$196 million**.
- o County passed budget assuming savings from waiver. Must revisit issue on October 1, taking harsher actions if waiver seems unlikely. Hospitals kept open, but many clinics being closed.
- o State budget required Governor to try to include other counties in any waiver.

County/state Response on August 3:

- o Proposed that trend factor increase should apply to fiscal year that just ended; however, HHS general counsel believes that a demonstration waiver should not include retroactive elements.
- o HHS believes proposal does not set out adequate milestones for how county system will reform over 5 years of the waiver, and finds it vague on documenting Medicaid eligibility in clinics, including ensuring that Medicaid does not pay for undocumented aliens.
- o If trend factor proves to be too high, state does not want to repay until after 5-year demonstration; HHS opposes, partly to discourage other states.

New HHS Proposal: \$155–252 million

- o To discourage other counties from participating in the waiver, pull the trend factor out of the waiver and grant it state-wide as an independent action. This would leave only the Medicaid eligibility expansion in the waiver, which could be tailored to L.A. and include tough measures on reform. The Medicaid expansion is worth a maximum of **\$50 million**.
- o HHS could then agree to the retroactive trend factor increase requested, since it is no longer part of a waiver. This would yield **\$105 million**. (In yesterday's meeting, we were told this would be \$210 million, but that was an error.) *on their own*
- o The county/state would have the option of requesting the higher trend factor again in 1995/96, but HHS is concerned about the risk of potential repayment. This would yield **\$97 million**.
- o OMB is concerned about how well this plan limits precedent, and may advocate doing the trend factor without the waiver. In addition to the extra funds the waiver would yield, HHS believes a waiver could facilitate reform of the system. *yes-in waiver - so can direct to clinics*

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Display 1995-1996 Bill Text - INFORMATION
BILL NUMBER: AB 911

BILL TEXT

department, and to providing an adequate quality of care and services to persons served by the department who reside in residential facilities, and make recommendations for overcoming these obstacles.

SEC. 8. Section 7353 is added to the Welfare and Institutions Code, to read:

7353. The State Department of Mental Health shall pay the premium for third-party health coverage for Medicare beneficiaries who are patients at state hospitals under the jurisdiction of the State Department of Mental Health. The department shall, when a mental health state hospital patient's coverage would lapse due to lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation or group coverage pursuant to federal law or converting from a group to an individual plan.

SEC. 9. Section 10743.5 is added to the Welfare and Institutions Code, to read:

10743.5. It is the intent of the Legislature that, if the department seeks a waiver for any experimental, pilot, or demonstration project in the 1995-96 fiscal year pursuant to the authority of Section 1315 of Title 42 of the United States Code that has as one of its objectives the obtaining of additional federal funds for health care services, the department shall notify all counties of its intent to seek a waiver. A county shall notify the department within three working days of its intent to participate in this waiver. The department shall include these counties if the necessary documentation required of the counties supports their inclusion in the waiver request. It is further the intent of the Legislature that the department seek to include as many counties as possible in this request.

SEC. 10. Section 14021 of the Welfare and Institutions Code is amended to read:

14021. Notwithstanding any other provision of this chapter, health care shall include the following mental health services:

- (a) Mental health services provided by a county or a city.
- (b) Mental health services provided in a Short-Doyle community mental health service or in a community mental health center organized under the Federal Community Mental Health Centers Act of 1963. No amount shall be paid for that portion of the total costs of care and services in a federally funded community mental health center which may be compensated by the United States government under the Community Mental Health Centers Act of 1963. No amount shall be paid to a Short-Doyle community mental health service or a federally funded community mental health center unless the Short-Doyle community mental health service or the federally funded community mental health center participates in a county or city mental health performance contract pursuant to Section 5650.
- (c) Outpatient drug abuse services under the jurisdiction of the State Department of Alcohol and Drug Programs provided by a county provider certified under this chapter or a private provider certified under this chapter which has an approved contract with the county or with the State Department of Alcohol and Drug Programs to provide covered drug abuse services.

(d) Inpatient hospital services in an institution for mental diseases to persons of all ages, provided that the institution for mental diseases is

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Sally - ltd for
Residence

HCFA prop: utf s-w 94-5 one time basis, to create space, then
sb1255 \$220m immed to la; if actual lower (1/97), give back (only
bec bks are still open);

waiver less attractive; only expansion of clinics; systems change
hook

msg to la: no spa w/o waiver; adv: accpts other counties, but
limit;

potential relief to a lot of counties: they get spa, waiver
optional

in some ways better deal than 95-6: only \$147 vs \$220, payoff
over 5 years, not 1 year, not as part of waiver;

They want dsh; 94-95 and 95-6

We offered \$147 plus expansion; now \$220 plus expansion; already
said we don't want dsh;

We would deny dsh; opport to pay off all w/in context of
bn/waiver, recoupment outside; more meat on bones, specific
benchmarks

state will be more nervous bec of disallowances; no state money;
puts pressure on state

another set of calls; various people to var people

our old offer: would put all in waiver; but now there's more
counties bec of state legis; state would require other counties
to put up

Other bad things in 10/1 plan

* ~~Big~~ LP tomorrow? paper

* Some WH call to LA next wk

OMB needs ~~PHS grants~~ ~~jack~~

May still go next wk

Emerson (or Angell)

competitive grants

Emerson back

Offer 1: \$197m - clinic = \$146m - just +f.

300m exp - ^{\$100 -} 150m - county resisted clinic rate fed share

→ really \$100m - 50m fed share

Total \$190m or less

Asked to consider 9/1/95 backcast -

Offer 2: Backcast TK

Waiver recoupment, ^{DSH} during life of waiver - not DSH

Can't do retro 11/5

129 avail TF - even w/HCFAs via 1255

32 w/existing +f
1/2: ~~F~~ already counted on?

Plus higher TF

Eligibility an issue in 2P clinics Year 2: 95/96

try to persuade not to be too risky, but worth

Offer 3:

+ ~~8210~~ 165

+ fed match for new eligibles (\$50m?)

and growing

Also, TF is automatic \$ to other counties - promote KB warns recoupment

Year 2
100-750
193 → 97
167

155
97
252

LA COUNTY PROPOSAL AND ISSUES A COMPARISON OF STATE AND FEDERAL PROPOSALS

On August 3rd, the State of California submitted to HCFA a draft section 1115 Medicaid demonstration proposal for LA County intended to partially address the county's fiscal problems. After review of the draft, HCFA and the Department identified key policy issues and began constructing a possible response. The State proposed to make all health system and financing changes under an 1115 demonstration. In July, Department officials offered a more narrow demonstration to State and County officials, which California officials believed would offer sufficient fiscal relief. We would now prefer a two part approach -- as a State plan amendment followed by a demonstration. A comparison of the State proposal and the Federal response follows.

State Plan Amendment

- **Increased Trend Factor Under 94-95 State Plan Amendment**

State Proposal - The State proposed to increase under the demonstration the trend factor used to estimate total hospital costs for the State retroactively for State fiscal year (SFY) 94-95, and prospectively for the current fiscal year (SFY 95-96). The proposed 8.9% trend factor is the five year average of the "Hospital and Related Services for all Urban Consumers CPI." This trend factor assumes that uncompensated care costs are rising at a higher rate than the County's historical experience would suggest. It therefore allows the State to make additional lump sum payments under its SB 1255 rate augmentation program, part of its 1915(b) waiver program, to bridge the funding gap for the hospitals. DSH payments would not be affected. Without a re-estimation of costs, any additional SB 1255 payments would be offset by a reduction in allowable DSH payments, due to the OBRA 93 hospital-specific DSH caps.

7. According to the County, HCFA's approval of a Medicare market-basket trend factor would yield \$65 million in Federal funds for LA County in SFY 94-95, while the increased trend factor would result in an additional \$210 million in Federal funds for the County, for a total of \$275 million. In SFY 95-96, the Medicare market-basket would yield \$50 million and the increased trend factor would yield an additional \$97 million, for a total of \$147 million in Federal funds. The increased trend factor would be applied statewide, however, the fiscal impact on other counties has not yet been supplied by the State. Federal officials had offered in July to increase the trend factor prospectively as part of a demonstration.

Federal Response - HCFA often approves states' use of trend factors to estimate costs incurred for the purpose of State plan amendments (SPA) and could therefore likely approve California's request as a SPA. However, HCFA would insist that a reconciliation occur once the actual costs for the time period are known. Reconciliation

is a normal part of HCFA's process whenever trend factor projections are used. If actual costs are less than the costs projected using the trend factor, HCFA would take a disallowance for any Medicaid payments paid in excess of the hospital specific DSH limit. Reconciliation would occur once the cost reports for the year have been finalized, generally 1-2 years after the fiscal year ends. While the Department would prefer to limit California's use of this inflated trend factor to the SFY 94-95 only, it would be difficult to prevent the State from using it in future years as well.

HCFA is also concerned that other states with potential OBRA 93 problems would request similar treatment. Currently, 23 states and the District of Columbia have pending hospital State plan amendments for 94-95, and ostensibly, all states could apply an inflated trend factor in future years to calculate uncompensated care costs in the absence of actual cost data. While we cannot prevent this from occurring, our insistence on reconciliation and recoupment would protect us against unreasonable cost projections.

- **Increased Payments to Hospitals under SB 1255**

State Proposal - The State plans to make additional payments to hospitals through its SB 1255 program if hospital cost projections are increased using a higher trend factor. SB 1255 is a rate augmentation program under which the California Medical Assistance Commission (CMAC) negotiates supplemental payments related to emergency services for some DSH hospitals. Local intergovernmental transfers provide the non-Federal share of these payments.

Federal Response - We agree that the State can make additional SB 1255 payments if the hospital cost cap is increased. (SB 1255 payments are not DSH payments and therefore do not count against a state's DSH allotment. However, if these payments, combined with DSH and other hospital revenues for uncompensated care, exceed actual uncompensated care costs, HCFA would recoup the overpayment.) Further, the increased spending under SB 1255 would go into the budget neutrality baseline for the section 1115 demonstration. However, if HCFA takes a disallowance in the first two years of the demonstration related to Medicaid payments in excess of the OBRA 93 DSH limits, the baseline would subsequently be reduced.

- **Waiver of cost-effectiveness requirement of 1915(b)**

State Proposal - The cost effectiveness requirement of the 1915(b) sets an upper limit to what the State can pay under SB 1255. The State has indicated that the program might not "appear to be" cost-effective if additional SB 1255 payments are made. Cost savings under the waiver are estimated to be \$225-350 million in FFP in SFY 94-95 and between \$415-600 million in FFP in 95-96. These amounts would be reduced if additional SB 1255 payments are made.

Federal Response - HCFA cannot waive cost-effectiveness under 1915(b). The State could avoid the cost effectiveness requirement if it folded the 1915(b) program into an 1115 demonstration. However, it would be difficult for the State to integrate a multi-county 1915(b) program into a single county demonstration, and the State seemed unwilling to consider it.

LA County's 1115 Demonstration Proposal

● Demonstration Goals

State Proposal - The primary goal of the State's August 3 draft proposal is to transition LA County's public health care system from its current emphasis on inpatient hospital care toward an emphasis on the more efficient provision of ambulatory services.

Federal Response - The State's concept proposal contains no specific plan for restructuring its health care delivery and financing systems and the Department has some concerns that the County is not committed to restructuring. The Department would require the State to clarify the goals of the project, include specific milestones and measurements for meeting those goals, and report quarterly on accomplishments, such as changes in inpatient capacity and utilization patterns.

The Department is also concerned that the County's current plan to close and or privatize the administration of several County outpatient clinics might undermine the provision of outpatient care and go against the stated goals of the demonstration.

● Budget Neutrality Methodology

State Proposal - The State proposes to use Federal Medicaid spending paid to the County health care system in SFY 1994-95 (including DSH payments) as the base year spending for the demonstration. These costs would then be tended forward at an 8.9% trend rate (this rate is the five year average of the "Hospital and Related Services for all Urban Consumers CPI" ending in December of 1994) over the five years.

Federal Response - The Department intends to review LA County's current Medicaid growth rates and determine whether county, national, or some other growth rates would be most appropriate. In addition, as California is a high DSH state, DSH spending should grow at 0%. It is not clear from the State's proposal whether base year spending includes the SB 1255 rate augmentation payments. We would propose to include these payments in the base year initially, and reduce the budget neutrality cap later if reconciliation for the OBRA 93 caps is necessary.

- **Demonstration Phase I: Federal Match for Indigent Care.**

State Proposal - The State proposes that the Federal government match aggregate uncompensated care costs for non-hospital ambulatory services provided by County clinics. Federal financial participation would be determined prospectively, and would be neither linked to eligibility for services nor retroactively adjusted for actual costs.

Federal Response - The Department indicated willingness to consider this request in the context of a demonstration at the July meeting with State and County officials since it would provide an additional source of revenue for the county clinics. However, the Department is concerned that the State's proposal (1) does not link cost of services to individuals eligible for those services, thereby possibly including the costs of undocumented aliens in the amount eligible for Federal match (undocumented individuals are only eligible for emergency services under Medicaid) and (2) does not reconcile estimated costs to actual costs. To address the concern with aggregate payments, we could require the State to establish an eligibility verification system for indigent individuals receiving care in these settings. To avoid overpayment, we could require that payments be reconciled to actual costs. [Alternatively, we could match estimated costs net of some proportion agreed to be related to undocumented persons, and not reconcile as long as the budget neutrality caps are not violated.]

- **Demonstration Phase II: County Control of DSH Funds**

State Proposal - In this phase, LA County would receive its share of the State's total DSH allotment directly from the Federal government and would continue to provide the non-Federal share of the funds. The County would then have the flexibility to distribute the funds to a full range of county health providers, not just inpatient hospitals.

Federal Response - The Department is required by law to make payments to states through a single State agency. This requirement has been waived in the past, however, it might require legislation on the part of the State for this to take place. It is not clear that the State favors this approach.

- **Waiver of Recoupment of OBRA 93 DSH Overpayments**

State Proposal - The State is requesting a waiver of the recoupment of any overpayments related to the OBRA 93 DSH limits resulting from the over-estimation of the uncompensated care incurred costs.

Federal Response - The Department views this as the same as a request for a waiver of the OBRA 93 limits -- something we have told other states we will not approve. The higher trend factor should provide a temporary source of additional and immediate cash to the State and the county, but reconciliation is necessary to maintain the integrity of the law.

- **Applicability of Demonstration to Other Counties**

State Proposal - The State passed a law requiring that all other counties have 72 hours in which to request to become part of the 1115 demonstration.

Federal Response - The Department is concerned that the participation of additional Counties will increase the Federal government's financial exposure. However, if the requirements of the 1115 demonstration are structured narrowly enough, it is possible that other counties will not be able to meet the criteria for participation.

Martha Foley is

Leon's staffer.

~~Sally \$270⁰⁰ 94-95~~

no rate ↑; w/IGT -
Some of it at least

SUMMARY OF LOS ANGELES COUNTY OPTIONS

Rel to Beno??
** #1 only?*
reason
don't m

Option 1

- just?*
- o Permit the state to use a higher trend factor for calculating the DSH limits
 - o The county would ask the state to implement a rate increase for freestanding outpatient clinics
 - o New federal revenue of \$196.5 million in state FY 1995-96
 - o \$146.5 million from the trend factor
 - o \$50 million from increased clinic rates
- benefit other counties*

fold in 112 as part of waiver?
how?

Option 2

- o Same two items in option 1 plus requesting the state to submit a Medicaid 1115 waiver proposal. The waiver would expand Medicaid eligibility by permitting the county to claim Medicaid match for indigent care provided in county-owned freestanding outpatient clinics. Increased federal costs in the first year would be offset by managed care savings and reduced hospital use in the out years.
 - o New federal revenue of at least \$296.5 million in state FY 95-96
 - o \$196.5 million from option 1
 - o ~~\$100-150~~ million from new federal revenue to county freestanding outpatient clinics
- part of settlement, even to fence off*

CAVEATS

urban CPI - not Louisiana
SR - Louisiana is diff.

- o All estimates of new revenues are based on data submitted by Los Angeles County and should be considered preliminary.
- o Both options require the state to raise provider payment rates to match new federal revenue. The state is reluctant to increase rates because of outstanding litigation.
- o Option 2 requires the state to submit a Medicaid Section 1115 waiver.
- o Increasing the trend factor used to calculate the DSH payment limits for L.A. County will almost certainly lead to pressure from other California counties for a higher trend factor. Other counties and states may also ask for a higher trend factor.
- o Approval of an Section 1115 waiver specifically for Los Angeles County will probably lead other counties to ask for a similar waiver.

- o Approval of an 1115 waiver will require the county to meet budget neutrality provisions over a five-year period.

LA PROPOSALS

LA County's most recent proposals have included the following elements:

(1) A request that HCFA allow intergovernmental transfers from the county to the State to be included in calculating the OBRA '93 DSH limits. (We have rejected this proposal as totally inconsistent with the law and Congressional intent.)

✓ (2) A request to permit the hospital cost portion of the DSH limits to be trended forward for FY 1995 and subsequent years on a basis that takes into account the higher than average costs incurred by LA public hospitals. Like the first proposal, this would raise the DSH limits for each hospital and would permit them to receive additional revenue from the Medicaid program through rate increases, DSH payments or other means approved by the State

✓ (3) A proposal for an 1115 demonstration project to test the effects of shifting some of the current large hospital DSH payments to other providers (especially free-standing clinics) in the county-wide system.

Although the State has not yet endorsed the demonstration proposal, the first two elements discussed above were set forth in a July 10, 1995 letter to the Administrator of HCFA from the Director of the State Medicaid program, John Rodriguez.

HHS COUNTER-PROPOSALS

While we cannot adopt the first proposal on intergovernmental transfers, our proposal adopts in principle the second and third of LA proposals. We believe the County should be presented with the following two options based on their recent proposals.

Option 1

- ◆ Permits \$196.5 million in additional Federal funding for State Fiscal year 1995-96

- In calculating the OBRA '93 DSH limit for State FY 1995-96, HCFA will permit the State to use the CPI for Hospitals and Related Services for All Urban Consumers as the trend factor to project hospital costs. Using this trend factor would allow an additional \$146.5 million in Federal funds to flow to the LA County hospitals without violating the OBRA '93 DSH limits.

Source of State share for payment increases is not clear, but could be County certified public expenditures (CPE).

- Request the State to implement a rate increase for the freestanding outpatient clinics. Increasing the rates by \$100 million would provide for an additional \$50 million in Federal funds. The State share of this increase will be County CPE.

Option 2

- ◆ Permits \$296.5 million in additional Federal funding for State Fiscal year 1995-96

- Includes option 1.

- In addition, the County would request the State to submit an 1115 Demonstration proposal for urban LA County. Under the demonstration, the State could expand Medicaid eligibility to cover the care provided to certain indigents in freestanding outpatient clinics. This would allow the State an additional \$100 million in Federal funds to be paid to these freestanding outpatient facilities. State share would be County CPE.

- The State has submitted a 1915(b) waiver which would provide for public provider managed care plans in 13 counties including L.A. County. It is consistent with this 1115 proposal.

: We must emphasize that all the estimates of funds to be made available under these options are based on information provided by LA County and have not independently been verified.

Also note that all of these options would require the involvement of the State. A DSH cap increase would require the State to approve rate increases, additional DSH funding, or other funding increases; and an 1115 demonstration proposal would have to be submitted by the State.

1. Facts/details; all ~~was~~ clear
1a. (also, cash option)
if they need it

2. → Waxman - in a.m.; ask to ~~meet~~ ^{present to} Molina
3. → Supervisors - Mon

4. Prep for press / positive presentation
(DS: depue @ LAS)

and the results of a public hearing and public comments on such plan, and

(B) that establishes milestones for achievement of the requirements of this subsection.

SEC. 228. PUBLIC TRANSPORTATION PROGRAMS AND ACTIVITIES IN EXISTING FACILITIES AND ONE CAR PER TRAIN RULE.

(a) PUBLIC TRANSPORTATION PROGRAMS AND ACTIVITIES IN EXISTING FACILITIES.—

(1) IN GENERAL.—With respect to existing facilities used in the provision of designated public transportation services, it shall be considered discrimination, for purposes of section 202 of this Act and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), for a public entity to fail to operate a designated public transportation program or activity conducted in such facilities so that, when viewed in the entirety, the program or activity is readily accessible to and usable by individuals with disabilities.

(2) EXCEPTION.—Paragraph (1) shall not require a public entity to make structural changes to existing facilities in order to make such facilities accessible to individuals who use wheelchairs, unless and to the extent required by section 227(a) (relating to alterations) or section 227(b) (relating to key stations).

(3) UTILIZATION.—Paragraph (1) shall not require a public entity to which paragraph (2) applies, to provide to individuals who use wheelchairs services made available to the general public at such facilities when such individuals could not utilize or benefit from such services provided at such facilities.

(b) ONE CAR PER TRAIN RULE.—

(1) GENERAL RULE.—Subject to paragraph (2), with respect to 2 or more vehicles operated as a train by a light or rapid rail system, for purposes of section 202 of this Act and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), it shall be considered discrimination for a public entity to fail to have at least 1 vehicle per train that is accessible to individuals with disabilities, including individuals who use wheelchairs, as soon as practicable but in no event later than the last day of the 5-year period beginning on the effective date of this section.

(2) HISTORIC TRAINS.—In order to comply with paragraph (1) with respect to the remanufacture of a vehicle of historic character which is to be used on a segment of a light or rapid rail system which is included on the National Register of Historic Places, if making such vehicle readily accessible to and usable by individuals with disabilities would significantly alter the historic character of such vehicle, the public entity which operates such system only has to make (or to purchase or lease a remanufactured vehicle with) those modifications which are necessary to meet the requirements of section 222(c)(1) and which do not significantly alter the historic character of such vehicle.

SEC. 229. REGULATIONS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Transportation shall issue regulations, in an accessible format, necessary for carrying out this part (other than section 223).

(b) STANDARDS.—The regulations issued under this section and section 223 shall include

standards applicable to facilities and vehicles covered by this subtitle. The standards shall be consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board in accordance with section 504 of this Act.

SEC. 230. INTERIM ACCESSIBILITY REQUIREMENTS.

If final regulations have not been issued pursuant to section 229, for new construction or alterations for which a valid and appropriate State or local building permit is obtained prior to the issuance of final regulations under such section, and for which the construction or alteration authorized by such permit begins within one year of the receipt of such permit and is completed under the terms of such permit, compliance with the Uniform Federal Accessibility Standards in effect at the time the building permit is issued shall suffice to satisfy the requirement that facilities be readily accessible to and usable by persons with disabilities as required under sections 226 and 227, except that, if such final regulations have not been issued one year after the Architectural and Transportation Barriers Compliance Board has issued the supplemental minimum guidelines required under section 504(a) of this Act, compliance with such supplemental minimum guidelines shall be necessary to satisfy the requirement that facilities be readily accessible to and usable by persons with disabilities prior to issuance of the final regulations.

SEC. 231. EFFECTIVE DATE.

(a) GENERAL RULE.—Except as provided in subsection (b), this part shall become effective 18 months after the date of enactment of this Act.

(b) EXCEPTION.—Sections 222, 223 (other than subsection (a)), 224, 225, 227(b), 228(b), and 229 shall become effective on the date of enactment of this Act.

PART II—PUBLIC TRANSPORTATION BY INTERCITY AND COMMUTER RAIL

SEC. 241. DEFINITIONS.

As used in this part:

(1) COMMUTER AUTHORITY.—The term “commuter authority” has the meaning given such term in section 103(8) of the Rail Passenger Service Act (45 U.S.C. 502(8)).

(2) COMMUTER RAIL TRANSPORTATION.—The term “commuter rail transportation” has the meaning given the term “commuter service” in section 103(9) of the Rail Passenger Service Act (45 U.S.C. 502(9)).

(3) INTERCITY RAIL TRANSPORTATION.—The term “intercity rail transportation” means transportation provided by the National Railroad Passenger Corporation.

(4) RAIL PASSENGER CAR.—The term “rail passenger car” means, with respect to intercity rail transportation, single-level and bi-level coach cars, single-level and bi-level dining cars, single-level and bi-level sleeping cars, single-level and bi-level lounge cars, and food service cars.

(5) RESPONSIBLE PERSON.—The term “responsible person” means—

(A) in the case of a station more than 50 percent of which is owned by a public entity, such public entity;

(B) in the case of a station more than 50 percent of which is owned by a private party, the persons providing intercity or commuter rail transportation to such station, as allocated on an equitable basis by regulation by the Secretary of Transportation; and

(C) in a case where no party owns more than 50 percent of a station, the persons providing intercity or commuter rail transportation to such station and the owners of the station, other than private party owners, as allocated on an equitable basis by regulation by the Secretary of Transportation.

(6) STATION.—The term “station” means the portion of a property located appurtenant to a right-of-way on which intercity or commuter rail transportation is operated, where such portion is used by the general public and is related to the provision of such transportation, including passenger platforms, designated waiting areas, ticketing areas, restrooms, and, where a public entity providing rail transportation owns the property, concession areas, to the extent that such public entity exercises control over the selection, design, construction, or alteration of the property, but such term does not include flag stops.

SEC. 242. INTERCITY AND COMMUTER RAIL ACTIONS CONSIDERED DISCRIMINATORY.

(a) INTERCITY RAIL TRANSPORTATION.—

(1) ONE CAR PER TRAIN RULE.—It shall be considered discrimination for purposes of section 202 of this Act and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) for a person who provides intercity rail transportation to fail to have at least one passenger car per train that is readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, in accordance with regulations issued under section 244, as soon as practicable, but in no event later than 5 years after the date of enactment of this Act.

(2) NEW INTERCITY CARS.—

(A) GENERAL RULE.—Except as otherwise provided in this subsection with respect to individuals who use wheelchairs, it shall be considered discrimination for purposes of section 202 of this Act and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) for a person to purchase or lease any new rail passenger cars for use in intercity rail transportation, and for which a solicitation is made later than 30 days after the effective date of this section, unless all such rail cars are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs, as prescribed by the Secretary of Transportation in regulations issued under section 244.

(B) SPECIAL RULE FOR SINGLE-LEVEL PASSENGER COACHES FOR INDIVIDUALS WHO USE WHEELCHAIRS.—Single-level passenger coaches shall be required to—

(i) be able to be entered by an individual who uses a wheelchair;

(ii) have space to park and secure a wheelchair;

(iii) have a seat to which a passenger in a wheelchair can transfer, and a space to fold and store such passenger's wheelchair; and

(iv) have a restroom usable by an individual who uses a wheelchair, only to the extent provided in paragraph (3).

Demo - what's enough - issue smet/letter
declaring concept of op attractive to Admin
recognizes dire danger, impressed by
Coy's resolve to be with lab.
emerg/urgent w/ deadlines in dis of D 30/60/90

4F -
B1255

DS → UP

Not yet
DS → HW

- 1) letter - our rec
- 2) press
- 3) sanitized options

TF Recs - tom recs
Bd Tues.
Vote by con

Tues a.m. (or Wed.)
conf to use 1 time

Chop away op - amb care can be rebuilt
Fed help?

Bd must accept -

Margolin home
310-838-8209

1-time recs - bridge to reform

Diff CAO - mastery
Wldnt mind

Mohr + Reed don't speak
Banks doing good
2R's like SR

HAS IT BEEN RULED OUT?

Yaroslavsky - 213-974-3333

Keep system breathing

Retro MAC \$226m

Since 1 time use for closure - SR

They cut \$60m / \$310 total USC County

\$250 - would love to use MAC

COUNTY OF LOS ANGELES

(204) 456-1121

\$1.0 BILLION BUDGET RESOLUTION STRATEGY

By LDDJ
MARTHA F.
JENNIFER P.

Available One-Time Funding

- \$22-150 Million
- Fund Balance?
- Refinancing Options
- Early Separation

Budget Deliberations Remaining Curtailments

- STBD

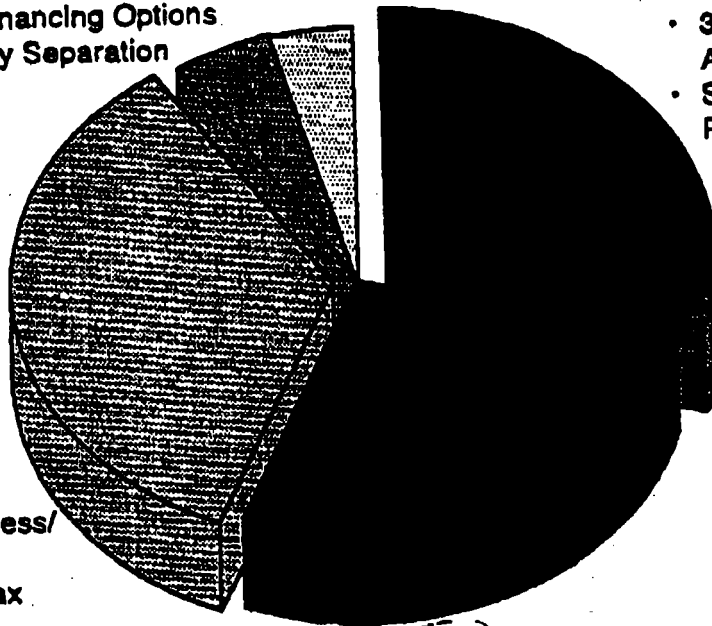
Pre-Budget Deliberation Curtailments

(Taken 6/20/95)

- \$294.8 Million
- 5,773 Budgeted Positions Removed
- 3,804 Layoffs Approved*
- Some Cuts are Problematic

State Approved Local Revenue Options

- \$250-900 Million
- Tippler's Tax
- ~~Tobacco Tax~~
- Countywide Business/Utility Tax
- 1/3 Cent Sales Tax



Available Local Revenue Options (Unincorporated Areas Only)

- \$42.8 Million
- Utility Users Tax
- Increase Landfill Rates
- Business License Tax
- Hotel Tax

State/Federal Revenue

- \$226 Million - Retro
- Retroactive SB 910 Reimbursement
- Raise OBRA '93 Cap

11,316 Preventable Layoffs

• Sheriff:	452	•
• Probation:	655	•
• District Attorney:	405	•
• Sup./Muni. Courts:	353	•
• Coroner:	21	•
• PD/APD:	294	•
• Assessor:	236	•
• Pub. Soc. Serv.:	1,782	•
• Health Services:	7,000	•
• Parks & Rec.:	118	•

*Action taken 6/20/95.

* 3843

This is what they expect from Fed on Dispute

* Actual number of layoffs will vary due to cascading process and department head discretion.

HD 13,000 includes unfilled

All 18,000

Added to
800-1,600
Emerson
207-4769

ELEMENTS OF EXPECTED HHS PROPOSAL

1. Outpatient rate increase: L.A. County would get \$50 million from such a rate increase at its freestanding clinics. The state has not yet supported this idea. It would benefit a number of counties in addition to L.A.
2. Trend Factor: In computing the cap on DSH payments, HHS would agree to a higher inflation factor for L.A. County, on the grounds that its costs are higher. This would not apply to the rest of the state. There are precedent questions here for other metropolitan areas.

This would net L.A. County \$146 million. Because of state-wide constraints on the DSH program, this would benefit the county by means of a rate increase rather than by increasing DSH payments to the county.

OMB says costs will ultimately be reconciled to actuals, so that, if the inflation factor is wrong, L.A. will owe us money back at some point.

This would require state approval.

3. Demonstration Waiver: L.A. County proposed a demonstration that would waive all the DSH rules. HCFA has precedent concerns on this, particularly after Louisiana. HCFA may propose an alternative waiver that would (1) extend Medicaid eligibility to people who come to L.A. freestanding clinics; and (2) increase rates at these clinics.

This would yield \$100 million this year. It would achieve budget neutrality because of the assumption that enrolling these people in managed care would reduce inpatient costs over 5 years, requiring a downsizing of system over time.

Issues: (1) what portion of those extended eligibility would be illegal aliens; (2) precedents for other areas; (3) what piece of paper could be produced quickly, since the usual process takes months; (4) the state must make this proposal; (5) waivers are ultimately reconciled to actual costs.

ISSUES

- o L.A. County may view this as not much of an offer, since it's all dependent on state action.
- o County is very focused on DOJ as a mechanism. DOJ is not working on any kind of settlement at this point. If/when L.A. County hears that the DOJ process has yielded nothing, they will probably react very strongly, at least initially.
- o We have discussed requesting an agreement from L.A. that they will not pursue litigation on the initial MAC claim if we assist them. However, the county may argue that the items above are unrelated to the claim. Also, it is the state that must waive litigation rights.

Hand to doalgs w/ state
OMB - weekend
TF: mtg tomorrow, rec Tue/Wed?

SENT BY:Xerox Telecopier 7021 : 7-21-95 : 1:14PM :

8164451424

444300023210

2021090-56.77



COUNTY OF LOS ANGELES
CHIEF ADMINISTRATIVE OFFICE
SACRAMENTO LEGISLATIVE OFFICE

1100 K Street, Suite 300
Sacramento, California 95814
(916) 441-7888 • FAX (916) 445-1424

SALLY R. REED
CHIEF ADMINISTRATIVE OFFICER

STEVE JUAREZ
CHIEF LEGISLATIVE REPRESENTATIVE

July 21, 1995

**Honorable Sandra Smoley, Secretary
California Health and Welfare Agency
1600 Ninth Street, Room 450
Sacramento, California 95814**

Kimberly Betshs', Director
California Department of
Health Services
714 F Street
P.O. Box 94732
Sacramento, California 95814

Dear Mr. Smoley and Mr. Belsho:

Los Angeles County is requesting your approval and formal submission to the Health Care Financing Administration of the attached concepts for a Demonstration Project for the Los Angeles County Health Care System. Pursuant to Section 1113 (a) of the Social Security Act [42 U.S.C. § 1315(a)], a Medicaid demonstration project is proposed to test an alternative method of distributing certain federal and non federal funds currently being distributed to the County's six hospitals that serve a disproportionate number of Medi-Cal and low income individuals.

As you know, the County health system is currently confronted by an unprecedented budget crisis. Your expeditious review, approval and continuing cooperation regarding the Demonstration Project is critical to the resolution of this crisis. The Demonstration Project by itself will not provide any additional funding to the County. However, it will permit the preservation of existing funds that are currently being received as disproportionate share hospital (DSH) funds (as converted to demonstration funds under the project), and will allow the County to retain new Medicaid funding sources that become available. The sources which we are currently seeking, and which still will require separate state and/or federal approvals, include:

SENT BY:Xerox Telecopier 7021 : 7-21-95 : 1:13PM :

8106401620

Mess. Smoley and Belsher

-2-

July 21, 1995

- Expansion of inpatient payments to our hospitals under the SB 1255 program.
- Expansion of outpatient payments, to our hospitals and clinics, contingent upon new state legislation and/or amendments to the Medi-Cal State Plan.
- Extended Clinic Visit (ECV) payments to our hospitals and clinics, contingent upon administrative implementation of a new ECV rate and amendments to the Medi-Cal State Plan.

We recognize that the above might have to be implemented in a way that would not require any new state general fund expense, nor will the Demonstration Project. However, implementation of the Demonstration Project will permit us to focus on securing the most appropriate funding mechanism(s) without fear of loss of DSH revenues.

During the past few days, we have pursued preliminary discussions with federal officials regarding the concepts for the potential Demonstration Project. The initial federal reaction has been positive, so we believe that expedited efforts at the State and local level could be very productive.

Los Angeles County staff stand ready to assist you in your review of this proposal on an emergency basis. Should you have any questions, please contact me at (916) 441-7886 or (213) 874-1151

Sincerely,

Gerald A. Roos

Gerald A. Roos
Senior Assistant Administrative Officer

GAR:pom
cc: Assembly Member Barbara Friedman

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BOARD OF SUPERVISORS COUNTY OF LOS ANGELES

856 KENNETH MAHN HALL OF ADMINISTRATION / LOS ANGELES, CALIFORNIA 90012 / (213) 974-4111

GLORIA MOLINA
SUPERVISOR, FIRST DISTRICT
CHAIR OF THE BOARD
FAX TRANSMITTAL

CALL
CARRIE SATKIN
regarding this
fax

JUL 18 1995

Date: 7.18.95

To: Carole Roscoe
Assist. to the President, Director of Domestic
Policy

FAX Number: (202) 456-7028

Sender: Burt Margolin, Chair Health Crisis Task Force
Gloria Molina, Supervisor L.A. County

Remarks: As was discussed with V.P. Gore.
This will be presented at tomorrow's
meeting with L.A. Delegation & Mr. Panetta.

Number of Pages (including cover sheet) 26

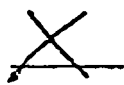
Phase 1 + rate increase =

lit + OBRA cap
Demo - LT solution?

NOTE: If the FAX you receive is incomplete or illegible, please contact
the appropriate office as indicated below. (give city copy)

This FAX originated from:

Burt 310-282-6848



Hall of Administration - 213/974-4111
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East Los Angeles Office - 213/881-4601
FAX - 213/887-7286

San Gabriel Valley Office - 818/350-4500
FAX - 818/448-1573

Sec - Jerry

→ 916-441-7888

Gates 213-240-8101

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**MEDICAID DEMONSTRATION PROJECT FOR THE
LOS ANGELES COUNTY HEALTH CARE SYSTEM**

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I. THE PROJECT.

The State of California and the County of Los Angeles ("County") propose a Medicaid demonstration project pursuant to Section 1115(a) of the Social Security Act (42 U.S.C. § 1315(a)) to test an alternative method of distributing certain federal and non-federal funds currently being distributed to hospitals that serve a disproportionate number of Medi-Cal and low income individuals.

Under current Medicaid and Medi-Cal provisions, special funding is available in the form of "payment adjustments" for *hospital inpatient services* provided by disproportionate share hospitals ("DSH"). Under the Medi-Cal program, these special funds are distributed based on a federally-approved formula tied to the volume of Medi-Cal *hospital inpatient days* provided each year by each DSH facility. The State and County believe that, in the context of a large, public health care system, the current Medi-Cal DSH payment methodology, and particularly the federal *requirements* that DSH funds be distributed as a component of payments for *hospital inpatient services*, may encourage the over-utilization of expensive inpatient services. The current system may undermine the County's ability to provide cost-effective non-hospital *ambulatory health care services* to the Medi-Cal and indigent populations, since such ambulatory care services are not included in the DSH payment program under Medicaid or Medi-Cal. The demonstration project ("Project") is

^{1/} Medi-Cal is California's medical assistance program implemented pursuant to the federal Medicaid statute, Title XIX of the Social Security Act (42 U.S.C. § 1396, *et seq.*).

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designed to address this situation and test the hypothesis that a modified payment approach for these special funds will promote improved health care for the Medi-Cal and indigent populations of Los Angeles County.

The County's health care system, operated by the County Department of Health Services ("County DHS"), is designed to provide a continuum of care from primary and preventive care, which is provided through numerous clinics located throughout the County, to the most complex, tertiary care provided in several large teaching hospitals. The State and County believe that decisions as to the appropriate level of care provided to an individual should be driven by the medical judgment of health care professionals, taking into consideration the health care needs of the individual, as well as cost effectiveness and efficiency factors. The need to assure a continuing level of DSH funding, achievable only by maintaining a high level of Medi-Cal hospital inpatient days at the hospitals operated by County DHS, may serve to influence the manner in which health care services are provided by the County. The State and County believe it would be in the best interest of the Medicaid and Medi-Cal programs to reduce this potential influence, and propose to test this proposition through the Project.

It is proposed that the Project include two phases. The initial phase ("Phase One") would eliminate the connection between Medi-Cal DSH payments and the provision of hospital inpatient services at the County's hospitals. In recognition of the fact that the County health care system as a whole serves a disproportionate number of low income individuals, the Project would involve an allocation of Medi-Cal funds directly to County

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DHS. For the 1995-96 State fiscal year, the allocation will be equal to the amount that the County DHS hospitals are projected to receive for the 1995-96 State fiscal year under the Medi-Cal DSH program.^{2/} The County will receive the grant regardless of the number of Medi-Cal inpatient days of services rendered by the County DHS hospitals. The funds will be available to support the entire health care system operated by County DHS, including the numerous ambulatory care clinics, public health services, AIDS projects, prenatal and perinatal services, emergency and trauma services, as well as hospital inpatient care. Phase One of the Project will be implemented on October 1, 1995, the same day as the Medi-Cal DSH program initiates payments for the 1995-96 State fiscal year.

The second component of the Project ("Phase Two") will involve additional initiatives focused on health reform for the County's health system and for Medi-Cal and uninsured patients. Phase Two will include a coordinated effort with the "Two-Plan Model for Medi-Cal Managed Care" that is under development by the State Department of Health Services ("State DHS"). Among other things, Phase Two will involve the enrollment of uninsured and indigent patients in managed care programs, one or more intergovernmental programs between the County and the Local Initiative Health Authority for Los Angeles County^{3/} and, potentially, a variety of public-private coordinated efforts to address the

^{2/} The current Medi-Cal DSH program was implemented pursuant to legislation enacted in 1991 (S.B. 855), and is codified at California Welfare and Institutions Code § 14105.98.

^{3/} The Local Initiative Health Authority for Los Angeles County is the public entity created pursuant to California Welfare and Institutions Code § 14087.96, *et seq.*, and is contemplated as one of two managed care entities in the region that will participate in the State DHS two-plan model for the expansion of Medi-Cal managed care.

health care needs of the entire population of Los Angeles County. It is envisioned that Phase Two would commence on or about July 1, 1997.

The County is currently confronted by an unprecedented budget crisis. While approval of the Project by itself will *not* result in preservation of the entire health care system currently operated by County DHS, it is believed that the Project will promote and ensure the preservation of various components of the system, including the County's trauma center capabilities, public health services, specialized AIDS services, the emergency "911" program, burn care services, and other specialized services. As they are not available elsewhere in the area, the preservation of these services is critical to preserve and promote health care for the entire population of Los Angeles County.

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II. BACKGROUND.

A. The County DHS Health Care System And The Population It Serves.

In recent years, the State of California has continued to experience a significant recession, while the rest of the nation has made strides towards recovery. It is generally recognized that California's most severe economic problems are concentrated in the Los Angeles County region. The poverty population for the region is about 1,400,000, an increase of 33% during the last decade. One in three County residents lives below 200% of the federal poverty level, while one in five residents receives public assistance, an increase of more than 100% over the past five years.

The Medi-Cal and uninsured population of the County is extraordinarily high. Medi-Cal enrollment within the County as of _____, 1995 was _____, an increase of _____ over a _____-year period. Approximately 30% of the County's population is uninsured as compared to 17% statewide and 10% nationally. Nearly half of California's six million uninsured individuals live in the County. The uninsured population has more than doubled in Los Angeles County over the last decade.

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The County's vast uninsured population is served primarily by the County DHS facilities. The County has six acute care hospitals, all of which are Medi-Cal DSH facilities. Among the County's hospitals is LAC+USC Medical Center, one of the nation's largest hospitals. The County DHS hospitals serve an especially critical role in the care of special populations, and provide continuity of care for individuals who only periodically qualify for Medi-Cal. It is usually the case that, for the uninsured, the County DHS providers are the primary source of needed health care services.

The County DHS system of ambulatory care services is the only source of medical care for many Medi-Cal beneficiaries and uninsured individuals, providing important and cost-effective services, such as primary preventive care, prenatal care, childhood immunizations, well-baby care, blood pressure treatment, and other specialized outpatient services. It has been widely recognized that ambulatory care services are cost-effective. For example, studies have shown that for every dollar spent on immunizations, \$14 is saved in hospitalization and other treatment costs for preventable diseases, such as diphtheria,

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measles, and polio. Moreover, ambulatory care often results in the avoidance of serious and more costly emergency room visits and inpatient hospitalizations.

As the providers of last resort, the County DHS facilities serve a unique patient population. County patients face the greatest number of language, educational, cultural, and socioeconomic barriers to understanding the health care system. These barriers hinder their ability to navigate through the health care system and understand and comply with physician instructions. Many of the County's patients are homeless, living in cars or on the streets. Because of the special needs of the patient population, outpatient services provided by County DHS facilities are more extensive and more costly than services provided in other ambulatory care settings. Typically, a County DHS outpatient visit includes extensive patient education and counseling. Patients and their families frequently need assistance in understanding the health care system as a whole, as well as the specific instructions regarding their individual treatment plans.

While the County DHS ambulatory care services are both important for the entire community, and unavoidably more costly than ambulatory care services provided to the general population, there is currently no special federal payment mechanism for these services. Unlike hospital inpatient services provided in the County DHS hospitals, ambulatory care, especially in the non-hospital setting, does not qualify for special payment consideration under the federal DSH program. This is one factor among a variety of factors that are placing the viability of the County's health care system in serious jeopardy. As a result of the recession, the region is experiencing significant growth in its poor and uninsured

population, and consequently an increased demand for free or low-cost health care services. The situation has reached a crisis stage, and the County has initiated serious discussions regarding the possible closure of LAC+USC Medical Center. An unprecedented health care crisis would ensue from the failure of such a key safety net provider.

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B. The DSH Payment Adjustment Program.

The federal Medicaid statute currently requires each state to take into account the special needs of hospitals serving a disproportionate number of low income individuals in setting rates of payment for inpatient hospital services. (42 U.S.C. § 1396a(a)(13)(A).) The statute describes in detail the types of hospitals that must receive special payment consideration, as well the required nature and scope of DSH payment programs. (42 U.S.C. § 1396r-4.)

The State of California has adopted the most restrictive definition permitted by federal law for eligibility as a Medi-Cal DSH facility. Medi-Cal DSH payment adjustments are based on the number of Medi-Cal hospital inpatient days of service provided by a qualifying DSH hospital, and are paid in conjunction with the hospital's paid-days of Medi-Cal hospital inpatient services. The non-federal share of the Medi-Cal DSH program is funded through intergovernmental transfers from counties and other local public entities. (Calif. Welf. & Inst. Code §§ 14105.98, 14163.)

During the State's fiscal year ending June 30, 19__, DSH payments represented __% of total Medi-Cal expenditures. Los Angeles County provided \$__ million as its portion of the non-federal share of DSH payments to public and private DSH hospitals in the State. Total Medi-Cal DSH payments to County DHS facilities amounted to \$_____ million.

Medi-Cal DSH funds have served to assist the County in preserving its safety net health care system since the 1991-92 State fiscal year. However, under the current DSH program, full funding can only be maintained through the provision of a high volume of Medi-Cal hospital inpatient days of service. Under this methodology, payments are based on hospital-specific inpatient factors, and do not take into consideration the benefits associated with non-hospital ambulatory care. Thus, the extraordinary volume of non-hospital outpatient and other clinic services provided to poor and uninsured patients in a comprehensive health care system such as that operated by County DHS is disregarded for DSH payment adjustment purposes, even though the fiscal pressures stemming from the provision of such services are no different from those faced by its hospitals. The strong incentive to utilize hospital inpatient services is in direct conflict with the stated goals at all levels of government to reduce health care costs through the application of managed care principles. Such principles, in particular, seek to moderate the use of costly hospital inpatient care whenever possible and consistent with quality medical care.

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III. GOALS AND OBJECTIVES.

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A. Project Objectives.

In its broadest terms, the goal of the Project is to optimize health care expenditures for Medi-Cal, indigent and uninsured populations through assuring the availability of services and more efficient utilization of health care resources on a local basis. The approach of the Project is twofold, in that it attempts to effect both systematic changes and the modification of patient utilization patterns.

The Project initially is directed at the stabilization and modification of the health care delivery system that serves these special populations. As described above, the County DHS facilities, as a whole, offer a comprehensive range of health care services and serve as the health care safety net for the region. The County system, however, is in serious financial distress. In this situation, a Medi-Cal allocation to the County system, in lieu of Medi-Cal DSH inpatient payment adjustments to individual County DHS hospitals, is designed to achieve the following objectives:

- To stabilize the County DHS health care safety net.
- To prepare and assist the County DHS infrastructure to emphasize outpatient and preventive care modalities.

Additionally, the stability and structure of the County health care safety net has significant implications for all other health care providers in the region. The Project therefore contemplates the participation of non-county health care providers. Such participation could involve bona fide donations of funding and services in kind, as permitted under federal Medicaid law (42 U.S.C. § 1396b(w)). The involvement of other health care providers in this Project would play an important role as the County DHS health care system retools for the impact that expanded managed care will have on the special populations served by the County.

The Project also is directed towards impacting the utilization of services. It is often the case that Medi-Cal, indigent and uninsured patients do not utilize preventive services and do not seek early treatment of medical conditions, ultimately necessitating more expensive treatment such as inpatient and emergency room services. The Project, by maintaining the availability of preventive and outpatient services to such populations, as well as an increased emphasis on patient education, is designed to achieve the following objectives:

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- To modify utilization patterns toward outpatient and preventive care modalities.
- To achieve cost savings through the efficient provision of appropriate services.

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- To improve the overall health status of poor and uninsured populations.

B. Consistency with Federal Research and Demonstration Interests.

In January 1994, the Health Care Financing Administration ("HCFA") issued its general solicitation for health care research and demonstration proposals. (59 Fed. Reg. 1951 (January 13, 1994).) The purpose of federal support for such research efforts, as articulated by HCFA, is to "stimulate, support and assist, through an active health services research and demonstration program, the resolution of major health care organization and financing issues." (*Id.*) More particularly, with respect to one priority topic -- Health Care Systems Reform and Financing -- HCFA's expressed interest is in three general areas:

- Extending access to needed services to all segments of our population.
- Controlling the growth in health care costs.
- Improving the quality of health care services and products.

(*Id.* at 1952.) In this regard, HCFA would "sponsor research concerning major U.S. health sector reform issues and also aspects of reforming health care financing incentives." (*Id.*)

The Project objectives as outlined above clearly are consistent with one of HCFA's priority research areas, as they are designed to address a "major U.S. health care

sector reform issue," i.e., the financing, structure and manner by which public health care systems provide care to poor and indigent populations in a changing health care environment. The Project will evaluate an alternative Medicaid financing arrangement for providing additional payments to public health care systems that serve an extraordinary volume of poor and uninsured patients. In this regard, the Project seeks to provide valuable information relating to incentives created as a result of Medicaid financing methodologies.

IV. DEMONSTRATION DESIGN - PHASE ONE.

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A. Research Questions.

The Project is designed to study the impact of a modified flow of Medicaid disproportionate share funding on a large, public health care system. Specifically, Phase One of the Project will provide the opportunity to analyze the consequences of shifting from a hospital inpatient focus to payments which are based on systemwide services to disproportionate numbers of Medi-Cal and low income individuals. The results should assist in determining whether the Medicaid DSH program promotes inefficiency in such a system by encouraging the use of hospital inpatient services and whether the goals of cost effectiveness and efficiency can benefit from the elimination of the incentives created by the current DSH program.

DRAFT**B. Project Design.**

Federal Medicaid DHS funds that would have been paid to the State as a component of Medi-Cal DSH payments to the County DHS hospitals will be made available to the County in the form of a quarterly allocation without regard to the number of Medi-Cal days of hospital inpatient services provided. The anticipated duration of Phase One of the Project will be five years, beginning October 1, 1995. It is estimated that the total federal Medicaid funds involved for this component of the Project will be:

- \$ _____ for the 1995-96 State fiscal year;
- \$ _____ for the 1996-97 State fiscal year;
- \$ _____ for the 1997-98 State fiscal year;
- \$ _____ for the 1998-99 State fiscal year;
- \$ _____ for the 1999-2000 State fiscal year.

The County will continue to fund a proportionate share of the non-federal portion of Medi-Cal DSH payments made to other DSH facilities in the State. The non-federal match for the Phase One allocations will be made in the form of certified public expenditures by the County DHS facilities or by intergovernmental transfers from the County to the State.

The federal funds will be received by and administered by County DHS. While State DHS will remain as the State's Medicaid single state agency, for purposes of

receiving Project funding and the administration of the Project, the County will serve as the "single state agency" under 42 U.S.C. § 1396a(a)(5). The funds will be available for the full range of services provided to Medi-Cal and uninsured patients throughout the County DHS health care system. In this manner, the funds will provide support for the systemwide infrastructure that is necessary to maintain the health care safety net in the County.

C. Project Staff.

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Current County DHS senior administrative staff will be responsible for administering the Project. No additional administrative staffing will be necessary to implement Phase One of the Project. County DHS will work closely with the Advisory Board, as described below. It is anticipated, however, that the services of national research experts will be obtained for data collection and evaluation purposes.

D. Advisory Board.

An Advisory Board consisting of five (5) members will be appointed to monitor the Project and make recommendations regarding health care services for Medi-Cal, indigent and uninsured patient populations in Los Angeles County. The Advisory Board will be comprised of experts in the fields of health care financing and health care and social services for the patient populations in question. The members of the Advisory Board will be appointed as follows:

- Two members will be appointed by the Board of Supervisors of the County. Both of these members must be residents of Los Angeles County;
- Two members will be appointed by the State (one member each by the Governor and the Senate Rules Committee). Both of these members must be residents of Los Angeles County; and
- One member will be appointed by the Secretary of the U.S. Department of Health and Human Services.

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E. Budget Neutrality.

Budget neutrality will exist under Phase One because the amount of the federal funds available for the Project will be equivalent to the federal portion of the Medi-Cal DSH funds that would have been payable to County DHS hospitals based on the existing structure of the Medi-Cal DSH program. The State allotment for federal DSH funds, currently established at \$2,191,451,000 per federal fiscal year, includes \$1,095,725,500 in federal funds.⁴ The State's allotment will be reduced in the future by the amount of federal funds provided to the Project. Therefore, there will be no increase in total federal DSH funding for the State.

⁴ See 60 Fed. Reg. 3250 (January 13, 1995).

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The federal requirements regarding DSH payments for hospital inpatient services (42 U.S.C. §§ 1396a(a)(13)(A), 1396r-4) will be waived for purposes of the Project. Since the Project funds will be expended for County DHS non-hospital services as well as hospital inpatient services, the hospital-specific payment limitations of 42 U.S.C. § 1396r-4(g) no longer will be relevant. To date, there have been no federal fund reductions for the County DHS facilities under 42 U.S.C. § 1396r-4(g). For a number of reasons, it will be impossible to determine how 42 U.S.C. § 1396r-4(g) might have affected any particular County DHS hospital had the Project not been implemented. Moreover, California's DSH program applies the most restrictive definition of a DSH allowed by federal law. It is clear that the State could avoid a statewide reduction in DSH payments as a result of § 1396r-4(g) by expanding its definition of a DSH to the broadest extent allowed by federal law, thereby continuing to receive its full State allotment of approximately \$2.2 billion. Therefore, in determining budget neutrality on a statewide basis for purposes of the Project, the § 1396r-4(g) limitations should not be taken into account.

It is projected that the Project will actually result in a reduction of federal expenditures that would otherwise occur, because hospital inpatient utilization in the County DHS facilities should diminish on a relative basis as a result of the Project. Medi-Cal expenditures for hospital inpatient services are currently funded at the fifty percent (50%) level by the federal government. The County DHS facilities are currently paid a base rate of approximately \$1000 per diem for each Medi-Cal hospital inpatient day. To the extent that Medi-Cal hospital inpatient days diminish as a relative matter as a result of the Project, there should be a savings of about \$500 per diem in federal funds.

F. Relationship To Other Medi-Cal Waiver Programs.

1. *Selective Provider Contracting Program* -- The Selective Provider Contracting Program ("SPCP") is a waived program for hospital inpatient services under § 1915(b) of the Social Security Act (42 U.S.C. § 1396n). Medi-Cal DSH payments are not made through the SPCP contracts. The County DHS hospitals participate as contractors under the SPCP and it is anticipated that they will continue to do so for the duration of the Project. Thus, there will be no changes made to the SPCP as a result of the Project.

2. *Managed Care Two-Plan Model* -- On June 29, 1995, the State submitted a waiver request pursuant to 42 U.S.C. § 1396n to implement its program for expanding Medi-Cal managed care. Phase One of the Project is designed to prepare the infrastructure of the County's health care system to assure its effective participation in the State's managed care plan. In addition, as discussed below, Phase Two contemplates the expansion of the State's plan for managed care to include the uninsured within the managed care framework for the Los Angeles County region.

V. DEMONSTRATION DESIGN -- PHASE TWO.

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It is anticipated that the reallocation of DSH funds among various sectors of the County's health care system will strengthen the system as a whole and prepare it for the implementation of a managed care system for most of its patients. Phase Two of the Project

will be implemented in or about June 1997. Although further development of Phase Two will be required, the fundamental aspects of Phase Two ~~will~~ be as follows:

A. Objectives.

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- To stabilize the health care safety net, improve the community's overall health status, and to coordinate Medi-Cal activities with other federal programs.
- To facilitate transformation to managed care by empowering primary care providers to coordinate appropriate levels of care, thereby improving the efficiency and effectiveness of health care services to Medi-Cal, indigent and uninsured populations.
- To promote access to services and continuity of care to Medi-Cal, indigent and uninsured populations.
- To facilitate maintenance and transformation of medical education, public health, and research programs, while ensuring satisfaction of appropriate educational and scientific standards.
- To promote interfaces between clinical preventive public health services (e.g., Maternal Health, Child Health, Immunization, Healthy Start) and

other federal programs which fund direct patient care (e.g., VA, CHAMPUS) to avoid redundancy and inappropriate utilization.

B. Research Goals.

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- Evaluate whether health care expenditures for Medi-Cal, indigent and uninsured populations can be optimized through expanded coverage and more efficient utilization of health care resources on a local basis.
- Evaluate whether the health care status of Medi-Cal, indigent and uninsured populations can be improved through coordinated managed care methodologies.
- Compare economics and health care status of Medi-Cal, indigent and uninsured populations to developments relating to other Medi-Cal managed care models (i.e., COHS model, GMC model, two-plan model).
- Evaluate whether dependency on welfare cash assistance can be reduced by assuring health care coverage regardless of such welfare linkage.
- Evaluate whether assurance of health care coverage at reasonable rates affects the likelihood that small employers will purchase health

insurance coverage for employees, and whether such circumstances are advantageous in promoting economic growth in local areas.

- Evaluate whether availability of continuing health insurance benefits eases the transition for individuals and businesses severely impacted by defense industry spending reductions.
- Evaluate impact of managed care transformation on medical education, public health and research programs.
- Involve the services of nationally recognized research organizations in research and demonstration components.

C. Phase Two Design.

- Generally, all Medi-Cal beneficiaries having aid codes that are not designated for mandatory participation in the Medi-Cal two-plan model would be included as potential participants in Phase Two of the Project.
- Designated volume of indigent persons not eligible for Medi-Cal coverage under current Medi-Cal program would be included.

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- Designated volume of employees of small businesses that do not otherwise offer health insurance would be included.
- Designated volume of individuals severely affected by defense spending reductions would be included.
- Designated volume of County-related personnel potentially could be included.
- Medi-Cal service coverage would be the same package as provided under Medi-Cal Two-Plan model for the traditional Medi-Cal enrollees.
- There would be a modified scope of benefits for the indigent, small business, defense-related, and County-related enrollees, if any.
- Specified individual and/or employer contributions would be applied towards premium costs.
- Specified copayments and deductibles would apply, based on a sliding scale.

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VI. EVALUATION AND ANALYSIS PLAN.

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The Project contemplates the participation of nationally recognized research organizations in the evaluation component. The evaluation will focus on the following:

- Whether, as a result of making Medicaid DSH payments available for ambulatory and other non-inpatient services, there is improved access of appropriate services to poor and uninsured populations.
- Whether there is reduced utilization of inappropriate hospital inpatient and emergency room services (of all health care providers in the region) by poor and uninsured populations.
- Whether there is an overall improvement in the health status of poor and uninsured populations.

The evaluation likely would involve analyses of costs of services and patient encounter data, and various surveys. For example, as measures of more efficient utilization of services, the ratio of outpatient service costs to inpatient service costs could be analyzed. Access to preventive and ambulatory services may be evaluated by conducting surveys of hospital inpatients.

VII. WAIVERS REQUESTED.

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A waiver of certain federal Medicaid requirements will be necessary to implement Phase One of the Project, as follows:

1. *Disproportionate Share Hospital Payments* -- Section 1903(a)(13)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(13)(A)) requires that Medicaid hospital inpatient payment rates take into account the special needs of hospitals that serve a disproportionate number of low income individuals. This requirement is implemented by regulation at 42 C.F.R. § 447.253(b). Additional requirements related to DSH payments appear at Section 1923 of the Act (42 U.S.C. § 1396r-4). Because, under the Project, DSH payments no longer will be tied to hospital inpatient services, a waiver of these requirements will be necessary.

2. *Statewideness* -- A waiver of § 1902(a)(1) of the Act (42 U.S.C. § 1396a(a)(1)) regarding statewideness also will be necessary to allow the State to limit the geographic areas of the project to the Los Angeles County region. Implementing regulations at 42 C.F.R. § 431.50 must also be waived.

3. *Single State Agency* -- Section 1902(a)(5) of the Act (42 U.S.C. § 1396a(a)(5)) requires the designation of a single state agency for the administration of the Medicaid program in each State. The State DHS is, and will remain, the single state agency for California's Medi-Cal program. To allow the direct receipt and administration of the

Project funds at the local level, however, necessitates a waiver of this requirement.

Implementing regulations at 42 C.F.R. § 431.10 must also be waived. This waiver is consistent with the waiver granted under the SPCP to allow the California Medical Assistance Commission to administer the hospital inpatient contracting program and to negotiate payment rates.

Additional waivers of federal requirements will be necessary to implement Phase Two of the Project. The additional waivers that are necessary will be identified at a later date.

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Kicked to TF

Fri noon - due

Bd acts next wk

Sally

\$655

- Louisiana

- 90 days - Karen thought fast

- State submits
- Bruce

All w/in 2 mos, LA - USC

1/2 Leth ctors

2 other open { Harbor
 { MCK - Drew

3 others

Sally's B

or LA-USC open

but close trauma + 3 non-trauma

MCK - Drew open

→ Dismisses OBRA 93 cap

Mark W

DSH \$ to 6 hosp

Separate

Then demo

\$600m

Entire DSH statute including cap

Phase 2: indig pte coord care
Sep mgd care beyond 1915b pop.
(public lock in? maybe)

Denn

2 phases

1. relief relief DSH cap SR - wave cap
(Andy Schneider) (Cap variable) - get \$ as enhanced OP rate

95-96 - state formula
redistributes DSH \$ among

Budget neutr
State /

OR SB1255 w/o rate increase
↳ increase IP public's only

wouldn't be add'l DSH

Route to 7000 - wld think 10-11, 000