CONTRA COSTA COUNTY HEALTH SERVICES DEPARTMENT ENVIRONMENTAL AND ORGANIZATIONAL ASSESSMENT

March 5, 1997

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EXECUTIVE SUMMARY

This report provides an assessment of the Contra Costa County Health Services Department (CCHSD) in the context of the rapidly evolving health care environment, and presents recommendations to equip the Department to accommodate to the new environment. The health-care industry has become highly competitive, with managed-care-at-risk arrangements now the norm rather than the exception. In addition, counties, traditionally the provider of last resort, have become dependent on Medi-Cal revenues to support their indigent-care programs. And Medi-Cal, once shunned by the private sector, has become a sought-after business line as declines in health-care utilization, accompanied by increasingly-cost-conscious health-care purchasers, have created a buyer□s market. Counties are thus in a vulnerable position. Those that recognize their responsibilities to their indigent populations are faced with shrinking revenues and growing demands.

The first chapter of this report attempts to place the Contra Costa County Health Services Department in the context of the health-delivery system as a whole -- nationally, statewide and locally. It begins with an explanation of the Department's major funding sources. It then discusses the increasingly intense pressures on payments for health-care services. Next, the role of disproportionate-share funds is discussed, followed by a review of the likely impact of congressional efforts to reform the Medicaid program and recently-enacted federal welfare reform. The local health system is then described, followed by a discussion of the mental health environment.

Both with respect to the provision of health services in general, and mental health, the Department will need to make significant strides in its planning and capabilities in order to meet the challenges of operating within a fixed budget once Medi-Cal physical and mental health dollars are capitated. At least three things will have to be accomplished: (1) the development of adult and children systems of care that meet client needs while controlling costs; (2) a clear delineation of clinical and financial responsibility for the funds assumed by the Contra Costa County Mental Health - Managed Care Plan and the Contra Costa Health Plan; and (3) the development of adequate infrastructures and systems to manage risk.

The bi-partisan drive for a balanced budget by the year 2002 and the enactment of welfare reform guarantee that Medicaid will face significant cuts and that safety-net providers will be forced to treat more uninsured patients with fewer dollars.

Chapter 2 discusses governance issues, as they have been approached in other counties, and how changes in governance might improve the Health Services Department's ability to compete for Medi-Cal patients and enrollees, to preserve its vital funding sources. Fundamental governance changes appear unnecessary in Contra Costa County, but targeted reforms designed to give the Health Services Department the flexibility to compete more effectively with private-sector health-care providers for publically-sponsored patients should be considered.

The final chapter presents findings and recommendations. The findings are as follows:

1. The Health Services Department needs to have the capacity to compete.

2. The Health Services Department needs to have clear lines of responsibility and accountability within itself.

3. The Health Services Department needs to develop strategic partnerships.

4. The Health Services Department needs to focus on its areas of strength.

5. The Board of Supervisors needs to take a leadership role in promoting a broader sense of responsibility for the uninsured.

6. Critical decisions will be made in Sacramento during the coming Legislative session that will have a major impact on the Contra Costa County Health Services Department. The Board of Supervisors has to be actively involved in attempting to influence these decisions.

Specific recommendations are advanced addressing each of these findings, as follows:

1. The tools necessary to enable the County health system to be competitive should be explored in depth, to determine how they can most effectively be provided. Some may be accomplished through changes in operating policies, with no Board action necessary. Others may require Board approval. And still others, may require a change in governance. The options should be prioritized and classified into the above three categories (i.e., no Board action needed, Board action needed, governance change needed). Under this approach, change can be accomplished in an incremental manner, and need not be caught up in debates concerning governance. If restructuring is necessary, the Board may wish to consider creating a pilot program where, for a defined period, broader administrative discretion is given to the Department in specific areas such as personnel, contracting or supplies and equipment acquisition.

2. The Department should set overall policy for each of its components and then allow each component to act more independently and be accountable for its own results. To the extent feasible, overall policy should provide for maximum coordination and integration, while enabling distinct units to benefit from market-place developments.

3. A set of guiding principles for public-private partnerships should be developed, and all initiatives in this area should be measured against them.

4. The Contra Costa Health Plan (CCHP) and its provider network should build on their relationships with the SSI population, and begin enrolling as many beneficiaries as possible voluntarily, to provide a solid base for the next stage in the evolution of the Two-Plan Medi-Cal Managed Care Model.

5. If, and when, it becomes apparent that the effects of welfare reform and related State action (or inaction), Medicaid reform or other developments, will result in an unacceptable increase in the uninsured population, CCHSD should prepare projections of budget shortfalls under various scenarios and apprize the Board of Supervisors of available alternatives (including increased general fund contributions, feasible State legislative initiatives, and joint public-private efforts). The Board should be actively involved in dealing with all available alternatives through developing necessary consensus among affected interests (e.g., consumers, providers, organized labor).

6. The Board should adopt positions on major pieces of legislation that are expected to have a major impact on CCHSD, and lobby the Legislature and Governor accordingly.

I. THE HEALTH-CARE MARKETPLACE

A. INTRODUCTION

The Contra Costa County Health Services Department (CCHSD) provides a wide array of public health and health-care services, including in-and out-patient mental and physical health services, through operating a network of clinics, its own hospital and its own HMO. The broad-based nature of its service offerings provides the Department with the ability to be a nearly self-contained, integrated health delivery system, coordinating all levels of care and benefitting from economies of scale. To realize this potential, however, in addition to coordinating its public health, mental health and medical-care functions, the county-operated health services system must be able to successfully compete with private providers and health plans. While such competition for private-paying patients was an option to improve the financial position of the County Health System in the past, the competition has now become critical to the health system's long-term viability as it has shifted to the public-payer dollar. Medi-Cal, once shunned by many private-sector providers, has become a desired source of revenue for a hospital industry

with redundant capacity and increasingly squeezed by managed-care purchasers. At the same time, Medi-Cal represents the most important source of revenue for all county health systems, and provides necessary funding to support county indigent-care obligations (Section 17000 obligation). The County health-care delivery system is broader than the county-operated functions, as CCHSD contracts with private providers for services it does not provide directly, or for services that are not geographically accessible in all regions of the County. County programs relying on private-sector-provider contracting for the largest volume of service are the Contra Costa Health Plan and the Mental Health Division.

This chapter attempts to place the Contra Costa County Health Services Department in the context of the health-delivery system as a whole -- nationally, statewide and locally. It begins with an explanation of the Department's major funding sources. It then discusses the increasingly intense pressures on payments for health-care services. Next, the role of disproportionate-share funds is discussed, followed by a review of the likely impact of congressional efforts to reform the Medicaid program and recently-enacted federal welfare reform. The local health system is then described, followed by a discussion of the mental health environment.

B. FUNDING

Funding for the health-care delivery functions of the Contra Costa County Health Services Department is derived from a wide variety of sources, all of which are becoming more and more restrictive. The total Health Services Department budget for the current fiscal year is $344 million, down from $357 million the previous year. For the hospital, clinics and Contra Costa Health Plan (i.e., the County health system), the current-year budget is $225 million, down from $234 million in 1995-96.[1] Major sources of funds for the hospitals, clinics and Health Plan include:

(1) State funds, which are mainly "Realignment" funds earmarked for counties, derived from a portion of vehicle license fees and sales-tax revenue. For the current fiscal year, this source is budgeted at $22.1 million;

(2) Disproportionate-share hospital (DSH) payments, estimated at $9.7 million for the current year. These are federal Medicaid funds matched against transfer payments from public hospitals and distributed to qualifying hospitals on two bases: (1) a statutory formula based on Medi-Cal patient days (SB 855); and (2) A smaller amount negotiated with the California Medical Assistance Commission (SB 1255);

(3) Direct payments for patient care (e.g., Medi-Cal, Medicare, insurance, self-pay), broken down as follows:

- Medi-Cal $47.2 million

- Medicare $15.6 million
- Private insurance $15.9 million;

(4) County general fund contributions. The Board of Supervisors is attempting to minimize eliminate this source of funding. For the current year, it is budgeted at $14.6 million. This traditional source of funding for county-obligation patients has been sharply reduced in many counties as county revenues have been diverted to the state, and disproportionate-share (DSH) revenue, which is tied to Medi-Cal volume, has become a major source of funding for county-indigent patients. For the Department as a whole, County general funds total $33.3 million, 10 percent of the total budget; and

(5) Payments for hospital care from the County Mental Health Division, budgeted at $13.3 million.

C. PAYMENT PRESSURES AND THE IMPACT OF MANAGED CARE

Payment levels for health-care services have tightened considerably in recent years. While Medi-Cal payment rates have always fallen short of costs, they have fallen considerably short in recent years. In particular, hospital outpatient payment rates (generally frozen since 1982) now average less than 50 percent of costs, and few hospitals have received inpatient payment rate increases in recent years, under the Selective Provider Contracting Program. Medi-Cal and Medicare payment shortfalls have traditionally been off-set by inflated charges to private payers (cost shifting). This ability has been largely eroded with the proliferation of managed care (and never was an important option for county health systems, which do not have a large base of privately-sponsored patients).

Besides severely restricting the hospital's ability to cost shift, managed-care payers have aggressively pursued alternatives to inpatient care. Complemented by advancements in medical science, inpatient utilization is dropping universally. Tight payment rates combined with shrinking volume is resulting in intense competition by hospitals for a shrinking pool of patient-care dollars. That competition has recently spread to Medi-Cal patients, notwithstanding that program's low payment rates.

Competing for Medi-Cal patients is a relatively new phenomenon. Given Medi-Cal's relatively low payment rates (on average, 50 to 60 percent of allowable costs for hospitals) and the belief by some providers that a high Medi-Cal load is not conducive to attracting private patients, until recently, most private hospitals did not try to expand their Medi-Cal patient base. That situation has changed for some hospitals. First, for those hospitals that have always had a high proportion of Medi-Cal patients, the availability of DSH payments has made Medi-Cal a profitable business line. In Contra Costa County, besides Merrithew Memorial Hospital, only East Bay Hospital (primarily an acute psychiatric hospital) and Brookside Hospital (in 1994-95 and 1995-96) qualify as DSH hospitals. Second, in the late 1980's, to deal with a shortage of

physician and hospital capacity available to Medi-Cal patients in the obstetrics area, Medi-Cal payments to physicians for prenatal care and deliveries were increased to levels comparable to private payers, and the California Medical Assistance Commission (CMAC) began to negotiate separate inpatient rates for obstetrics. This has served to make Medi-Cal obstetrics patients far more desirable than previously, to both hospitals and physicians, especially the latter. Third, the proliferation of managed care in the private sector and advancements in medical science (e.g., orthoscopic and laser surgery) have resulted in a dramatic reduction in inpatient utilization, leaving hospitals with more and more empty beds, and few, if any, charge-paying purchasers to subsidize them. And fourth, with the movement to Medi-Cal managed care, many hospitals and physicians believe they can manage this population in a cost-effective and profitable manner.

It is far from certain, however, that this line of business will remain profitable or desirable to a large number of private-sector providers in the long run.

Three managed-care models are being implemented by the Medi-Cal program in the State's urban areas.[2] The models are as follows:

> (1) County Organized Health Systems (COHS), where designated county governments assume responsibility, on a capitation basis, for the entire Medi-Cal population within their jurisdictions. Five COHSs are now operational -- Santa Barbara, San Mateo, Solano, Orange and Santa Cruz. Under current federal law, no additional COHSs can be designated in California;
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> (2) The two-plan model being pursued in 12 counties. Under this model, all Aid to Families with Dependent Children (AFDC), and no-share-of-cost Medically-Needy Families and Children will be required to sign up with one of two local HMOs. The major HMO is envisaged as a consortium of each county's safety-net providers -- the "local initiative" -- organized by the county boards of supervisors. The other HMO is to be a single, commercial HMO selected by the State. The former is to be comprised of disproportionate-share hospitals, community clinics and "traditional" providers (i.e., physicians and hospitals which have traditionally served Medi-Cal patients). This model was intended to protect disproportionate-share hospitals, the most important of which in terms of Medi-Cal volume are county hospitals, and other safety-net providers that are dependent on Medi-Cal revenue. Local initiative health plans are to be Knox-Keene-licensed HMOs, and as such must eventually have an enrollee mix that is at least 25 percent non-Medi-Cal, non-Medicare.[3] In Contra Costa County, the Local Initiative will be the Contra Costa Health Plan, expected to be operational by February 1997. Foundation Health has been awarded the commercial plan contract, and is targeting an April 1 start-up. The beneficiary population covered under the two-plan model (approximately 77,000) accounts for approximately two-thirds of total Medi-Cal beneficiaries, and one-third of Medi-Cal patient days; and

(3) Geographic Managed Care (GMC) is being pursued in two counties -- Sacramento and San Diego. In Sacramento, it was implemented in April 1994. Implementation in San Diego is scheduled for 1996. While GMC covers the same beneficiary mix as the two-plan model, here beneficiaries choose from among a variety of commercial plans -- seven in Sacramento. Health plans are encouraged to contract with safety-net providers.

Notwithstanding the above-mentioned "safeguards," implementation of Medi-Cal managed care, combined with the inability of hospitals to be reimbursed for their excess capacity, is expected to place county health systems at significant risk of losing major portions of their Medi-Cal patient loads. Protection of Med-Cal revenue is vital to the survival of most, if not all, county health systems.

D. DISPROPORTIONATE-SHARE FUNDS

1. SB 855

Provision of care to Medi-Cal and other indigent patients is intertwined. This is evident by the manner in which supplemental funds are distributed to hospitals with high Medi-Cal and indigent patient loads. These hospitals are defined as Medi-Cal disproportionate-share hospitals (DSH) in SB 855. The DSH definition and payment formula are based on both Medi-Cal and indigent patient percentages. To compensate DSH hospitals for unreimbursed charity and county-indigent costs, disproportionate-share payments flow through the Medi-Cal payment mechanism, in terms of supplemental payments for every Medi-Cal inpatient day. Thus, for example, a hospital with no Medi-Cal patient days and a high proportion of unsponsored indigent patients would receive no Medi-Cal disproportionate-share payments. This relationship is reinforced by the manner in which Medi-Cal managed care is being implemented in various counties, as discussed above. Merrithew Memorial Hospital expects to receive approximately $6.8 million in DSH funds in the current year.

2. SB 1255

These federal Medicaid funds are distributed to disproportionate-share hospitals on the basis of negotiations with the California Medical Assistance Commission (CMAC). While there is more flexibility with respect to this funding source, there is also less predictability. Moreover, these allocations are applied against the "savings" attributed to the Medi-Cal Selective Provider Contracting Program. Since the Program's effectiveness is judged by its estimated savings, CMAC would be reluctant to be overly generous in its SB 1255 allocations. For the current year, $2.9 million in net payments to Merrithew are budgeted from this source;

3. SB 1732

Another source of future funding for Merrithew is the SB 1732 program, which will subsidize more than 50 percent of debt-service payments for the Merrithew replacement project (approximately $5.1 million of $9.9 million total payments annually).

SB 1732 (1988) established the Construction/Renovation Reimbursement Program (CRRP), administered by the Department of Health Services as part of the Medi-Cal program. CRRP is intended to provide supplemental debt-service payments to disproportionate-share hospitals for eligible projects. Eligible projects are limited to construction and acquisition of fixed equipment. Medi-Cal's share of debt service payments is determined by the hospital's Medi-Cal percentage of inpatient days. The Medi-Cal debt-service share would vary from year to year based on the Medi-Cal patient days percentage, but would be subject to a floor. This floor, or lower limit, is 90 percent of the base-year percentage. The latter is determined by the Medi-Cal patient days percentage for the year immediately preceding plan submittal to the Office of Statewide Health Planning and Development (OSHPD). Thus, if a hospital's Medi-Cal patient days percentage is 60, the funding floor would be 54 percent of debt-service payments.

Eligible projects must be available to Medi-Cal hospital patients, must be on behalf of Medi-Cal contracting hospitals (through the Selective Provider Contracting Program), must be financed through tax-exempt debt, and must involve at least $5 million in capital expenditures (construction and fixed equipment), unless they are for the purpose of correcting licensing or accreditation deficiencies. With some exceptions, plans for eligible projects must have been filed with OSHPD between July 1, 1989 and June 30, 1994. Thus, the "window" is now closed and costs to the program are predictable. Since the bill's enactment in 1988, the program has become more expansive through several amendments that, for the most part, extended the plan-submittal window for specific, narrowly-defined projects (up to June 30, 1995).

Under the statute, the state pledges to bond holders that until debt service is fully paid, the state will not limit or alter the rights vested in the hospital to receive supplemental reimbursement.[4]

E. MEDICAID AND WELFARE REFORM

The Medicaid program, the central source of revenue for the Contra Costa County health system accounting for $56.7 million, 16.6 percent of the budget, is the focus of an intense national debate over whether and how it should be restructured.[5]

While Medicaid has undergone previous reform efforts where the focus has been on cost containment, this debate has an important difference: the impetus for saving money is almost exclusively tied to the effort to balance the federal budget through new curbs on spending. Increasing access to cost-effective care, redirecting money from expensive to less costly modes of treatment, creating new incentives for less costly care, finding the funds to expand access to new populations -- key factors in previous cost-cutting efforts -- are minimal factors in the current dialogue.

This debate began in earnest in 1995 at the start of the 104th Congress when a newly triumphant Republican majority proposed a block grant which would have ended the federal entitlement and freed states of most restrictions as to how Medicaid funds were spent. Their proposal was part of a seven-year plan to produce a balanced federal budget. The initial 1995 Republican Medicaid block-grant legislation proposed saving the Federal government $187 billion in matching fund payments over seven years.

The Kaiser Commission on the Future of Medicaid, a nationally respected non-partisan research organization funded by the Kaiser Family Foundation, estimated that California would receive $18.3 billion less in matching payments, a reduction of nearly one fifth. California will spend approximately $17 billion in the current fiscal year to cover over 5 million beneficiaries.

There are certain potential advantages to a block grant. Increased state flexibility could decouple Medi-Cal funding for indigent care from Medi-Cal volume and allow the state to dispense with the complex and inefficient DSH payment system, and directly support county-indigent care.

The price for this flexibility, however, a nearly 20 percent reduction in federal revenue, could more than off-set the benefits. The loss of billions of dollars could produce these impacts:

* The state would be under enormous pressure through either the California Medical Assistance Commission, or whatever organization took its place, to ratchet down hospital reimbursement rates.

* Already inadequate outpatient rates would likely face the prospect of significant reductions.

* Private hospitals, battered in recent years by significant revenue loss through the expansion of managed care and currently in an increasingly intense competition with the public sector for Medi-Cal revenue, would be compelled to escalate their effort to siphon Medi-Cal patients from the County.

* The state may be forced to simply terminate coverage to maintain the solvency of the program. By the year 2002, it has been estimated that as many as 1.3 million Californians could lose coverage. A large reduction in Medi-Cal eligibility not only decreases revenue to the County, but increases the patients referred to the County under the Section 17000 obligation. The pressures on the health care safety net, already enormous, could produce an explosion.

The Clinton Administration has firmly rejected the block grant concept. It did, however, enter the seven year balanced budget debate in 1995 with its own proposal to impose a per-capita cap on the amount of federal reimbursement available to each state, based on the number of beneficiaries. The Clinton cap was estimated by the Congressional Budget Office to save $55 billion over seven years, less than one-third the savings called for in the Republican proposal.

This debate occurred in an environment in which it was estimated that without federal reform, Medicaid costs would have grown by an estimated 10 percent per year over the next seven years. It was assumed that this increase would be driven nationally by enrollment growth, principally in the number of disabled beneficiaries. In California, increased costs would have been driven more by expanded enrollment of children and pregnant women, along with the rising per-capita expense of serving the disabled population.

The cap, which preserves the entitlement, would have had the advantage of removing the potential of a wholesale termination of Medi-Cal beneficiaries with the domino effect that would have on the County system. It would have protected high growth states such as California from the adverse impact of a fixed allocation. It also would have responded to the impact of economic recessions on the growth in Medicaid rolls for a particular state.

Nevertheless, a cap which would have saved an estimated $55 billion dollars during an era of beneficiary growth would have forced states and counties to develop strategies to serve the same populations with less funds. The downward pressure on hospital reimbursement and outpatient rates would intensify. While the federal government would be protected from excessive growth driven by such factors as renewed health inflation, the state would be at full risk for program costs per beneficiary that exceed the cap.

The differences between President Clinton and the Congress on this issue produced a stalemate, with Medicaid reform removed from the agenda during the closing months of the 1996 session. The reform effort stalled for two key reasons:

(l) President Clinton's commitment to universal coverage, the dominant theme of his first two years in office, translated eventually into a "line in the sand" challenge to the Republicans on the issue of a block grant; and

(2) Both the Clinton per capita cap and the block grant suffered from a failure to resolve the equity issues created by a new national formula for the distribution of Medicaid funds. Any formula that locks in current Medicaid spending patterns penalizes two categories of states:

- states that have been the most effective in controlling costs. Their new baseline allocation would be smaller than that for states that applied minimal effort to Medicaid cost-containment strategies; and

- states that have not pursued federal options to expand coverage or maximize reimbursement.

Friction between the winning and losing states in the formula fight was especially critical in the creation of this impasse. Inequities in the current system, which have evolved over time and are largely tied to choices freely made by the states as to how they chose to prioritize health spending, were far easier to accept then the new injustices of the proposed federal changes.

They were especially infuriating to the states adversely impacted because they seemed to penalize states that were historically the most cost conscious.

California would have been a loser under both key criteria. California's selective contracting system, the result of a 1982 Medicaid waiver, has put California in a position of national leadership in the field of hospital cost containment. Yet, under these reforms our pioneering effort in the creation of the Medi-Cal "czar," followed by the California Medical Assistance Commission, and the hundreds of millions of dollars the state has saved the federal government, would have been a liability in determining our base spending level. California has also lagged far behind states like Tennessee, Washington, Minnesota, New Mexico, Vermont and New York in expanding coverage for low-income children.

The most dramatic illustration of how difficult it is for Congress to resolve these equity issues in Medicaid reform occurred in the summer of 1996 when the Republican leadership delinked Medicaid reform from Welfare reform. Prior to that July decision, the two reforms were viewed as part of a congressional leadership package. House Republican pessimism about the prospects of working out a compromise on Medicaid reform with President Clinton led the leadership to conclude that welfare reform, which had much greater potential for a presidential signature, would be doomed if it remained tied to Medicaid.

When the two issues were severed in July, all attention shifted to welfare reform and the Medicaid restructuring effort, heralded at the beginning of 1995 as an all-but-certain product of this Congress, was put on the shelf for the new Congress in 1997 to address.

When the 105th Congress convened in January of 1997, the Medicaid reform debate entered a new and much-changed phase. While the President remained committed to the goal of a balanced budget by the year 2002 and believed that holding the line on Medicaid spending was an important component of that effort, the scope of the discussion had narrowed substantially. Instead of a congressional battle with cuts on the table ranging from $55 billion to $187 billion, the President recommends in his FY 1997 budget a net Medicaid savings of only $9 billion.

The President's plan calls for $22 billion in cuts offset by $13 billion in new spending on a children's health initiative designed to reduce significantly the number of uninsured children and on mitigating the health-care impact of welfare reform. The savings are to be achieved through a much more modest per-capita cap proposal and a restructuring of the DSH program so that so-called "high-DSH" states like California (states that rely heavily on DSH funds for their safety-net financing; there are 14 in the nation) are only marginally impacted.

The congressional Republicans have made a complete retreat from their block-grant proposal and have advanced no plan. They intend to address Medicaid reform through the budget negotiations over the President's plan.

The dramatically-changed environment is the result of a number of factors, which include:

* The 104th Congress' impasse on Medicaid made both the Congress and the President pessimistic about the prospects for bi-partisan agreement on a far-reaching Medicaid reform.

* The Congressional Budget Office (CBO) released in January of 1997 new assumptions about the growth in Medicaid which showed a substantially lower rate. Instead of the 10 percent per year assumption that drove the 1995-1996 debate, the CBO now projects an average annual growth rate of 8 percent. This new growth rate helped produce a nearly $90 billion savings in Medicaid over a seven-year period without the benefit of reform. Some of the key factors that produced this new estimate, which serves as the authoritative benchmark for any congressional action, are downward revisions of enrollment growth, smaller-than-expected increases in medical inflation and lower-than-projected utilization. The end of the recession, the enactment of welfare reform and changes in federal law in the early '90s, designed to limit the abilities of states to access DSH dollars, are some of the specific catalysts for this sharply reduced estimate.

While the impact of Medicaid reform, therefore, is certain to be far less than assumed in the 104th Congress, the bi-partisan negotiations in the 104th Congress over a balanced budget by the year 2002 will guarantee that some level of Medicaid cut will be part of the national debate. Although the Clinton plan attempts to minimize the impact of the DSH cuts on states such as California that qualify as "high-DSH" states, there is no guarantee that Congress will agree to this distinction in pushing for cuts in this program.

Although the block-grant debate in the 104th Congress failed to produce a fundamental reform, Medicaid did not escape unscathed. Welfare reform impacts Medicaid because of the way it is linked to Medi-Cal eligibility. Medicaid funding is now at risk due to the provisions of H.R. 3734, the historic welfare reform bill signed into law by President Clinton in August 1996.

The most serious threat to Medicaid, however, was averted when the Chaffee-Breaux amendment was negotiated into the bill in conference. Senator Chaffee, a supporter of the concept of maintaining a safety net, prevailed in his effort to grant Medicaid eligibility for those families who are currently eligible for AFDC even if they lose welfare coverage under the new Transitional Aid to Needy Families (TANF) program. Thus, families and children will still qualify for Medi-Cal if they would have been Medi-Cal eligible under the rules in effect on July 16, 1996.

The main harm to Medi-Cal occurred in the provisions of H.R. 3734 which impact legal immigrants. Over 40 percent of the $54 billion in savings (over six years) generated by this bill

comes from cuts in spending on programs for legal immigrants. California is damaged disproportionally since 41 percent of the nation's immigrants live in our state.

Under welfare reform, the state has the option of denying non-emergency Medicaid to current legal immigrants. Immigrants arriving after the enactment of H.R. 3734 are barred from Medicaid for non-emergency services for five years. Illegal immigrants, who currently have eligibility for a limited scope of benefits including prenatal services, can only continue to receive these benefits if the state passes a law after the enactment of the federal welfare reform authorizing them. Absent such a law, they will only be entitled to receive emergency medical services.

The National Immigration Law Center estimates that 500,000 immigrants in California could lose non-emergency health care coverage at a loss of $5 billion in state and federal matching funds over six years. The mandatory bar of new immigrants from Medi-Cal coverage is estimated to result in additional $5 billion loss. Assuming current statewide Medi-Cal expenditures of $17 billion per year increase at an average annual rate of 5 percent, they would total $116 billion over the six-year period beginning July 1, 1996. The $5 billion loss from barring new immigrants represents a 4.3 percent decrease in Medi-Cal expenditures over this period. Barring current immigrants would result in an 8.6 percent decrease. The bulk of this shortfall would be absorbed by counties.

A county-by-county analysis by the California Association of Public Hospitals and Health Systems suggests Medi-Cal payments on behalf of Contra Costa County residents will be reduced $62 million over the six-year period, if the bar from Medi-Cal is only applied to legal immigrants arriving after August 22, 1996 (approximately $6 million for the first full year of implementation -- 1997-98).[6] The approximately $6 million annual loss should be compared to the Fiscal-Year 1996-97 sum of: (1) DSH revenue ($9.7 million); (2) Realignment revenue ($22.1 million); and (3) County subsidy ($14.6 million). These non-Medi-Cal revenues total $46.4 million. Assuming no increase in Realignment or DSH funds, the County subsidy would have to increase 40 percent to fully offset the Medi-Cal funding reduction.[7] Failure to provide essential health services to this population could result in adverse economic and public health effects, including higher risks of low-birth-weight babies and the spread of communicable diseases to the population at large.

If the Medi-Cal bar were extended to current legal immigrants, the annualized loss in Medi-Cal payments on behalf of Contra Costa County beneficiaries would be $17 million, in addition to the $6 million discussed above, associated with new immigrants. Increases in County responsibilities of this magnitude are not feasible; nor is denying care to this population.

While data on the Contra Costa County population at risk (i.e., Medi-Cal eligible non-citizen immigrants) are not available, the State Department of Health Services estimates that of the County's 94,373 Medi-Cal eligibles, 3,460 (3.7 percent) are undocumented immigrants, which will surely lose Medi-Cal eligibility for non-emergency services and prenatal care.

Governor Wilson has unveiled a plan for implementing welfare reform which contains both good and bad news for the financing of health-care delivery. On the positive side, the Governor rejected the federal option of denying Medi-Cal to current legal immigrants, by far the most serious financial threat posed by federal reform. At the same time, the Governor has set in motion a plan, temporarily delayed by legal challenge, that will end prenatal care for undocumented women. The Governor has also declined to provide state-only funding for the health-care needs of newly-arrived legal immigrants.

The issue of how much Medi-Cal revenue will be lost under welfare reform is now subject to a negotiation process involving a special 18-member conference committee recently established by the Assembly and Senate leadership. Hearings are underway, but a final agreement between the conferees and the Governor's office will likely not occur until the budget is resolved in late June or July of this year.

While welfare reform guarantees that safety net health care financing will be on the agenda in Sacramento this year, the Legislature and Governor have been reluctant in recent years to confront the larger questions involved in how safety net health care services are provided. After spending much of the 1980's and early 1990's debating the merits of a state level health care reform, the last few years have seen little attention paid in the State Capital to health care funding issues.

With crime and education dominating the Capital legislative agenda, health care was reduced primarily to a battle over the regulation of the burgeoning managed care industry, largely a series of patient and physician rights questions, and the implementation of the two plan model for Medi-Cal managed care, an effort to control the long-term growth in the Medi-Cal budget. The larger issue of how California can expand coverage opportunities for the over 6 million Californians without health insurance and how we can stabilize the increasingly fragile health care safety net received little attention.

Major factors that have produced this period of relative inaction, including:

* The failure of the Clinton health care plan sent a message to many elected officials that reform efforts were doomed in the current political environment;

* Employer pressure for health care reform, driven by uncontrolled increases in health care costs, relaxed somewhat as the managed care market-place reforms provided some measure of temporary relief to the private-sector purchasers of health care;

* The passage in 1992 of the Health Insurance Plan of California (HIPIC) gave small employers new options for controlling their costs and providing coverage to their employees;

* Term-limits removed from the Legislature most of the institutional expertise and memory required to advance a health care reform agenda. The most

acrimonious and prolonged Speakership battle in the Assembly's history in 1995 diverted attention and legislative energy away from serious policy work in almost every subject area, including health; and

* The Governor set a state agenda which barely referenced health care as an area requiring state action.

The 1997 Legislative session will see some of these factors change. The Democrats have regained the Assembly Speakership with a 43-37 majority, which should allow for two years of relatively stable leadership. Health care inflation may be beginning to reheat with the HIPIC unable to produce rate decreases this year as they have in past years. There appears to be a growing backlash on the part of consumers and physicians to choice restrictions placed on managed-care enrollees. The new legislature will be the first totally elected under term limits and some of the dislocation and confusion that came from the system transforming from one era to the next may be diminished.

In the end, 1997 will very likely be a year in which the Legislature, thanks in large part to the reality of welfare reform, will be forced to confront a series of key questions involving the funding of health care at the County level. In addition to the questions surrounding whether or not legal immigrants should be allowed Medi-Cal eligibility, the future of the DSH program will be the probable subject of a major policy debate. Equity issues involving how funds are distributed to County hospitals and the private DSH hospitals, which have long simmered without clear resolution, will be the focus of the discussion. When the SB 855 program began in 1991-92, county hospitals received 74 percent of the net payments. That percentage has dropped in each year, to 47 percent in 1995-96, primarily because of the entry of more and more private hospitals onto the DSH eligibility list. Since private hospitals do not transfer funds into the program, their entry results in spreading a fixed pool of funds over a greater number of recipient hospitals. At the same time, federal limits in DSH payments are defined in terms of uncompensated costs incurred in treating Medicaid and unsponsored indigent patients. The funds transferred into the program by county health systems are not recognized, yet the gross payments received are counted. Thus, county hospitals are faced with substantially lower limits on the amount of DSH funds they are allowed to receive. In general, private hospitals' eligibility for DSH funds derives from their relatively high Medi-Cal patient loads, not from provision of care to unsponsored indigents. Change in the distribution formula for DSH payments will have to occur to prevent a further worsening in the position of county health systems. Since providing protections for the latter will necessarily entail a worsening in the status quo for private hospitals, a heated legislative debate is inevitable.

The most concrete example of renewed interest in health care reform is the decision by the California Medical Association (CMA) to promote this year in Sacramento a highly controversial new approach to tackling the issue of how to expand access to health insurance. The CMA plan would consolidate into a single health insurance purchasing pool nearly all existing state indigent-care financing dollars (DSH, Proposition 99 [tobacco] funds, County Realignment dollars, etc.). The CMA argues that this pool would provide coverage for nearly 4

million of California's over 6.6 million uninsured. The CMA cites welfare reform and its negative impact on the safety net as the catalyst for considering a far-reaching system overhaul.

The CMA understands that its proposal will be received with skepticism by many of the health-care system stake holders alarmed by the prospect of losing a guaranteed revenue stream. The leadership of the CMA contends that their concept, which has not yet been introduced as a bill, is intended to stimulate a new debate over health reform and will be subjected to substantial reworking based on discussions held throughout the spring with interested parties. More than the specifics of the approach, the CMA action is significant because it marks the beginning of a much more ambitious debate over the future of health care in California.

The Legislature will also consider various proposals to expand access to health coverage for children. Health-care reform advocates agree that children as a population are relatively inexpensive to cover and represent a logical next step in the effort to reduce the population of uninsured.

At the federal level in 1997, the President and Congress have begun a debate over whether or not to mitigate the impact of welfare reform. President Clinton has repeatedly emphasized that he signed the welfare reform bill with the strong belief that many of the restrictions on legal immigrants were unwise and had nothing to do with moving people from dependence to work. As part of his 1998 budget, the President has proposed a series of benefit restorations for legal immigrants, including eligibility for Medicaid for certain non-citizens who become blind or disabled after their entry into the United States and allowing Medicaid eligibility for immigrant children on the same basis as citizen children.

The Clinton plan would restore $17 billion over five years. The original welfare reform bill was designed to save $54 billion, with $23 billion based on the restrictions in assistance to immigrants.

California, with over 40 percent of the legal immigrant population, would benefit more than any other state in the nation if the Clinton welfare-mitigation plan were approved.

The initial response of the Republican congressional leadership has been negative. They argue that they do not want to "reopen" last year's welfare reform bill and that the legal immigrant cuts are an important policy statement about the importance of not coming to this country unless you can be self-sufficient or have the assistance of a citizen sponsor. The congressional leadership has suggested a possible block grant to provide states like California that have been hit especially hard by the financial impact of welfare reform with some extra money for a time-limited period to ease the transition.

Given the Republican position, the prospects for passage of a bill to restore legal immigrant benefits are poor. Some action, however, may still be taken this year. A possible agreement on this issue as part of the budget agreement next fall is within the realm of possibility.

While 1997 will not see a new national debate over fundamental health care reform in Washington, D.C., the President has put forward a Children's Health Initiative directed to the 10 million children without health coverage. The Clinton plan hopes to extend coverage to up to 5 million children. The President's plan has three parts:

(1) Annual grants to states to cover health insurance premiums for a limited time period for families, with children, who are between jobs and seeking employment;

(2) Annual grants to states to develop new programs to subsidize health coverage for families with too much income for Medicaid but too little to afford private coverage unassisted; and

(3) A series of Medicaid reforms designed to help stabilize coverage for children who are eligible for, but not enrolled in, Medicaid. This section of the Clinton plan calls for Medicaid "continuous eligibility" which would mean that children would not be bounced on and off coverage as their parents change jobs or move from welfare to work. It also includes an aggressive Medicaid outreach designed to reach more of the estimated 3 million poor children who meet the eligibility criteria but are not enrolled.

While nowhere near as bold as the Clinton health-care reforms of his first term, this children's program is indicative of the new emphasis on incremental, stage-by-stage reform that will likely dominate health insurance reform discussions in Washington for the next few years.

With the battle to balance the budget more and more a bi-partisan objective, it seems increasingly clear that the Medicaid program will undergo a series of significant changes within the next few years. The likely outcome will be increased state flexibility coupled with decreased federal and state funding in terms of real dollars. It is possible the increased state flexibility could decouple Medicaid funding for county-indigent care (through DSH payments) from Medi-Cal volume, enabling Medi-Cal funds to directly support county-indigent care. It is also probable the advantages of this new flexibility would be more than off-set by Medi-Cal funding reductions in general.

At the same time, the need for a viable network of safety-net providers may be increasing. Given the already growing uninsured population and the lack of political will to enact universal health coverage, welfare reform and future Medi-Cal and Medicare funding cuts will only exacerbate a growing problem.[8] First, cutting Medi-Cal funding will directly reduce Medi-Cal access and remove beneficiaries from the Medi-Cal rolls (and welfare reform will directly remove beneficiaries from Medi-Cal eligibility). Second, cutting Medi-Cal and Medicare payments will, to some extent, lead to a cost-shift to some private payers (e.g., insurance carriers, HMOs, self-insured employers) who will in turn be forced to increase their health-insurance premiums, which will result in a reduction in health-insurance coverage in terms of both benefits and insured lives. Thus, greater strains will be placed on safety-net providers to treat unsponsored patients.

F. THE LOCAL HEALTH SYSTEM

1. County Hospital and Clinics

The county hospital, Merrithew Memorial Hospital (MMH), located in Martinez, with 174 licensed beds, is in the process of being totally replaced. Construction of the 144-bed replacement hospital is scheduled to be complete in late 1997. While the hospital is located in the central part of Contra Costa County, the greatest concentrations of indigent populations are in the eastern and western regions. For example, of the County's 91,161 Medi-Cal eligible population (as of March 1994), 31 percent reside in the eastern region, 45 percent in the western region and 25 percent in the central region. The county hospital is thus complemented by a network of clinics distributed throughout the county. In addition, the County has contracting arrangements with Brookside Hospital for provision of inpatient and emergency care to a portion of medically-indigent west county residents, and with Alta Bates in Berkeley for all services and payer sources. The County is also pursuing development of a joint venture with Kaiser in its new Richmond facility.

2. Contra Costa Health Plan

The Contra Costa County Health Services Department has a national reputation as an innovator, largely due to its own health maintenance organization, the Contra Costa Health Plan (CCHP), which enrolls the county indigent population, Medi-Cal and Medicare beneficiaries, county employees and small employer groups. The county system also has a family practice residency program affiliated with the University of California at Davis. This program is viewed as responsible for placing a large number of its graduates throughout the community.

CCHP has been operating as an HMO since the early 1970s. Of its 24,000 members, 11,000 are Medi-Cal, 1,000 Medicare (cost-based) and 12,000 are "commercial". The later group includes approximately 6,000 Basic Adult Care (BAC) recipients (county indigents) and 6,000 county employees. Its provider network is comprised of physicians employed by Merrithew Memorial Hospital, eight clinics operated by the County (including three senior clinics) and the hospital. Additional services are contracted for (i.e., certain specialty services) with private providers as necessary (approximately $6.5 million for the current year). At this time, most of the volume and revenue generated by the CCHP provider network (i.e., the county hospital and clinics) is fee-for-service, mainly Medi-Cal. This patient volume, flowing directly through the clinics and the hospital, bypasses the HMO entirely. CCHP's 1996-97 budget is $55.1 million, $38.1 million of which is paid to the Hospitals and Clinics for services provided. This compares to the latter's budget of $169.8 million.

As a creature of county government and as a health plan based on the county-operated health delivery system, CCHP's viability is fully dependent on its ability to enroll and effectively manage Medi-Cal-sponsored patients. With the impending movement to Medi-Cal managed care in Contra Costa County and with the new-found desirability of Medi-Cal patients on the part of underutilized private hospitals and commercial health plans looking for rapid growth,

CCHP's survival, and the viability of its delivery system (the County delivery system), rests on its ability to significantly expand its Medi-Cal HMO enrollee base through converting its existing fee-for-service clients.

By April 1997, it is expected that the Medi-Cal Two-Plan model will be implemented in Contra Costa County. At that time, as the Local Initiative, CCHP will be competing with Foundation Health (and its private-sector provider network) for the approximately 50,000 Medi-Cal eligibles residing in Contra Costa County that will be required to select a managed care plan and are not currently enrolled in one, and to maintain its existing 11,000 Medi-Cal enrollees, who will be marketed by Foundation Health.[9] Of CCHP's 11,328 Medi-Cal enrollees, as of March 1996, 9,818 (87 percent) are AFDC, and thus particularly vulnerable to Foundation's marketing efforts.

To maintain the county clinics' current Medi-Cal volume will require CCHP to enroll approximately one-third (16,500) of the currently unenrolled 50,000 eligibles, in addition to maintaining its current membership. The county clinics account for a 33 percent market share of services provided to Mandatory Eligibles (AFDC, Medically-Needy No-Share-of-Cost Families, and Medically Indigent Children) residing in Contra Costa County, currently in the fee-for-service system.

Given the likelihood of reduced inpatient utilization on the part of managed-care enrollees, maintaining Merrithew's inpatient volume will most likely require an even greater market share. Assuming managed care results in a 20 percent reduction in inpatient use, the 16,500 new enrollees necessary to maintain current outpatient volume expands to over 20,000 to maintain current inpatient volume. Thus, a total Medi-Cal enrollment target of approximately 32,000 (including the 11,000 current enrollees) should be sufficient to keep the county health system employed at its current level. Significant shortfalls from this target could result in layoffs and financial problems for the entire County system. (On the other hand, since CCHP will be at full risk, reducing inpatient utilization will result in savings for CCHP. Given the current SB 855 payment formula, it is unlikely these savings will compensate for lost DSH payments to Merrithew. As Medi-Cal managed care is implemented on a large scale, it will be necessary to modify the SB 855 payment formula [through legislation] to decrease its reliance on patient days.)

While the Mandatory Eligibles represent the majority of beneficiaries (approximately two thirds), they account for half the reimbursement for outpatient services and one third of inpatient reimbursement among all providers serving this population.[10] (For Merrithew, the mandatory beneficiaries account for less than 22 percent of Medi-Cal reimbursement, indicating that hospital's relatively greater role in treating the aged and disabled Medi-Cal populations.) Thus, if utilization patterns on behalf of the non-mandatory population are not affected by the Two-Plan Model, the county system will still be able to maintain a significant portion of its Medi-Cal fee-for-service volume. It is likely, however, that such utilization patterns will change, as providers adapt to managed-care utilization-review mechanisms across-the-board.

The key challenge facing CCHP, whose future is intertwined with its delivery system, is three-fold:

(1) To attract the majority of the Medi-Cal beneficiary population in the mandatory aid categories into the Local Initiative. In addition to efforts to improve the operation of its own sites, this will require private-sector contracting for services not available within its own network, and to increase geographic accessibility. Of its current budget of $55.1 million, $6.5 million is earmarked for private-provider contracts. In particular, CCHP will subcontract with Kaiser to care for 10,000 CCHP enrollees, and will subcontract with community primary care physicians, including Planned Parenthood;

(2) To effectively manage the health care of this population within very tight capitation payments from the State; and

(3) To plan for the time the Two-Plan Model is expanded to require enrollment of the Supplemental Security Income (SSI) Medi-Cal population. This group represents the bulk of Merrithew's Medi-Cal patient load, and is essential to the Hospital's viability. Thus, efforts should begin as soon as possible to build the necessary relationships with this client base.

Table 1, below, presents some comparative utilization data for CCHP and other plans with respect to the AFDC population. Note that the CCHP experience is similar to that of other plans. Note also the wide variation, most likely reflecting the voluntary nature of plan enrollment during 1994.

TABLE 1

AFDC PATIENT DAYS PER 1,000 ENROLLEES
SELECTED PLANS
1994

Plan	AFDC Patient Days/1,000
Kaiser North	350
Kaiser South	459
Ross-Loos	223
Community Health Plan	132
Foundation	150

Plan	AFDC Patient Days/1,000
United	277
Community Health Group	193
Universal	164
CCHP	252
Unwtd Avg	244

Source: Contra Costa Health Plan.

3. Private-Sector and District Hospitals

In addition to MMH and the two currently operating district hospitals (Brookside and Mt. Diablo), Contra Costa County residents are served by two Kaiser hospitals (in Richmond and Martinez), Delta Memorial Hospital in Antioch, Doctors Hospital of Pinole, East Bay Hospital in Richmond (which is mainly psychiatric), John Muir Medical Center in Walnut Creek and San Ramon Regional Medical Center. In terms of indigent care, only two hospitals -- MMH and Brookside -- are major providers. Delta Memorial, Mt. Diablo and John Muir, however, are Medi-Cal contracting providers, and can be counted on to be part of Foundation's Medi-Cal provider network. John Muir and Mt. Diablo have recently announced plans to affiliate. The passage of Measure MM, on the November ballot, will allow both hospitals to consolidate services. The first candidates for consolidation are the heart and obstetrics programs.

Los Medanos, a district hospital located in the eastern portion of the County, in Pittsburgh, is closed due to bankruptcy. Extensive negotiations for the County to lease portions of the building for outpatient and skilled nursing facilities have failed. Thus, should all or portions of Los Medanos reopen, the County is unlikely to have any role in its operations.

Brookside Hospital, which has a history of severe economic difficulties, implemented a lease agreement with Tenet effective January 21, 1997. Tenet is the second largest for-profit hospital system in the United States. This should prevent Brookside's closure over the near term. Since Tenet also operates Doctor's Hospital of Pinole, which is close to Brookside, there is potential for coordinating services between the two hospitals. This could improve access for Medi-Cal beneficiaries in the western portion of Contra Costa County. Improved governance at Brookside could provide CCHSD with a more viable and responsive partner. It could also create a more effective competitor for the County system's Medi-Cal patients. In 1994, 40 percent of CCHP's Basic Adult Care enrollment (i.e., the County's MIA population) resided in the western

portion of the County, as did 15 percent of its Medi-Cal enrollees. This discrepancy demonstrates the wider array of choices available to the Medi-Cal population (45 percent of the Medi-Cal population resides in this area), which CCHP will have to address if it is to succeed in its marketing efforts.

Table A1, in the Appendix, provides data for each hospital located in Contra Costa County for a five-year period (1992-96), focusing on indigent care, capacity and overall volume. Table A2 presents indigent-care data for 1996 (12-month period ending September 30, 1996), along with individual hospital shares of county-wide totals. Of particular interest here are the following:

(1) Brookside and John Muir account for 26 percent and 20 percent of county-wide bad-debts expense, respectively;

(2) Brookside and John Muir account for 45 percent and 24 percent of charity expense, respectively;

(3) MMH and Brookside account for 53 percent and 19 percent, respectively, of Medi-Cal expenses incurred by all hospitals located in the County;

(4) MMH accounts for 92 percent of county-indigent expenses incurred by all hospitals; and

(5) Combining bad debts, charity and county indigent expenses, MMH accounts for 71 percent of such expenses, followed by Brookside at 8 percent.

G. MENTAL HEALTH

1. Environment for Mental Health Services

The environment for public mental health services in the 1990s has changed rapidly. Realignment legislation in 1991 and the subsequent Medi-Cal consolidation have placed the funding and authority for public mental health services clearly in the hands of the counties.

Under realignment the counties receive a fixed portion of the state's sales tax and vehicle license registration fees to support their mental health programs. This funding fluctuates with economic conditions and is not tied to the number of indigent clients requiring mental health services, nor to the demand for non-Medi-Cal reimbursable services. An increase in the number of uninsured and/or a reduction in the coverage of mental health benefits within commercial health insurance plans can place an added burden on the county's Mental Health Division (MHD).

Medi-Cal consolidation will be complete with the scheduled transfer of fee-for-service outpatient mental health services to the counties in July 1997. At that point the counties will

have responsibility for all mental health services to the Medi-Cal-eligible and the indigent populations. In the short term, the counties will continue to have an open-ended entitlement to federal dollars for medically necessary covered Medi-Cal mental health benefits under the Short-Doyle Medi-Cal program. The expectation is that these funds will be either capped or capitated by the Federal and/or the State government within the next few years. At that point the counties will bear the full financial risk for all Medi-Cal mental health benefits.

The consolidation of funding under a single authority and the flexibility from the adoption of the Rehabilitation Option under the Short-Doyle/Medi-Cal program provide the counties with an opportunity to design and implement comprehensive, coordinated systems of mental health care for Medi-Cal and indigent clients. But there is substantial challenge and financial risk attendant to this opportunity. The counties will have to manage the system to provide a mandated set of mental health services for Medi-Cal clients and a less well defined set of benefits for indigent clients within a single fixed budget.

2. Challenges for Contra Costa County's Mental Health Division

The county developed a Phase I plan to manage the Medi-Cal inpatient consolidation which began in January 1995. The Mental Health Division (MHD), operating as the Contra Costa County Mental Health Managed Care Plan (CCCMH-MCP), assumed the responsibility for fee-for-service Medi-Cal inpatient care. The CCCMH-MCP utilizes the services of the Contra Costa Health Plan for utilization management. The CCCMH-MCP has an inpatient network consisting of Merrithew and three community hospitals (East Bay Hospital in Richmond, Walnut Creek Hospital, and First Hospital of Vallejo). We are unaware of the status of planning for the July 1997 outpatient consolidation.

The CCHSD will need to make significant strides in its planning and capacities in order to meet the challenges of operating within a fixed budget, once Medi-Cal mental health funding is capped or capitated. Most critically, CCHSD will need to accomplish at least three things:

(1) The development of adult and children systems of care that can meet client needs while controlling costs;

(2) A clear delineation of clinical and financial responsibility for the dollars assumed by the Contra Costa County Mental Health - Managed Care Plan (CCCMH-MCP); and

(3) The development of adequate infrastructures and systems to manage the risk.

1) Systems of care.

The best way to ensure that clients continue to receive the services and support they need under a more financially constrained capped budget is to design and implement systems of care

for children and adults a) that ensure that appropriate levels of care are available; b) that provide for continuity across these treatment settings; and, c) that, particularly with the children's system, incorporate substantial interaction and coordination with other county services.

The MHD has made considerable strides in implementing a system of care for children and youth. MHD leadership in this area has been consistent, innovative programs have been initiated, and significant efforts have been undertaken to work in conjunction with all the agencies and programs that bear some responsibility for the children and families served by MHD.

Progress towards a comprehensive coordinated system of care for adults has been slower. The System of Care Design Adult Subgroup in the Phase I planning focused its attention primarily on recommendations for the expansion of service alternatives to inpatient care. The group recognized that additional planning was necessary in order to address basic system issues for the system to evolve into a model of services appropriate to a managed care environment.

2) Delineation of clinical and financial responsibilities

Consolidating funds and responsibilities under one authority greatly facilitates the smooth operation of a system of care. It helps ensure that the financial incentives for all parts of the system are in alignment and that they support the most appropriate clinical care for clients. As envisioned by the state's managed care initiative, the CCCMH-MCP has this responsibility.

The current structure of responsibility and accountability for the mental health system in Contra Costa County is complex. Three parties -- the Mental Health Division (the nominal manager of the CCCMH-MCP), Merrithew, and the CCHP -- currently have a portion of the clinical and financial responsibility for the management of mental health services for the Medi-Cal and indigent clients. Authorizations for Medi-Cal fee-for-service inpatient care are conducted by the CCHP for both its members and all other Medi-Cal enrollees; the CCHP is also responsible for management of the full range of mental health services for its Medi-Cal clients; management of inpatient care at Merrithew is under the control of the hospital; and the MHD manages the Psychiatric Emergency Service and the balance of the non-inpatient Short-Doyle/Medi-Cal and indigent services.

The issue of divided responsibility, mixed roles, and unclear financial accountability is most apparent in regard to the funding and control of inpatient services. The decision to utilize space within the new Merrithew for inpatient psychiatric care could create a strong potential for conflicting incentives. Unless the hospital is placed on a capitated payment arrangement, it will have the financial incentive (at least in the short run) to maximize the revenue it receives from mental health clients, while the MHD as the CCCMH-MCP would benefit from expending as little as possible on inpatient care (either by reducing usage and/or by using potentially less expensive community hospitals) and using the savings to augment its community support services.[11] The potential for these conflicting incentives around inpatient care highlight the

critical importance of carefully specifying the roles and expectations of each of the components within the Health Services Department.

Creating a comprehensive coordinated system of care under this tripartite structure will be a challenge. The benefits from consolidating funding and responsibility will be difficult to achieve unless the lines of responsibility and the flow of funds are clearly established.

3) MIS and infrastructure capacities

The managers of the mental health systems of care need accurate and timely information about the usage of services and financial performance. This requires not only that the above issues of responsibility and accountability be clarified and specified, but also that they have the needed MIS and other infrastructure supports. Some of this infrastructure exists within the CCHP and some within the MHD; careful planning will be needed to ensure that the CCCMH-MCP has available the infrastructure it needs.

H. SUMMARY

1. The Contra Costa County Health Services Department (CCHSD) is faced with a growing set of challenges. While its primary funding sources are shrinking, its responsibilities in terms of provider of last resort are increasing.

2. The Board of Supervisors has indicated a clear policy of directing the health-care delivery components of CCHSD to be self supporting, with no general fund support.

3. Without general fund support, the financial viability of the indigent-care program will be fully dependent on disproportionate-share hospital funds, which are decreasing as more and more private hospitals become eligible for this generally fixed pool of dollars.

4. Since disproportionate-share funds are driven by inpatient Medi-Cal volume, CCHSD's ability to provide necessary care to unsponsored, county-indigent patients is dependent on its ability to draw a sufficient number of Medi-Cal patients.

5. This ability is threatened by competition from private hospitals anxious to fill empty beds, and by the implementation of the Two-Plan model for Medi-Cal managed care, where the commercial plan (Foundation Health), is anxious to enroll Medi-Cal beneficiaries in hopes of generating profits through minimizing health-care expenditures within state-promulgated capitation rates.

6. The primary vehicle for CCHSD to protect its Medi-Cal funding sources is the Contra Costa Health Plan (CCHP), which, as a governmental entity, is constrained in its ability to effectively respond to competitive pressures.

7. While funding will be less secure, inevitable cuts in Medicaid funding, due to likely federal Medicaid reforms in 1997 or 1998, and just-enacted welfare reform, will lead to an expansion of the county-indigent population.

8. This expansion will be superimposed on an already growing uninsured population due to an economy shifting from a manufacturing to a service industry base, where employer-based health insurance coverage is less prevalent.

9. Private-sector providers and district hospitals cannot be expected to absorb significant increases in indigent patient loads without a payment source.

10. The ability to successfully compete for Medi-Cal enrollees will require CCHP to invest in services, facilities and infrastructure that will attract Medi-Cal beneficiaries with private-sector choices.

11. To effectively manage its mental health system in a fully capitated environment, will require similar investments and initiatives.

II. GOVERNANCE

Responsibility for the running of most public health care systems typically rests with the elected leadership of the jurisdiction. However, many local governments in California and throughout the nation have considered and, in some instances, implemented alternative governance structures.

The alternative structures vary in the degree of independence from the elected body, and the scope of their authority. In breaking down the options that are available, degree of autonomy from the elected officials is a key defining criteria. The options most jurisdictions have considered break down into these three broad categories:

l. Autonomous Governance Structure: These organizations have a clearly independent right to make decisions regarding the direction of the health care system they manage. The systems in New York City, Dallas and Denver are examples of this type of structure.

2. Semi-Autonomous: In this structure, a committee of health experts makes day-to-day decisions regarding the running of the system, with the elected officials reserving the right to establish broad policy.

3. Advisory: Outside advisors sit on a panel that reviews key issues and makes recommendations to the Board. They have no independent power and make recommendations only. Ventura County has such a panel.

While the specific circumstances that influence the decision to change governance of a health system vary widely, one consistent theme emerges: a belief by the locally elected officials that managing a health care system that must compete with the private sector in an era of almost constant transformation in the science and economics of health care is too complex and hazardous a responsibility to be fully entrusted to lay leaders without formal training.

While many other policy choices made by local officials involve complex issues, the most important factor that distinguishes health care is the private-sector competition. No other county service falls or rises based upon its ability to win market share in a contest with the private sector. This is what makes health care in the public sector increasingly risky and it is what leads policy makers to consider more and more frequently governance reforms.

A recent example of the way in which the governance issue surfaces occurred in Los Angeles County in 1995 when its health care system faced imminent collapse. An

unprecedented $655 million shortfall in the $2.3 billion Los Angeles County Department of Health Services led the Board of Supervisors to consider shutting down Los Angeles County +USC Medical Center, the largest public hospital in the nation and the anchor for the sprawling L.A. County system.

In the political and policy debate that ensued, L.A. County ultimately obtained a federal Medicaid waiver which allowed it to access sufficient funds to avoid a system "meltdown" and to restructure over time from a hospital dominated system to one which more strongly emphasizes primary and preventive care delivered in an outpatient clinic setting. While the system was saved for the moment, the Board of Supervisors initiated a public debate directed at analyzing whether governance was a factor in the system's close brush with collapse and whether a change in governance would help the County succeed in its ambitious restructuring program.

While the Board believed that a failure of leadership in the Department of Health Services was a factor in the creation of the crisis, it chose not to make any immediate change in the relationship of the Board to the Department. Instead it recruited and hired a new director, Mark Finucane, formerly with Contra Costa County, who they believed would provide the County with stronger management skills and a more forceful approach to the restructuring mission. In the hiring of a new Director, the Board also made a clear commitment to give the new Director special assistance in areas such as personnel to ensure that he could competently handle the massive responsibilities he had assumed.

A key factor in L.A.'s decision not to pursue a major change in governance was a reluctance on the part of the Board to become embroiled in a process debate which could easily have been long and acrimonious at a time when substantive work on repairing the system needed to be done immediately.

Alameda County represents another example of a county engaged in a debate over the governance of its health care delivery system. Motivated by several years of significant budget shortfalls (it closed a gap of approximately $150 million over the past five years) accompanied by turnover and turmoil in the leadership of Highland Hospital, its largest facility, the Board has spent much of the past two years preparing for a new governance structure.

In making its governance decision, the Board looked at its system in terms of three distinct functions:

1. Provider of care: Its two hospitals, recently consolidated under a single management structure, serve as the anchor for the county system that directly delivers care.

2. Protector of health: A public health unit investigates and responds to threats to the health of the larger community.

3. Purchaser of care: This role is played through contracting with the private sector and the County's participation in the Alliance, the Alameda Local Initiative.

Alameda has preliminarily concluded that governance changes are not critical factors in the performance of its role as protector of public health and purchaser of care. It has, however, made the initial judgement that its role as provider of care, the role that requires management of its hospitals, does require a change in governance.

The Board reached its conclusion based largely on the difficulty it was experiencing in implementing the programmatic and financial changes it needed to prepare its system to survive in an increasingly competitive health care marketplace. Lack of flexibility in personnel policy was one perceived impediment.

The Board's preferred option is the creation of an autonomous health authority. It sponsored legislation which the Governor signed into law in September of 1996, which gives it the option of creating such an authority with its initial membership appointed by the Board of Supervisors. Under this structure, the Board would decide on the overall size of the hospital system budget, but leave the detailed decision-making regarding system policy and the expenditure of dollars to the independent health authority.

Opposition to the creation of such an authority, led by elements of organized labor, sponsored Measure E on the November ballot, which was intended to effectively block the Board from implementing the health authority the new law allows. Measure E, however, was defeated by a narrow margin of slightly over 50 percent of the vote, clearing the way for the Board to move ahead with the creation of a new governance structure for its hospitals.

Jurisdictions that ultimately choose to make governance changes are typically driven to consider the issue by a funding crisis In weighing the decision to create one of the three models outlined above, a decision to restructure governance normally follows a conclusion by the Board that:

l. It lacks the expertise to satisfactorily evaluate existing options or develop new ones.

2. Private sector competition is growing stronger as the County grows weaker.

3. The individual district constituencies of the Members of the Board make "single system" decisions difficult if not impossible to make.

The last point is one worth emphasizing since it is often a key factor in a public health system's inability to remain competitive in the marketplace. Private health care systems run by a single management team can open or close facilities, downsize or enlarge bed capacity based on the overall economics of their system. As managed care squeezes the margins on which all

health care is delivered, the ability to restructure in a disciplined, cost-effective manner is critical to survival.

In many public systems, these same decisions (e.g., opening or closing facilities, downsizing) interact with the district needs of individual elected officials. Closing a facility in one community can be viewed as an assault on the Board Member's constituency rather than a necessary step to preserve the overall stability of the system. To the extent that public systems are viewed through the prism of individual district boundaries, they are at risk of preserving inefficiencies that would not be tolerated by their private sector competitors.

In a jurisdiction troubled by an inability to view its department as a single integrated system of care, a change in governance would be a way of insulating the decision-making process from district politics and allow the public sector to compete with the private sector on more equal terms.

Using the criteria that other jurisdictions have applied, Contra Costa County does not appear to be in an environment where a fundamental change in governance (the creation of an autonomous health authority, for example) is required. On major issues impacting the strategic future of the Department such as the structure of the Local Initiative and the construction of a replacement county hospital, the Board, with the advice and expertise of the Contra Costa County Health Services Department, has confronted the questions raised and made clear decisions. The County health system is not currently facing a significant budget shortfall.

To the extent Contra Costa County needs to consider governance changes, they more properly involve the narrower issues of whether the Health Services Department has adequate administrative discretion to change its programs in response to changes in the private market. Questions that need to be addressed would include such issues as:

1. Does the Department have the ability to maximize work-place productively?

2. Does the Department have the ability to act quickly and with flexibility, without political interference, to enter into private-sector partnerships (a key factor in maintaining competitiveness)?

3. Does the Department have the budgetary flexibility to move funds to where they are most needed?

These are all management questions where centralized Board control could be relaxed in order to allow the Health Services Department to function in a manner that is more analogous to its private sector competitors. A recent report prepared for the Contra Costa County Health Services Department suggests, based on extensive interviews with staff physicians and other health-care personnel, that the Contra Costa Health Plan is severely hampered in its ability to compete with private-sector providers and plans for Medi-Cal patients, due to centralized (centralized <u>outside</u> the Department) decision making, and restrictions on personnel and

purchasing decisions.[12] It appears that such limitations are endemic to public agencies, which until recently, have not been expected to compete with the private sector.

It should be noted that if a governance change is to be pursued, its objective should be to improve the efficiency of the county-administered health system. A governance change will not enable a county to be relieved of its Section 17000 obligation. Such relief would require state legislation totally unrelated to county health-system governance.

III. FINDINGS AND RECOMMENDATIONS

Finding #1. The Health Services Department needs to have the capacity to compete.

If the Department is not going to rely on County general fund support and will be expected to operate as a business, it will need the flexibility to be able to operate as such. To successfully compete for sponsored (publicly and privately) patients will require CCHP (and its provider network) to have the following tools:

> (1) the ability to introduce financial (and other work-place) incentives to its employees, venders and suppliers to encourage cost-effective provision of health care and patient satisfaction;
>
> (2) flexibility in maximizing the productivity of its workforce through, ideally, being exempt from civil-service constraints. This would include the ability to hire, fire, promote and demote all levels of personnel, and the ability to adopt and enforce productivity and other medical-care benchmarks. Since the ideal is not possible at this time, an interim step to provide added flexibility can and should be undertaken as a high priority. Such flexibility can be achieved within the civil service system by transferring personnel analysts to the Health Services Department (operating under broad guidance from the County Personnel Department), thereby assuring more timely personnel decisions, and decisions made from the perspective of CCHSD;
>
> (3) flexibility in purchasing equipment and services. While it is reported that currently the acquisition of supplies, services and equipment is not a problem, this is likely to change in the future as reimbursement and capitation are further eroded. The health system will find itself in the position of having to reduce costs through staffing adjustments, but having little or no leverage over supply costs. A series of action steps to avoid this future problem need to be planned now. Ultimately, suppliers need to be, like the health system, sharing in the risk. Expenses and revenues need to be in balance, and move in the same direction. This means all the elements of the health system, including suppliers, should be tied together.

It will take time to achieve such a "business alliance" with suppliers, but it can be done in two stages. The first stage involves converting most of the health system supplies (e.g., drugs, medical supplies) to a "just-in-time" operation, with the business alliance vendors carrying the inventory. The second stage is to convert to a capitation (or per patient day, per visit) basis, so that the business-alliance vendor partners share in the health system rewards and risks.

(4) the ability to enter into joint ventures with private health-care providers and health plans in a timely manner (e.g., establishing a clinic that emulates a private medical office, entering a partnership with a private health plan, joining various purchasing cooperatives);

(5) the ability to integrate public health, mental health and medical services in a cost-effective manner to maximize continuity of care and economies of scale and scope;

(6) flexibility in planning and budgeting, including the ability to shift funds among various accounts (e.g., among services, between operating and capital);

(7) being exempt from potential political pressures that may not be in the system's best interests (e.g., pressures generated by the private sector to restrict competition, political interference over decisions on where and how to provide or cut services);

(8) the ability to reconfigure the health system to be more "patient friendly" in terms, for example, of customer relations, scheduling and other amenities; and

(9) the ability to market its services in a state-of-the-art manner.

Recommendation #1 -- Capacity to Compete

The necessary tools, enumerated above, should be explored in depth, to determine how they can most effectively be provided. Some may be accomplished through CCHSD changes in operating policies, with no Board action necessary. Some changes in policy may require Board approval. And providing other tools may require a change in governance. The options should be prioritized and classified into the above three categories (i.e., no Board action needed, Board action needed, governance change needed). Under this approach, change can be accomplished in an incremental manner, and need not be caught up in debates concerning governance. If the only way to accomplish a high priority goal is through restructuring, the Board will be able to focus on the trade-offs involving those goals and the political problems associated with a governance change. At the same time, however, the Department can proceed on other important goals. In the context of restructuring, the Board may wish to consider creating a pilot program where for a defined period, perhaps one year, broader administrative discretion is given to the Department in

specific areas such as personnel decisions, contracting questions or equipment and supplies acquisition. The pilot would be evaluated in terms of whether or not the Department's efficiency was enhanced in a manner that did not compromise the Board's ultimate public policy responsibility.

Finding #2. The Health Services Department needs to have clear lines of responsibility and accountability within itself.

As CCHSD takes on broader scopes of managed-care responsibilities in both health care and mental health, it will be faced with more complicated relationships between the management and provider functions. In a capitated environment, CCHP's interests will at times conflict with those of Merrithew. CCHP's interests may even conflict with its salaried medical staff if, for example, private medical groups are willing and able to provide service at lower costs. Merrithew may benefit from contracting with Foundation, which could compromise CCHP's ability to distinguish its provider network. These potential conflicts among the individual components of the system can be resolved through the Health Director making decisions in the best interests of the entire system, notwithstanding adverse effects on particular components.

Recommendation #2 -- Lines of Responsibility

The Department should set overall policy for each of its components and then allow each component to act more independently and be accountable for its own results. To the extent feasible, overall policy should provide for maximum coordination and integration, while enabling distinct units to benefit from market-place developments.

Finding #3. The Health Services Department needs to develop strategic partnerships.

The County-operated health delivery system can benefit from partnerships with private providers through enhancing the breadth and scope of its provider network. Such strategic partnerships could accomplish the following objectives:

(1) improve the marketability of CCHP through having a stronger network;

(2) expose the County-operated system to private-sector operating procedures, some of which may be desirable;

(3) better position the County system as a competitive entity, through avoiding duplication, and thus minimizing costs;

(4) enable the County system to draw from the best of the private and public sectors; and

(5) "soften" the image of the County system so it is perceived more as a mainstream provider.

Recommendation #3 -- Strategic Partnerships

A set of guiding principles for public-private partnerships should be developed, and all initiatives in this area should be measured against them. The principles should address factors such as:

(1) enhanced geographic access;

(2) lower cost alternative to expanding County owned facilities or salaried staff;

(3) enhanced continuity of care and medical capabilities;

(4) compatibility between prospective partners and County providers and County mission;

(5) financial security of prospective partners;

(6) prospective partners willingness to share in indigent care responsibilities, in addition to the business line specifically addressed in the partnership; and

(7) long-run economic advantage to the County.

In addition, all service expansions or major capital expenditures contemplated by the CCHSD should be measured against the alternative of achieving the same ends through potential partnership arrangements.

Finding #4. The Health Services Department needs to focus on its areas of strength.

The County health system has considerable experience in treating hard-to-manage indigent and Medi-Cal patients (e.g., homeless, AIDS, substance abusers, aged, disabled), and ethnically and culturally diverse populations. These capabilities make the County system unique. And these capabilities are reflected in Merrithew s Medi-Cal patient mix, which has relatively more SSI beneficiaries than do other local hospitals. Since the SSI population represents the largest concentration of acute-care dollars in the Medi-Cal program, these capabilities should work to Merrithew s advantage. As the Two-Plan Model expands to incorporate the SSI population, CCHP should be positioned to be the health plan of choice for this group. Moreover, in developing strategic partnerships, one of the advantages CCHSD brings to the table is expertise in treating a hard-to-manage population.

Recommendation #4 -- Areas of Strength

CCHP and its provider network should build on their relationships with the SSI population, and begin enrolling as many beneficiaries as possible voluntarily, to provide a solid base for the next stage in the evolution of the Two-Plan Model.

Finding #5. The Board of Supervisors needs to take a leadership role in promoting a broader sense of responsibility for the uninsured.

The uninsured population is likely to grow, with welfare reform, future Medicaid reform, the continued transition of the U.S. economy to a service-industry orientation, and lack of political will to enact a universal coverage program at the federal or state levels. A likely response by the State Legislature to deal with the added burdens placed on counties is to consider releasing them from their Section 17000 obligations. Repealing Section 17000, however, does not solve the problem. What it would do is put stress on the broader health-care community, while the County system will still be the primary source of care for unsponsored-indigent patients. Refusing to care for sick people is not a viable option for the County. Should the CCHSD become overwhelmed with indigent patients, without sufficient revenue from federal, state and local sources, help from the private sector will have to be enlisted, in the following forms:

(1) With strong encouragement from the State Department of Health Services, a commitment from the Commercial Plan (i.e., Foundation) to enroll a specified percentage of the indigent population, or to restrict its Medi-Cal enrollment to a level that would enable the County system to maintain its Medi-Cal revenue at a sufficient level; and

(2) Commitments from private providers to assume a portion of the indigent care, or to restrict their competition for Medi-Cal patients not enrolled in one of the two managed-care plans (i.e., Medi-Cal beneficiaries in the non-mandatory aid categories -- share-of-cost, aged, disabled -- that will not be required to enroll in a plan).

The alternative to such an approach is a growing public health problem, and a chaotic situation not acceptable in an affluent, industrialized society.

Recommendation 5 -- Shared Responsibility

If, and when, it becomes apparent that the effects of welfare reform and related State action (or inaction), Medicaid reform or other developments, will result in an unacceptable increase in the uninsured population, CCHSD should prepare projections of budget shortfalls under various scenarios and apprise the Board of Supervisors of available alternatives (including increased general fund contributions, feasible State legislative initiatives, and joint public-private efforts). The Board should be actively involved in dealing with all available alternatives, and should convene meetings with all interests (e.g., consumers, providers, organized labor) to

develop the necessary consensus to approach the Legislature or to develop a sense of shared responsibility among all major players.

Finding #6. Critical decisions will be made in Sacramento during the coming Legislative session that will have a major impact on the CCHSD. The Board of Supervisors has to be actively involved in attempting to influence these decisions.

The Legislature will be implementing Federal Welfare Reform, rethinking the Section 17000 obligation, and, most likely, dealing with Medicaid reform and changes in the SB 855 distribution formula. All these issues will have major impact on the operations and viability of the Contra Costa County Health System. State enabling legislation going beyond federal mandates in terms of restricting services to current legal immigrants will have major adverse effects on counties and private-sector providers. Changes in the SB 855 payment formula will be necessary to maintain funding for county indigent care. Maintaining the Section 17000 obligation is necessary to preserve state funding for services many counties would elect to continue providing even in the absence of such funding. This obligation is also necessary to preserve a political force striving to maintain the health-care safety net (i.e., counties dependent on realignment funds).

Recommendation 6 -- Critical Legislative Decisions

The Board should adopt positions on major pieces of legislation that are expected to have a major impact on CCHSD, and lobby the Legislature and Governor accordingly.

Legislation will likely be introduced to reduce or eliminate the Section 17000 obligation. The Board should recognize that such a policy will adversely impact the local health system, and that relieving some counties of this obligation will reduce the political clout of those counties that recognize the necessity of this obligation.

The Board should strongly support the public-hospital side in the SB 855 debate, arguing for changes in the payment formula to place greater weight on outpatient services and indigent care.

The Board should be involved in the Welfare Reform deliberations, with the intent of maintaining the county's ability to provide necessary care to its indigent population.

END NOTES

1. Budget figures for the hospital and clinics include some $27 million in bond revenue related to the hospital replacement project, discussed below.

2. See the Legislative Analyst's Analysis of the 1995-96 Budget, for a summary of these programs.

3. Expanding Medi-Cal Managed Care, California Department of Health Services, March 31, 1993, p. 56.

4. Welfare and Institutions Code, Section 14085.5 (b)(5)(A).

5. Medi-Cal revenue is allocated within the Department as follows:

(1) Hospital and Clinics	$32.9 million;
(2) Contra Costa Health Plan	$14.3 million (much of which is paid to the hospitals and clinics for services provided); and
(3) Mental Health	$9.5 million.

6. "Welfare Reform Legislation -- Impact on Medi-Cal," California Association of Hospitals and Health Systems, September 1996.

7. While the projected $62 million reduction is to all providers (public and private), the County health system would bear the brunt of providing needed care to former Medi-Cal beneficiaries who become unsponsored indigents.

8. The number of Californians with no health insurance, Medicare or Medi-Cal coverage increased by 273,000 between 1992 and 1993, to over 6.5 million individuals. See E. Richard Brown, "Health Insurance Coverage in California, 1993," UCLA Center for Health Policy Research Policy Brief, April 1995.

9. The State Department of Health Services has determined that of the approximately 60,000 mandatory eligibles (including those currently enrolled in prepaid health plans), 40,000 are targeted as minimum enrollment for the Local Initiative. This would be accomplished by assigning "default" enrollment to the Local Initiative (i.e., those beneficiaries that do not make a choice), until the latter has achieved its targeted minimum enrollment. After that point, however, should the Local Initiative be unable to retain sufficient enrollment levels due to competition from the commercial plan, the targeted minimum would no longer be operative.

10. Medi-Cal Provider Statistics File, calendar-year 1994. Payments are on behalf of residents of Contra Costa County, to providers in any location.

11. Even with Merrithew on a capitated payment arrangement, the current SB 855 formula still creates incentives to maximize inpatient volume.

12. See Contra Costa Health Plan Provider Organization Study, Henry W. Zaretsky & Associates, Inc., August 1995.