CMSP

GOVERNING BOARD

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SENATE BUDGET AND FISCAL REVIEW COMMITTEE
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Good morning Mr. Chairman and Committee Members,

My name is Lee Kemper. For the past thirteen years, until the end of last December, I served as Executive Director for the County Medical Services Program Governing Board, commonly referred to as CMSP. I now serve under contract to the Governing Board as Director of Policy and Planning.

On behalf of the CMSP Governing Board, I would like to thank the Committee for the opportunity to present the views of the Board and the 35 member counties it represents on the proposed Medi-Cal expansion to include low-income single adults, its opportunities and risks, and the role for CMSP counties under federal health reform.

I would like to start my remarks by providing a little background on CMSP because many Committee Members are likely to be unfamiliar with the program for either of two reasons:

- It does not operate in your district because the county or counties you serve operate their own indigent health care programs; or,
- It has not come to your attention because the program is funded entirely by 1991 Health Realignment funding and operates as a county-only program outside of the State Budget.

I will point out, Mr. Chairman, that you previously represented a district that includes a CMSP county, Marin County. In addition, Senator Nielsen and Senator Berryhill represent districts with CMSP counties.

As a program, CMSP was established in 1982 at the time the medically indigent adults, or MIAs, were dropped from the Medi-Cal program and transferred to counties with specified funding. CMSP was established as a vehicle for smaller and rural counties to pool their resources and serve the population through a single benefit program administered by the State Department

of Health Services. To participate, counties "contracted back" with the State. California law, specifically Welfare and Institutions Code Section 16809 et seq., authorizes counties with populations up to 300,000 to participate in the program.

The statute authorizes 39 counties to participate in the program. Today, 35 counties participate. These counties cover approximately 90,000 square miles of California, have roughly 3.5 million residents, contain many remote and frontier areas of the state, have some of the deepest pockets of poverty, and experience some of the greatest difficulties in delivering needed medical care due to a lack of sufficient health care providers – primary care, specialty care, behavioral health care, and ancillary support services. I have distributed a map of the participating CMSP counties for your information.

Today, CMSP serves roughly 70,000 average monthly enrollees through two programs: CMSP and Path2Health, the CMSP Low Income Health Program, or LIHP. However, the reach of these programs is greater than monthly enrollment totals. Between 110,000 and 120,000 unduplicated persons are served by these programs each year.

Since 2000, the Governing Board has taken number of steps to strengthen CMSP and assure it can serve enrollees in the 35 counties with available Realignment revenues. Through these changes, and because of a strong economy in the period of 2004 through 2007, the Governing Board was able to build a Contingency Reserve to support the program should annual expenses exceed annual revenues. By 2008, this Reserve was approximately $250 million.

It is important to note here that the strength of the revenues supporting CMSP is inversely related to the need for health care services by low income people. When revenues are strong, the economy is strong and more people have jobs; some may have health coverage. When the economy declines, people lose work and the need for health care services increases. Recognizing this dynamic, the Governing Board retained a Contingency Reserve for the inevitable "rainy day."

That rainy day came. It was called the recession. Demand for services grew 50% in three years and by June 30, 2012 the Contingency Reserve was reduced to less than $2 million. Because the Governing Board established a LIHP beginning January 1, 2012, operations continued with the support of federal matching funds and an effective transition was made without interruption of services to CMSP and Path2Health enrollees. And, importantly, during the 2008-2011 recession, as enrollment escalated, the Governing Board used funding from the Contingency Reserve to assure continued health coverage to the growing population and prevented any cuts to eligibility, benefits, or provider payment rates.

With this background, I'd like to address the questions posed by Committee staff.

The FY 2012-13 Budget for CMSP/Path2Health is just over $400 million. Of this, Health Realignment funds comprise approximately $225 million. These Realignment funds are used to match the federal LIHP funds, pay for services to enrollees in CMSP that do not qualify for the LIHP, and for program administration. The maintenance of effort amount established under the LIHP program is approximately $125 million.

For FY 2013-14, the CMSP/Path2Health Budget is predicated upon a full year of Health Realignment funding. This funding is required to make claims payment for continued residual populations that do not become eligible for Medi-Cal or Covered California and for medical claims of covered LIHP and CMSP enrollees for the last six months of calendar year 2013. These "incurred but not paid" claims, as they are known, will be paid over the first 6-9 months of 2014, and are a part of the calculation that requires full Health Realignment funding through FY 2013-14.

Beginning January 1, 2014, we expect to see all LIHP enrollees move to Medi-Cal because they will be eligible under federal rules. The movement of other populations in CMSP to Medi-Cal or Covered California is less certain, and will be affected by the application process for those not immediately transferred to Medi-Cal and by decisions of individuals about whether or not to apply for Covered California during its Open Enrollment period. We anticipate a continuing residual service population of up to 20% of currently covered enrollees.

On Tuesday of this week, the Governing Board's Executive Committee met via conference call to consider the Administration's two proposed options for the Medi-Cal expansion. The Committee, which is authorized to speak for the Governing Board on all legislative matters, unanimously approved a set of principles that calls for a Medi-Cal expansion that builds on the State system. The Governing Board and its member counties are not prepared to take on the responsibility required under a County-based Option, most notably because of the need for network development to serve a substantially expanded population, estimated to be up to 160,000 persons. The Governing Board does not have capacity to achieve this by January 1, 2014.

In addition, this set of principles recognizes that there are no costs to the State of California for the Medi-Cal expansion for three years, 2014-2016, and in consideration of this fact, states that no transfer of Health Realignment funds should be considered unless:

- There are *net* costs to the State associated with Medi-Cal's expansion to cover low income, single adults;
- Counties retain sufficient Health Realignment funds to address residual responsibilities, including serving the remaining uninsured and carrying out public health service obligations; and,

- Counties, including CMSP counties, retain free-up revenues beyond documented net State costs and utilize these resources for reinvestment in local health and public health systems and programs.

Beginning in FY 2014-15, if the maintenance of effort calculation used for CMSP's participation in the LIHP were used, roughly $100 million would be retained by CMSP for continued services to residual populations and roughly $125 million would be retained by CMSP for reinvestment in rural health delivery systems. Under this policy approach, roughly $250 million would be retained by CMSP counties for reinvestment before the State experiences any costs with the Medi-Cal expansion population.

Over the past 30 years, the State of California's commitment to the healthcare infrastructure of rural and small counties has been nominal, at best. Because the majority of California's population does not live in these areas, it has simply not been a priority. But, in the face of health care reform, the CMSP Governing Board recommends that the rural and small counties it has served since 1993 need to be a priority. The CMSP Governing Board is poised to make effective use of the Health Realignment resources for this purpose. Over the past 15 years, the Governing Board has provided funding for rural clinic expansions, hospital retrofits, wellness and prevention programs, mental health and substance use treatment pilot programs, and care management pilot programs. The Governing Board has invested nearly $25 million.

In closing, I'd like to point out that during the period of 2010 and 2011, the Governing Board assisted the State of California with claiming of federal matching funds on the basis of CMSP expenditures that were funded entirely by Realignment funds. This federal claiming allowed the State of California to receive approximately $260 million in federal funds that went only to the State. CMSP counties did not benefit from this federal funding.

It is the CMSP Governing Board's position that Health Realignment revenues should be retained by the CMSP counties and the Governing Board until the State experiences costs for the expansion population. The Governing Board will utilize these revenues to serve the residual populations left uncovered by the Medi-Cal expansion, and the remaining funds will be reinvested in the health care infrastructure of the CMSP counties, specifically provider network and infrastructure development for primary care, specialty care, behavioral health, and health home supports. With the Medi-Cal expansion in rural counties, provider network capacity to serve the population is vital.

The CMSP Governing Board looks forward to working with Legislature, the Administration and stakeholders to make the most of the important opportunities provided by the expansion of Medi-Cal to cover low income single adults – opportunities to expand coverage to low income persons, continue coverage and services to those left out of federal health reform, and to invest

in the essential health care infrastructure California's small and rural counties need to make federal health reform successful.

Thank you, again, Mr. Chairman and Committee Members, for this opportunity to provide testimony today. I am happy to answer any questions.