How to use this document:

Pages 2-17:

On pages 2-17 there is a **Medicaid Strategy Literature Review**.

This document was an environmental scan completed by CPCA staff to get a better idea on the current research related to five pre-determined categories. Each row lists important information:

Color Category & Citation # referenced in Data & Framing Documents	Title/Link	Summary	Key Points/Findings	Authors	Date Published

This Literature review has also been color coded as to the related category. If an article has information pertaining to one or more of the predetermined categories, the color in the first column indicates so.

The five pre-determined categories include:

CA FQHC's and Medicaid
People covered by Medi-Cal
Cost Savings of Medi-Cal
Expansion (Natl or in CA) before and after Medi-Cal
FQHCs & high quality care/value

Pages 18-25:

On pages 18 – 25 there is a **Framing the Argument with Supportive Literature.**

This strategy framing document is a companion document to the literature review. *Specifically this document highlights areas of the below message with direct quotes and figures from the literature cited in the review.*
This document is also color coded to align with components of the message:

- ***The Affordable Care Act has strengthened, enhanced, and begun to modernize the health care system in America.***
- ***We need to keep the building blocks of a program that has afforded new health care coverage to over 20 million Americans.***
- ***This includes securing funding to community health centers that are the bedrock of Medicaid and the health home for almost 25 million people across the country.***
- ***Without Medicaid and without health centers the country will lose one of the highest quality low cost choices on the market.***

It is organized by rows with two columns. The left side column indicates the portion of the above message is being supported. The right column is all the direct quotes from the literature review which supports various elements of the message. Each quote followed by a citation and sub-reference (ex. [1a])

Pages 26-27:

On pages 26-27 there is a **Key Data Sources Cited in Framing Document.**

This key data document is a companion to the Framing the Argument document. In the Framing the Argument document there were sub-references (ex. [1a]) after each direct quote. The data sources that support these sub-references can be references can be found in this document. The same color coding can be found in this document as the Literature Review. The document is organized by rows with three columns.

Color Category & Citation # referenced in Lit Review and Framing Document	References Cited in Framing Document:	Sub-Reference Data Sources:

Medicaid Strategy Literature Review

Updated on Monday, December 19, 2016

This literature review supports the goal to: pause and slow down repeal/replace ACA and blowing up Medicaid.

MESSAGE: The Affordable Care Act has strengthened, enhanced, and begun to modernize the health care system in America. We need to keep the building blocks of a program that has afforded new health care coverage to over 20 million Americans. This includes securing funding to community health centers that are the bedrock of Medicaid and the health home for almost 25 million people across the country. Without Medicaid and without health centers the country will lose one of the highest quality low cost choices on the market.

The literature reviewed compiles relevant and timely studies and reports where a value analysis can be developed. It is categorized by color into five primary areas.

*Related Categories:

CA FQHC's and Medicaid

People covered by Medi-Cal

Cost Savings of Medi-Cal

Expansion (Natl or in CA) before and after Medi-Cal

FQHCs & high quality care/value

Color Category & Citation # referenced in Data & Framing Documents	Title/Link	Summary	Key Points/Findings	Authors	Date Published
1	Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose	This factsheet highlights achievements of the ACA. The ACA has allowed California to lead the way in state efforts to implement the ACA, resulting in significant gains: reducing the uninsured rate in California to a historic low and expanding health coverage to millions through Medicaid expansion, Covered California, and Employer Shared Responsibility provisions.	• "Over 5 million Californians have insurance as a results of the ACA--roughly a quarter of all Americans covered under the law." • "91% of Californians are now insured. The uninsured rate in California fell from 17% in 2013 to a historic low of 8.5% in 2015" • "3.7 million Californians enrolled in Medi-Cal under the ACA expansion--representing more than a quarter of the 13.6 million Californians now covered under Medi-Cal."	CHCF	11/2016

N/A	California Community Health Centers: Financial & Operational Performance Analysis, 2011-2014	This report presents an aggregate financial and operational profile of California health centers, utilizing UDS data and audited financial statements of FQHCs from 2011-2014. Throughout this 4-year period, California FQHCs and FQHC Look-ALikes experienced 4 upward trends: growth and expansion in patients, visits, and sites, increased revenues and operating margins, healthy operating reserves, and steady utilization. Conversely, provider productivity experienced a downward trend. California FQHCs continue to expand in order to serve California's growing Medi-Cal population as well as uninsured patients.	• "The California FQHC program continued to expand, providing services to 3.7 million patients in 2014, up 28% from 2010. Annual patient visits increased 31% to 16.2 million over the review period." • Medi-Cal, California's Medicaid program, increased enrollment to cover 56% of patients served at FQHCs in 2014 while the percentage of uninsured patients dropped to 26%.	Capital Link	2016
N/A	Health Centers Have a Powerful National Impact	This infographic, produced by a simulation software, predicts the community, economic, and tax impact of CHCs from 2010-2014. It utilizes 2014 UDS data. The projections show that community health centers have significant community, economic, and tax impacts.	• "Health centers save the healthcare system $28.8 billion annually through collective patient care management," with a 10% in cost savings from 2010-2014 • "Health centers directly supported 170,331 full-time jobs plus an additional 169,463 jobs in other industries in 2014." • "Health centers collectively generated more than $45.6 billion in total economic activity in 2014" • "Health centers annually contribute approximately $5.8 billion in federal and state and local tax revenue."	CHCF	01/2016
2	Stepping Up to the Plate: Federally Qualified Health Centers Address Growing Demand for Care	This longitudinal study analyzes challenges faced by 7 California FQHCs in implementing the ACA and the role of collaborative initiatives in helping to address them. Notable challenges include funding constraints and clinician shortages. To ensure FQHCs are able to serve the growing number of newly insured patients under the ACA	• "Clinician shortages remain significant barriers" for FQHCs. (pg 20) • "With more people insured and more focus on primary care as part of value-based care models and population health management strategies, competition among providers for PCPs and mid-levels has increased significantly between FQHCs and large hospital systems, which also are expanding	CHCF Laurie Felland	10/2016

		expansion, they have begun to develop collaborative initiatives that allow them to expand access, enhance quality, and improve efficiencies. While promising, each initiative come with its unique challenges that FQHCs must strategically work through.	their affiliated physician organizations." (pg 6) • "Many hospitals are seeking to train and develop more PCPs as part of their population health management and value-based payment strategies, in which they are looking for the most cost-effective ways of treating patients (i.e., outside of inpatient and emergency department settings). These programs are supported with funding through the Primary Care Residency Expansion (PCRE) program under the ACA, which prioritizes training in a health center, rural hospital, or other community-based setting." (pg 9) • "The funding future is also uncertain; PCRE funding under the ACA started in 2010 and lasts five years, so whether these programs will be sustained after federal funding ends is unknown." (pg 10)		
3	Health Insurance Coverage and the Affordable Care Act, 2010-2016	This policy brief highlights changes in health coverage before and after the ACA. It utilizes data from the National Health Interview Survey and Gallup-Healthways Well-Being Index from 2010-2016 to determine coverage changes for non-elderly adults and young adults. The analysis shows that coverage has increased significantly for non-elderly adults who gained covered through Medicaid expansion and young adults who were allowed to remain on their parent's plan until age 26 as part of the ACA.	• "The uninsured rate for non-elderly adults (ages 18 to 64) declined by 43 percent between October 2013 and early 2016 (from 20.3 percent to 11.5 percent)." (pg 2) • "In total, an estimated 6.1 million young adults gained coverage from 2010 through early 2016. " (pg 5) • "We estimate that the provisions of the ACA have resulted in gains in health insurance coverage for 20.0 million nonelderly adults (ages 18 to 64)." (pg 7)	Namrata Uberoi Kenneth Finegold Emily Gee	03/03/2016
4	Disentangling the ACA's Coverage Effects – Lessons for Policymakers	This paper uses data from the U.S. Census Bureau from 2012 through 2014 to describe the effects of key provisions of the ACA on insurance coverage. While	• "We find that the biggest factor in the coverage expansion in 2014 was Medicaid, which produced 63% of the gains we identified."	Molly Frean Jonathan Gruber	10/27/2016

		Medicaid expansion and premium subsidies have had significant effects on coverage gains, the individual mandate has had no effect on coverage.	• "Even among people who were eligible for Medicaid under pre-ACA criteria, we found a large increase in coverage. That increase was made possible by the ACA's streamlining of the application process for Medicaid, removal of onerous asset tests for determining eligibility for most applicants, and increased public awareness about insurance coverage options. Moreover, expanding eligibility to the parents of children who were already eligible can help bring coverage to entire families. We found evidence of this "woodwork," or "welcome mat," effect in all states, whether or not they expanded Medicaid."	Benjamin Sommers	
5 & 24	Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit	The analysis presented potential effects of Trump's three proposed health policies on health coverage using a simulation model. Findings suggest a sharp increase in the number of insured Americans, particularly the most vulnerable individuals. Additionally, repealing the ACA may result in a dramatic increase in the federal deficit.	• "Repealing the ACA would result in 19.7 million fewer people with health insurance in 2018" • "According to our analysis, repealing the ACA would increase the deficit by a net $33.1 billion in 2018. Although repealing the law would reduce federal outlays on Medicaid and tax credits, repeal would also eliminate the ACA's revenue-generating provisions, such as changes to Medicare payment and taxes on health plans, medical devices, and other goods and services." • "The policies would increase the number of uninsured individuals by 16 million to 25 million relative to the ACA. Coverage losses disproportionately affect low-income individuals and those in poor health." • The policies would increase the number of uninsured individuals by 16 million to 25 million relative to the ACA. Coverage losses disproportionately affect low-income individuals and those in poor health. Enrollees with individual market insurance	The CommonWealth Fund Evan Saltzman Christine Eibner	09/2016

			would face higher out-of-pocket spending than under current law. Because the proposed reforms do not replace the ACA's financing mechanisms, they would increase the federal deficit by $0.5 billion to $41 billion.		
18 & 6	Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety-Net	This summary brief looks at the post-ACA landscape through mid-2015 in terms of enrollment and health plan investments in the safety-net. Findings identify safety-net clinics as vital players in ensuring access to care for millions of Californians, including newly insured individuals under the ACA. In fact, over half of new Medi-Cal managed care members receive their care at safety-net clinics. As such, health plans have made more investments in safety-net clinics since the implementation of the ACA.	• "54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers" • "Safety-net clinics are at the center of ensuring access for both public and commercial Medi-Cal managed care plans."	CHCF Bobbie Wunsch TIm Reiley	12/2015
7	Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era	Study of the uninsured population in 31 community health centers in 4 states (2 expansion states and 2 non-expansion states)	• "Nationally, the number of insured patients using CHCs rose from 12 million in 2010 to 16.5 million in 2014, an increase of 35 percent.3 In all four states studied, the total number of insured patients increased as well, with the greatest growth in California (from 1.67 million to 2.70 million, a 61 percent increase)" • "The numbers of uninsured CHC patients are substantial across all four states in our study. In the nonexpansion states of Georgia and Texas, the total number of uninsured CHC patients increased from 2010 to 2014, while New York experienced a modest decline. Only California showed a significant decline in the number of uninsured served by CHCs, but more than 1 million patients remained uninsured."	UCLA Center for Health Policy Research	10/2016

			• "CHCs across all four states reported that challenges to recruiting and retaining staff led to more financial and capacity challenges. One of the most common difficulties was the ability to provide competitive salaries for hiring and retaining clinical staff,9 who were being recruited by private sector providers increasing staffing due to an influx of insured patients." •		
N/A	California Community Health Centers: Financial & Operational Performance Analysis, 2010-2013		• California FQHCs provided services to 3.4 million patients in 2013, up 16% from 2010. Annual patient visits increased 19% to 14.8 million over the four-year period. • Medi-Cal, California's Medicaid program, covered 47% of patients served at California FQHCs in 2013 while 39% of California FQHC patients were uninsured. • Similarly, utilization at California health centers has increased consistently each year, with the number of FQHC patients growing 16% to 3.4 million over the 2010-2013 period and patient visits growing 19% to 14.8 million.	Capital Link	2015
10	Community Health Centers and Private Practice Performance Ambulatory Care Measures	This study compares FQHC and FQHC Look-Alike physician performance with private practice primary care physicians on ambulatory care quality measures. Researchers conducted a cross-sectional analysis of visits in the 2006-2008 National Ambulatory Medical Care Survey, comparing performance on 18 quality measures. Findings show that FQHCs and look-alikes performed equal or better than private practice physicians.	▪ Compared with private practice primary care physicians, without adjusting for patient characteristics, FQHC and look-alikes performed statistically significantly higher on 6 measures ($p < 0.05$), statistically significantly lower on 1 measure ($p < 0.05$), and no differently on 11 measures. ▪ FQHCs and look-alikes demonstrated equal or better performance than private practice primary care physicians on select quality measures despite serving patients with more chronic disease and socioeconomic complexity.	Goldman, L. Elizabeth et al. "Community Health Centers and Private Practice Performance on Ambulatory Care Measures." *American journal of*	08/2012

				preventive medicine 43.2 (2012): 142–149. *PMC*. Web. 7 Dec. 2016.	
N/A	Federally Qualified Health Center Use Among Dual Eligibles: Rates of Hospitalizations and Emergency Department Visits	This national study investigates the association between use of FQHCs and hospitalization and ED visits for ambulatory care-sensitive conditions among dual eligibles. Findings show that use of FQHCs was associated with lower rates of hospitalization for ambulatory care-sensitive conditions among black and Hispanic dual eligibles. Conversely, FQHC use was associated with higher rates of hospitalization for ambulatory care-sensitive conditions among whites, Asians, and other races. Additionally, use of FQHCs was associated with increased rates of ED visits.	▪ There were fewer hospitalizations for ambulatory care–sensitive conditions among blacks and Hispanics who used these health centers than among their counterparts who did not use them (16 percent and 13 percent fewer, respectively). Use of the health centers was also associated with 3 percent and 12 percent fewer hospitalizations for ambulatory care–sensitive conditions among nonelderly disabled blacks and Hispanics, respectively. These findings suggest that federally qualified health centers can reduce disparities in preventable hospitalizations for some dual eligibles. ▪ We also found that ED visit rates for ambulatory care–sensitive conditions were higher among users of federally qualified health centers, compared to nonusers, for both elderly and nonelderly disabled dual eligibles.	Wright, Brad, Andrew J. Potter, and Amal Trivedi. "Federally Qualified Health Center Use Among Dual Eligibles: Rates Of Hospitalizations And Emergency Department Visits." *Health affairs (Project Hope)* 34.7 (2015): 1147–1155. *PMC*. Web. 7 Dec. 2016.	07/2015
12	Preparing Physicians to Care for Underserved Patients: A Look at California's Teaching Health Centers	This report describes progress of California's six teaching health centers to date toward increasing the number of primary care physicians practicing in underserved areas and discusses barriers to sustaining teaching health centers and establishing new ones. Findings suggest that teaching health centers are a promising model for	▪ Most graduates of teaching health center residency programs continue to practice in underserved areas following residency. ▪ Teaching health centers provide a means for expanding residency training to additional areas of California that have shortages of primary care physicians. Unlike academic health centers, which are concentrated in California's largest metropolitan areas,	Janet Coffman Margaret Fix Kristine Himmerick	08/2016

		preparing physicians to provide primary care to underserved populations.	FQHCs are located in underserved areas throughout the state. ▪ Leaders of the six existing teaching health centers indicated that they would have great difficulty continuing their residency programs if the HRSA teaching health center grants are not reauthorized.		
N/A	The Adoption and Use of Health Information Technology by Community Health Centers, 2009-2013			Jamie Ryan Michelle Doty Melinda Abrams Pamela Riley	05/2014
N/A	A Medical Home Framework for Increasing Cervical Cancer Screening Rates: Best Practices for FQHCs				
8	Medicaid Expansion Spending and Enrollment in Context: An Early Look at CMS Claims Data for 2014	An analysis of nationwide cost trends of data from CMS' Medicaid Budget for Jan - Dec 2014	• The new adult eligibility group, including those newly eligible for Medicaid under the ACA expansion and those previously eligible that were matched at traditional rates but now receive a higher federal match, represented a relatively small share (10%) of total Medicaid spending across all states in 2014. • Spending for the new adult group made up 16% of total Medicaid spending in expansion states. • 94% of spending for the new adult group was federal dollars in 2014. • The new adult group made up a relatively small share (13%) of total enrollment in 2014, and a larger share (23%) of enrollment in expansion states.	Laura Snyder, Katherine Young, Robin Rudowitz, and Rachel Garfield	1/2016

			• Spending per enrollee for the new adult group was significantly lower than spending per enrollee across all groups ($4,513 vs. $7,150).		
9	States Expanding Medicaid See Significant Budget Savings and Revenue Gains	A study on 11 states that implemented Medicaid expansion and the impact on their state budgets and revenue.	• Some expansion states are seeing savings from accessing enhanced federal matching funds and by replacing general funds with Medicaid funds particularly in mental and behavioral health programs, public health programs, and health care services for prisoners. • Some study states are experiencing revenue gains. Nearly all states raise revenue through assessments or fees on providers and/or health plans. As provider and health plan revenues increase with expansion, this translates into additional revenue for states.	Manatt Health Solutions, prepared by the Robert Wood Johnson Foundation 's State Health Reform Assistance Network	3/2016
11	ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs	A national study on Medicaid expansion and its positive effect on Health Care for the Homeless, also known as the 330(h) program. The study compares expansion states with non-expansion states.	• HCH projects in expansion states had larger gains in revenue and smaller increases in costs compared to those in non-expansion states. • For HCH projects in expansion states, third-party payments increased as a share of total revenue due to coverage gains among patients. HCH projects in non-expansion states experienced little change in third-party payments as a share of revenue and remain heavily reliant on grant funding. • The distribution of costs by service type at HCH projects remained fairly stable between 2013 and 2014 in both expansion and non-expansion states.	Matt Warfield, Barbara DiPietro, and Samantha Artiga	3/2016
13	The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and	National examination on early data on expansion-related decreases in uncompensated care costs and related state budget implications, including impending reductions in federal support	• Hospitals in expansion states experienced substantially greater declines in the volume of admissions or discharges by uninsured patients.	Manatt Health Solutions, prepared by the	6/2016

	Policy Implications for States	for Medicaid Disproportionate Share (DSH) payments and waiver pools.	• Early data from hospital associations have shown up to a 46.5% decrease in admissions by uninsured patients and up to a 59.7% decrease in hospital uncompensated care costs following ACA implementation.	Robert Wood Johnson Foundation's State Health Reform Assistance Network	
14	The Impact of Medicaid Expansion on Medicaid Focused Insurers in California	Analysis of 27 California Medi-Cal plans' enrollment, utilization, and cost data in 2014 to determine plan financial performance and the cost of care. Data was derived from DMHC's financial statement database.	With Medi-Cal expansion there was: • Decreased loss ratio to Medicaid insurers • Decreased inpatient days per thousands of patients • Lower administrative cost ratios • Plans grew profits by 6% in 2014 vs 3% in 2013	The Journal of Health Care Organization, Provision, and Financing	7/2015
15	Community Health Center Utilization Following the 2008 Medicaid Expansion in Oregon: Implications for the Affordable Care Act	Analysis of previous trends of expanding Medicaid and its effect on utilization patterns of newly insured populations	• Both newly insured groups increased utilization in the first 6 months. After 6 months, use among those who maintained coverage stabilized at a level consistent with the continuously insured, whereas it returned to baseline for those who lost coverage. • Individuals who maintained coverage through Oregon's Medicaid expansion increased long-term utilization of CHCs, whereas those with unstable coverage did not.	Brigit Hatch, MD, MPH, Steffani R. Bailey, PhD, Stuart Cowburn, MPH, Miguel Marino, PhD, Heather Angier, MPH, and Jennifer E. DeVoe, MD, DPhil	4/2016
19	Beyond the Reduction in Uncompensated Care: Medicaid		• Compared to non-expansion states, states that have expanded Medicaid have seen major reductions in uncompensated care	Georgetown University, Health	6/2016

	Expansion Is Having a Positive Impact on Safety Net Hospitals and Clinics		delivered by safety net institutions, significant drops in the number of uninsured residents, and budget savings for hospitals and community health clinics. • Executives at safety net providers in Medicaid expansion states report opening new clinics, buying new equipment, and hiring new staff—all of which allow them to begin filling gaps in the current health system. By contrast, health executives in non-expansion states say they continue to face substantial financial pressures. • Health executives in Medicaid expansion states report working actively to integrate and improve the care they deliver while those in non-expansion states are more likely to report "status quo" in their systems. • Improvement of access to specialty care was identified as a priority by executives in both expansion and non-expansion states. However, those in Medicaid expansion states noted new programs and efforts aimed at improving specialty access.	Policy Institute, Center for Children and Families	
20	Medicaid Expansion Is Producing Large Gains in Health Coverage and Saving States Money		• Health reform's Medicaid expansion has proven successful for the states that have taken the option, reducing both their uninsured populations and their health care-related costs and producing budgetary savings. • Meanwhile, policymakers in non-expansion states — many of which have high uninsurance rates, limited Medicaid eligibility for parents, and no eligibility for poor adults without children — have forgone significant savings and have placed the burden from their decision not to expand on their poorest residents.	The Center on Budget and Policy Priorities	4/2015

				• In the non-expansion states, 3.7 million uninsured adults remain in a "coverage gap," with incomes too high for Medicaid but too low for subsidies to buy coverage in the marketplace.		
16		Evaluation of Uncompensated Care Financing for California Designated Public Hospitals	This report reviews funding, Medi-Cal payment, and hospital costs for care provided by the DPHs to Medicaid recipients and the uninsured. Services provided in state fiscal year (SFY) 2013/14, which began on July 1, 2013 and ended on June 30, 2014, were used for this analysis.	• From July 2013 to June 2014, total uncompensated care cost for the Designated Public Hospitals (DPHs) was calculated to be $225 million when including the additional 75 percent of DSH claimable cost allowed under Federal statute for Medi-Cal. • Total cost of care provided at the DPHs to the uninsured was $2.0 billion, which was calculated as gross costs minus uninsured patient payments. Of this $2.0 billion, just under $1.5 billion was determined to be from charity care, while the remaining $0.5 billion was bad debt when calculated using strict and conservative guidelines for the definition of charity care. When using the DPH imputed charity care values, which are calculated using IRS Form 990 guidelines, $1.768 billion was identified as charity care and just under $0.25 billion was determined to be bad debt.	Navigant/California Department of Health Care Services on behalf of Blue Shield of California Foundation	5/2016
21		How is the ACA Impacting Medicaid Enrollment?		• As of March 2014, Medicaid and CHIP enrollment grew by more than 4.8 million people compared to average monthly enrollment in the three months leading up to the start of open enrollment. • Enrollment growth in states that have expanded Medicaid coverage to low-income adults outpaced the national average, and was significantly higher than growth in non-expanding states (12.9% vs. 2.6%). • The recent data show very strong enrollment growth relative to historic trends, with the recent growth exceeding reported growth at the height of the most recent economic downturn.	The Henry J. Kaiser Family Foundation, Vikki Wachino, Samantha Artiga, and Robin Rudowitz	5/2014

				• Overall, the data suggest that the ACA is having a positive impact on Medicaid and CHIP enrollment, particularly in states that have implemented the Medicaid expansion. However, it remains challenging to quantify and separately identify the impacts of the specific ACA policies on enrollment. • Although enrollment gains are an important indicator of progress, ultimately the key measure of the ACA's success in achieving its coverage goals will be a reduction in the number of uninsured.		
22		Taking Stock: Californians' Insurance Take-Up Under the Affordable Care Act		• Take-up under the ACA in Medi-Cal, California's Medicaid program, has far exceeded predictions. • According to administrative data, net enrollment in full-scope Medi-Cal has increased by 4.2 million from the end of 2013 to June 2016. This growth accounts for 28% of the national growth in Medicaid, compared to the state's 12% share of the U.S. population. The state with the next largest increase in enrollment, New York, saw an increase of less than 750,000 people. • While take-up rates vary, California has made significant progress in enrolling people in the newly available health insurance options under the ACA and reducing health coverage disparities by income level. To maintain these take up rates, the state must continue its efforts at outreach and enrollment as people's incomes, ages, and insurance offers change and they transition in and out of various eligibility categories.	UC Berkeley Labor Center, Miranda Dietz	10/2016
23		Five Years Later: How the Affordable Care Act is Working for California		• In California, 1,412,200 consumers selected or were automatically re-enrolled in quality, affordable health insurance coverage through the Marketplace as of Feb. 22. Nationwide, nearly 11.7 million	U.S. Department of Health and Human	11/2015

				consumers selected a plan or were automatically enrolled in Marketplace coverage. • 90 percent of California consumers who were signed up qualified a tax credit through the Marketplace. • 460,531 consumers in California under the age of 35 are signed up for Marketplace coverage (33 percent of plan selections in the state). And 387,297 consumers 18 to 34 years of age (28 percent of all plan selections) are signed up for Marketplace coverage. • Thirty states plus DC have expanded Medicaid under the Affordable Care Act, including California has. And as of January 2015, 3,013,138 Californians have gained Medicaid or CHIP coverage since the beginning of the Health Insurance Marketplace first open enrollment period. Across the nation, approximately 11.2 million more Americans are now enrolled in Medicaid and CHIP.	Services (HHS)	
17		Medi-Cal Monthly Fast Facts: Characteristics of the Medi-Cal population as captured by the Medi-Cal Eligibility Data System	Infographics put together by DHCS in June 2016 that captures Medi-Cal data and trends. Has many different statistics regarding Expansion population demographics.	• June 2016 Medi-Cal Breakdown: Fee-for Service 644,113 17%, Managed Care 3,044,751 83% • Medi-Cal enrollment charted from January 2013 to May 2016	DHCS	6/2016
N/A		Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose	One page fact sheet on the latest numbers on the ACA as collected by CHCF	• 91% of Californians are now insured. The uninsured rate in California fell from 17.0% in 2013 to a historic low of 8.5% in 2015 • In California, the uninsured rate dropped across all racial/ethnic groups, with the greatest gains seen among Latinos. Between 2013 and 2015, the number of California Latinos who were uninsured fell by 1.5 million, and the uninsured rate in this population fell from 23% to 12%.	California Health Care Foundation	11/2016

18	Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety Net	This summary brief looks at the post-ACA landscape through mid-2015 in terms of enrollment and health plan investments in the safety net. It highlights the main findings in Medi-Cal Managed Care Plans and Safety-Net Clinics under the ACA.	• Safety-net clinics now have 41% of beneficiaries enrolled in Medi-Cal Plans, including 30.3% in CCHCs and another 10.3% in county clinics. • Safety-net clinics' share of overall enrollment rose from 33% in 2013 to 41% in 2015. • Public Medi-Cal public plans members assigned almost 1.3 million new members to safety-net clinics in response to the expansion. • 54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers. • The safety net had 60% enrollment growth with public plans and 42% enrollment growth with commercial plans. • COHS plans had 73% of their growth enrolled in safety-net clinics.	California Health Care Foundation	12/2015
N/A	Day One And Beyond: What Trump's Election Means For the ACA	The day after the election, the author summarizes quickly and very briefly the reality of Trump's statement, "On day one of the Trump Administration, we will ask Congress to immediately deliver a full repeal of Obamacare," as a complete fallacy and unfeasible.	• First, any repeal proposal would be subject to a filibuster in the Senate and the Democrats retain more than enough votes to stop a repeal bill. • The ACA contains hundreds of provision affecting Medicare, program integrity, the health care workforce, biosimilars, prevention, and other issues unrelated to what most Americans think of as "Obamacare" • Republicans will have to decide what they want to do with our health care system and figure out how to do it. • "They now own the problems of health care, and they will be judged in future elections for how they address them."	HealthAffairs	11/9/2016
N/A	What Would Block Grants or Limits on Per	If we had to choose per capita or block grants for California, per capita is better	• Block grants set limits on total annual spending regardless of enrollment • Caps limit average spending per enrollee	The Commonwealth Fund	

	Capita Spending Mean for Medicaid	but ultimately either will set healthcare back potentially decades.	• By 2024, Medicaid is expected to cover 77.5 million Americans, the total bill will be $920.5 billion with the federal match of 61% • Medicaid has relied on open-ended federal funding, as well as significant contributions from states. • The high cost of Medicaid and the fear of uncontrolled growth has led some conservative policymakers to call for establishing absolute limits on spending—in effect, reversing a 50-year trend of expanding Medicaid to protect some of the most vulnerable Americans. • California: is one of 11 states that spends less than $5,000per Medicaid enrollee. $5,000-$6,499 (25 states); $6,500-$7,999 (8 states); $8,000+ (6 states + DC) • California is one of 12 states where 50%-59% of the Medicaid covered of nonelederly patients have incomes of <200% FPL. Other date includes: 30%-39% (13 states); 40%-49% (24 states); 60%+ (1 state + DC)		

Framing the Argument with Supportive Literature (Medicaid Strategy)

Updated on Monday, December 12, 2016

This strategy framing document is a companion document to the literature review and continues to support the goal to: pause and slow down repeal/replace ACA and blowing up Medicaid.

Specifically this highlights area of the below message with direct quotes and figures from the literature cited in the review.

MESSAGE: ***The Affordable Care Act has strengthened, enhanced, and begun to modernize the health care system in America. We need to keep the building blocks of a program that has afforded new health care coverage to over 20 million Americans. This includes securing funding to community health centers that are the bedrock of Medicaid and the health home for almost 25 million people across the country. Without Medicaid and without health centers the country will lose one of the highest quality low cost choices on the market.***

Claim	Literature Review
The Affordable Care Act has strengthened, enhanced, and begun to modernize the health care system in America.	▪ **Reduced number of uninsured Americans (strengthen)** • "90% of all Americans are now covered: The uninsured rate fell from 14.4% in 2013 to a historic low of 9.4% in 2015." [1a] • "As of 2015, 41 percent of uninsured people under 65 were eligible for Medicaid in expansion states compared to 13 percent in non-expansion states. Furthermore, county-level uninsured rates across the nation in 2015 show that the share of people who are uninsured is far higher in Medicaid non-expansion states than in expansion states. Children living in Medicaid expansion states had nearly double the rate of improvement in their uninsured rates than children in **non-expansion states."** [19a] • "In expansion states the rate of uninsured patient stays in hospitals typically declined by nearly 36.9 percent while the rate in non-expansion states of decline was slight: 2.9 percent. Other research reporting on major hospital systems in multiple states shows comparable declines in admissions of uninsured patients. For example, Hospital Corporation of America (HCA) members in expansion states had a 48 percent decline in uninsured admissions from 2013-14 as compared to HCA hospitals in non-expansion states where there was only a 2 percent decline in uninsured admissions. Research in specific states like Kentucky mirrors these studies, showing

	large drops in uncompensated care for hospitals compared to neighboring states that did not expand. Available research on community health centers mirrors the hospital data showing a wide gulf between experiences in Medicaid expansion and non-expansion states. Initial research indicated a decrease of as much as 40 percent in uninsured clinic visits to community health centers. Additional research estimates that from 2013-14 in expansion states the share of community health center patients with Medicaid coverage increased by 20 percent and the share of uninsured patients dropped 29 percent. In contrast, community health centers in non-expansion states saw an increase in Medicaid coverage of 3 percent and a decrease in uninsured patients of 8 percent." [19b] • "States that expanded Medicaid experienced the greatest gains in health coverage. In just one year, Arkansas and Kentucky cut their uninsured rates in half, from 22.5 to 11.4 percent and from 20.4 to 9.8 percent, respectively. Other Medicaid expansion states with large drops in their uninsured rates include Oregon (19.4 to 11.7 percent), Washington (16.8 to 10.1 percent), and West Virginia (17.6 to 10.9 percent). Nine of the ten states with the largest drops in uninsured rates are Medicaid expansion states." [20a] • "California has seen a remarkable decline in its uninsured rate over the first two years of Affordable Care Act (ACA) implementation. California experienced the largest percentage point decline in the uninsured rate of any state—a drop from 17.2% in 2013 to 8.6% in 2015 according to the US Census Bureau. This historic accomplishment represents an increase of 3.2 million more Californians who now have health insurance coverage." [22a] ▪ **Increased funding for healthcare workforce initiatives to address the workforce shortage (strength & enhance)** • "With more people insured and more focus on primary care as part of value-based care models and population health management strategies, competition among providers for PCPs and mid-levels has increased significantly between FQHCs and large hospital systems, which also are expanding their affiliated physician organizations." [2a] • "Many hospitals are seeking to train and develop more PCPs as part of their population health management and value-based payment strategies, in which they are looking for the most cost-effective ways of treating patients (i.e., outside of

	inpatient and emergency department settings). These programs are supported with funding through the Primary Care Residency Expansion (PCRE) program under the ACA, which prioritizes training in a health center, rural hospital, or other community-based setting." [2b] • "CHCs across all four states reported that challenges to recruiting and retaining staff led to more financial and capacity challenges. One of the most common difficulties was the ability to provide competitive salaries for hiring and retaining clinical staff, who were being recruited by private sector providers increasing staffing due to an influx of insured patients." [7a] • Most graduates of teaching health center residency programs continue to practice in underserved areas following residency. Teaching health centers provide a means for expanding residency training to additional areas of California that have shortages of primary care physicians. Unlike academic health centers, which are concentrated in California's largest metropolitan areas, FQHCs are located in underserved areas throughout the state. [12a] ▪ **Meaningful use (modernize)** ***Meaningful use is not a provision in the ACA but in the American Reinvestment and Recovery Act. The ACA takes the implementation of Meaningful Use and supports the creation of ACOs and HIE strategies to develop accountable and coordinated health systems through EHR.***
We need to keep the building blocks of a program that has afforded new health care coverage to over 20 million Americans.	▪ **Increased access to care (people covered by Medicaid before and after ACA expansion)** • CA: "3.7 million Californians enrolled in Medi-Cal under the ACA expansion--representing more than a quarter of the 13.6 million Californians now covered under Medi-Cal." [1c] • National: "We estimate that the provisions of the ACA have resulted in gains in health insurance coverage for 20.0 million nonelderly adults (ages 18 to 64)." [3b] • "We find that the biggest factor in the coverage expansion in 2014 was Medicaid, which produced 63% of the gains we identified." [4b]

	• June 2016 Medi-Cal Breakdown: Fee-for Service 644,113 17%, Managed Care 3,044,751 83%[17b] • "As of 2015, 41 percent of uninsured people under 65 were eligible for Medicaid in expansion states compared to 13 percent in non-expansion states. Furthermore, county-level uninsured rates across the nation in 2015 show that the share of people who are uninsured is far higher in Medicaid non-expansion states than in expansion states... Similarly, there is evidence of gains in access to and affordability of health care. In expansion states, adults were more likely to have a usual source of health care in March 2015 compared to September 2013. They were also less likely to report problems in getting access to care or to have an unmet need due to the cost of care or to have problems paying family medical bills." [19b] • "As of March 2014, Medicaid and CHIP enrollment grew by more than 4.8 million people compared to average monthly enrollment in the three months leading up to the start of open enrollment. Enrollment growth in states that have expanded Medicaid coverage to low-income adults outpaced the national average, and was significantly higher than growth in non-expanding states (12.9% vs. 2.6%). The recent data show very strong enrollment growth relative to historic trends, with the recent growth exceeding reported growth at the height of the most recent economic downturn. Overall, the data suggest that the ACA is having a positive impact on Medicaid and CHIP enrollment, particularly in states that have implemented the Medicaid expansion." [21a]
This includes securing funding to community health centers that are the bedrock of Medicaid and the health home for almost 25 million people across the country.	▪ **Role of FQHCs in caring for Medi-Cal and uninsured patients** • "Nationally, the number of insured patients using CHCs rose from 12 million in 2010 to 16.5 million in 2014, an increase of 35 percent.3 In all four states studied, the total number of insured patients increased as well, with the greatest growth in California (from 1.67 million to 2.70 million, a 61 percent increase)" [7b] ▪ **Expansion/development of FQHCs to increase access to care for millions, including newly insured Medi-Cal patients** • "54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers" [6a]

	• "Safety-net clinics are at the center of ensuring access for both public and commercial Medi-Cal managed care plans." [6b] • Safety-net clinics now have 41% of beneficiaries enrolled in Medi-Cal Plans, including 30.3% in CCHCs and another 10.3% in county clinics.[18a] • Safety-net clinics' share of overall enrollment rose from 33% in 2013 to 41% in 2015.[18] • Public Medi-Cal public plans members assigned almost 1.3 million new members to safety-net clinics in response to the expansion.[18b] • 54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers.[18c] • The safety net had 60% enrollment growth with public plans and 42% enrollment growth with commercial plans.[18d] • COHS plans had 73% of their growth enrolled in safety-net clinics.[18e] • "In expansion states, hospitals and health centers are generally more able to move toward integrating care through new systems and relationships. One FQHC director pointed to dramatically increased communication with other health providers that allows the clinic to improve care coordination across the community. Increased integration has been especially valuable for the delivery of behavioral health and primary care—a long-standing need in Medicaid. One health system executive reported that they can now provide and bill a behavioral health visit and a primary care medical visit on the same day, which enables better integration of care for people with both types of conditions. Another highlighted adding psychologists and nurses to the staff so that they can integrate care for populations such as those who are homeless. Expanded services were not limited to behavioral health. One FQHC has expanded dental services as well as improved access to prescription medications. One hospital executive referred to purchases of new radiology equipment in his facility in an expansion state, while "we would not dream of that in our hospital [in a neighboring non-expansion state]."" [19c]
Without Medicaid and without health centers the country will lose one of the	▪ **FQHCs & high quality/value** • "FQHCs and look-alikes demonstrated equal or better performance than private practice primary care physicians on select quality measures despite serving patients with more chronic disease and socioeconomic complexity." [10a]

highest quality low cost choices on the market.	▪ **FQHCs & low-cost**
	• Spending per enrollee for the new adult (expansion) group was significantly lower than spending per enrollee across all groups ($4,513 vs. $7,150).[8a]
	• Spending for the new adult group made up 16% of total Medicaid spending in expansion states.[8b]
	• Individuals who maintained coverage through Oregon's Medicaid expansion increased long-term utilization of CHCs, whereas those with unstable coverage did not.[15a]
	
	▪ **Cost-savings of Medi-Cal**
	• Some expansion states are seeing savings from accessing enhanced federal matching funds and by replacing general funds with Medicaid funds particularly in mental and behavioral health programs, public health programs, and health care services for prisoners.[9a]
	• Health Care for the Homeless (330h) projects in expansion states had larger gains in revenue and smaller increases in costs compared to those in non-expansion states.[11a]
	• Early data from hospital associations have shown up to a 46.5% decrease in admissions by uninsured patients and up to a 59.7% decrease in hospital uncompensated care costs following ACA implementation.[13a]
	• With Medi-Cal expansion there was:
	  • Decreased loss ratio to Medi-Cal insurers
	  • Decreased inpatient days per thousands of patients
	  • Lower administrative cost ratios
	  • Plans grew profits by 6% in 2014 vs 3% in 2013[14a]
	• From July 2013 to June 2014, total uncompensated care cost for the Designated Public Hospitals (DPHs) was calculated to be $225 million when including the additional 75 percent of DSH claimable cost allowed under Federal statute for Medi-Cal.[16a]
	• Total cost of care provided at the DPHs to the uninsured was $2.0 billion, which was calculated as gross costs minus uninsured patient payments. Of this $2.0 billion, just under $1.5 billion was determined to be from charity care, while the remaining $0.5 billion was bad debt when calculated using strict and conservative guidelines for the definition of charity care. When using the DPH imputed charity care values, which are

	calculated using IRS Form 990 guidelines, $1.768 billion was identified as charity care and just under $0.25 billion was determined to be bad debt.[16b] • "Expansion had significant fiscal effects on state budgets with savings ranging from $25 million in Kentucky to over $100 million in Washington State.10 Hospitals have experienced positive fiscal effects from state Medicaid expansions.11 A study of a single nonprofit Catholic multi-state hospital system with 131 acute care hospitals in 23 states and the District of Columbia compared performance between states. In Medicaid expansion states charity care costs decreased 40.1 percent compared to only 6.2 percent decrease in non-expansion states." [19d] ▪ **Effects of eliminating ACA** • Millions without health coverage ▪ "Repealing the ACA would result in 19.7 million fewer people with health insurance in 2018" [5a] ▪ "According to our analysis, repealing the ACA would increase the deficit by a net $33.1 billion in 2018. Although repealing the law would reduce federal outlays on Medicaid and tax credits, repeal would also eliminate the ACA's revenue-generating provisions, such as changes to Medicare payment and taxes on health plans, medical devices, and other goods and services." [5b] ▪ "The policies would increase the number of uninsured individuals by 16 million to 25 million relative to the ACA. Coverage losses disproportionately affect low-income individuals and those in poor health." [24a]

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[6] Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety-Net

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Key Data Sources Cited in Framing Document

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Legend for Literature Category
CA FQHC's and Medicaid
People covered by Medi-Cal
Cost Savings of Medi-Cal
Expansion (Natl or in CA) before and after Medi-Cal
FQHCs & high quality care/value

Color Category & Citation # referenced in Lit Review and Framing Document	References Cited in Framing Document:	Sub-Reference Data Sources:
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23	Five Years Later: How the Affordable Care Act is Working for California	Not cited in Framing document.
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