



County Innovations in Financing Care for California's Medically Indigent Adults

Introduction

Counties have a statutory obligation under California Welfare and Institutions Code Section 17000 to meet the health care needs of low-income uninsured residents who have no other source of care. This includes medically indigent adults (MIAs) without public or private health coverage who cannot afford to pay for their own care. Due to varying resources and county policies, county-sponsored programs for low-income uninsured adults differ throughout the state in terms of their eligibility rules and the scope of benefits provided.

This issue brief is based on a survey of county representatives. It differs from the California HealthCare Foundation's previous reporting about indigent care programs in several ways. This analysis:

- Describes the context in which indigent care programs are funded and operate;
- Highlights current financing and delivery issues;
- Summarizes the experiences of selected counties; and
- Reports on county objectives and strategies for the future.

The criteria used in selecting the counties for this survey included population size, location, availability of county health clinics and hospitals, and direct county administration or use of local managed care plans. Both urban and rural counties were surveyed. San Francisco County was specifically chosen because it is redesigning

the system of care for its medically indigent residents, with a goal of providing health care to all uninsured adult residents.

Background

In 1982, facing a recession and massive government budget deficit, the state legislature acted to reduce Medi-Cal expenditures. As part of a larger effort, the state transferred the responsibility for medically indigent adults from Medi-Cal to the counties. In response, larger counties administered their own MIA programs, and had complete discretion in program design, benefits, delivery systems, and provider payment. Smaller, mostly rural, counties exercised a statutory option to contract with the state for services, in what later became known as the County Medical Services Program (CMSP). Following a series of legislative changes, the CMSP became a self-administered program of the 34 participating counties. These programs are largely funded by county sales tax and motor vehicle license fees, known in budgetary circles as "realignment revenue." But as these sources of income are not steady, counties are at constant risk of deficits they cannot control.

Today, responsibility for medically indigent adults remains with California counties, but the funding that counties receive from the state to support these programs does not keep pace with the need. Shifts in property taxes from local governments to school districts, the suspension of state payments for reimbursable state mandates, and the transfer of an increasing share of the costs to counties for

mandated health programs have reduced county discretionary funding for indigent health care.

Governor Arnold Schwarzenegger's health care reform proposal could substantially alter how county indigent care programs are financed, organized, and operated. The governor's proposal calls for using a federal Medicaid waiver to move low-income, single, childless adults, who now make up the largest segment of people in county indigent care programs, to the Medi-Cal program. The proposal suggests redirecting county realignment funds back to the state to fund this Medi-Cal expansion. Since eligibility criteria for county indigent care programs vary and state statutes restrict realignment funding, it is unclear how this proposed funding mechanism would be implemented.

What is clear is that counties would be responsible for the health care of undocumented adults without insurance, supported financially by some amount of state realignment revenue. It is not yet clear what mandates would be placed on counties in terms of scope of coverage for undocumented individuals, and whether existing statutes permit the use of state realignment funds for this purpose. A number of counties do not include undocumented individuals in their county indigent care programs, except for emergency services. Also, there are many questions about the future of the CMSP and the impact of the governor's proposal on other health care coverage programs for low-wage workers, such as In-Home Supportive Services (IHSS) employees.

In late 2006, the state Department of Health Services issued a request for proposals to expand coverage to low-income, uninsured individuals, authorized by SB 1448 (Kuehl, D-Santa Monica), known as the "Coverage Initiative," under the provisions of a 2004 federal Medicaid hospital waiver. On March 29, 2007, the governor announced that \$540 million was awarded to ten counties from among the 17 county proposals submitted in January. The announcement noted

that approximately 180,000 low-income, uninsured individuals would be served through programs in these selected counties. Following federal approval of the allocations, the selected programs will receive combined federal and state financial support for three years, without any assurance of funding afterward. The programs will provide lessons on expanding coverage to uninsured adults, while using preventive care, early intervention, and managed care best practices such as a medical home, care management, chronic disease management and some aspects of electronic health records. For most counties, enrollment under the Coverage Initiative began on September 1, 2007.

County Programs

This issue brief focuses on three approaches to serving indigent, uninsured county residents. The approaches are:

- County indigent care programs in Contra Costa, Fresno, and San Mateo counties; and the County Medical Services Program in several counties, including Plumas County;
- Programs covering uninsured IHSS home care workers in Alameda and Los Angeles counties; and
- San Francisco County's effort to address the problem of the uninsured population.

County Indigent Care Programs

County indigent care programs vary widely. Each county decides how much emphasis to place on care for the indigent in relation to other local spending priorities. Counties also choose how to balance inpatient and emergency services with primary care and outpatient services, and what network of public and private providers will be used to deliver services. Some counties own and operate large health care delivery systems with outpatient clinics and hospitals, serving both uninsured and insured patients. Other counties purchase medical services for a designated indigent population from local hospitals, community clinics, and other providers. Still others

use a combination of county facilities and community providers.

- **County Medical Services Program.** Originally established in 1983, the CMSP is now a self-governing entity for 34 small and rural counties, which jointly operate a program for medically indigent adults. The CMSP uses Blue Cross Life & Health as its benefits administrator.
- **Contra Costa County.** Basic health care is available to county residents of all ages, without regard to immigration status. It is administered by the Contra Costa Health Plan and operated by the county, and it uses county inpatient and outpatient facilities.
- **Fresno County.** The Medically Indigent Services Program (MISP) is open to adults between 21 and 64 years of age, without regard to immigration status. The county has a 30-year contract with a local medical center and its affiliated hospitals and clinics to determine eligibility and provide inpatient and outpatient services.
- **Plumas County.** This rural county is one of 34 counties participating in the CMSP.
- **San Mateo County.** The WELL Program serves adult county residents between 21 and 64 years of age, without regard to immigration status, and undocumented immigrants 19 years of age and older. Health services are provided through San Mateo (County) Medical Center and its affiliated clinics.

Programs Covering Uninsured IHSS Workers

California, through its In-Home Supportive Services (IHSS) program, has been providing “consumer-directed” home care services to frail, elderly, and disabled Medi-Cal beneficiaries since the early 1970s. In the 1990s, there were two key developments affecting IHSS and its low-wage workers. First, California enacted legislation to make the benefits of collective bargaining possible for these workers by designating counties or public authorities established by counties as the IHSS workers’

employers of record. Second, the federal government extended the Medi-Cal scope of benefits to include IHSS, thereby allowing federal funding to be used to reimburse home care workers. These two developments led some counties to offer health care benefits to IHSS workers, in part to stabilize the IHSS workforce and improve the dependability and quality of IHSS services. The IHSS workers’ health insurance program exemplifies how local action and federal and state incentives can be combined to offer health care insurance coverage to a low-wage, low-income population.

- **Alameda County.** The Alameda County Public Authority for In-Home Support Services offers a comprehensive medical, dental, and vision plan called Alliance Group Care for IHSS workers. The plan is administered by the Alameda Alliance for Health.
- **Los Angeles County.** The Personal Assistance Council, a public authority created by the County of Los Angeles, offers medical benefits to IHSS workers through the county’s Community Health Plan. L.A. Care Health Plan administers the plan.

A County’s Effort to Address the Problem of Uninsured Residents

The Healthy San Francisco program is a coverage program that restructures the way the county meets its Section 17000 obligation as “the provider of last resort” to the medically indigent. It was designed to make health care services accessible and affordable to uninsured San Francisco residents, regardless of employment, immigration status, or pre-existing medical condition. Established by county ordinance on July 18, 2006, the program is now being implemented. Healthy San Francisco is overseen and administered by the San Francisco Department of Public Health, in partnership with the local Medi-Cal managed care plan, San Francisco Health Plan, to perform some administrative functions. With few exceptions, the county ordinance also requires medium- and large-sized employers in the county to spend a minimum amount per hour on health care for

their employees, a controversial provision known as the “employer spending requirement.”

Issues Faced by Counties

Counties interviewed for this issue brief face a number of difficult challenges in providing services to medically indigent adults. Several of these challenges are described below.

Financing Programs and Managing Costs

Counties struggle financially to meet the current needs of medically indigent adults and to prepare for the future needs of county residents. Despite these programs, many more residents still have no health coverage. Medical cost inflation is a constant worry, even when counties adjust eligibility requirements. IHSS caregiver health insurance programs have extended protection to low-wage workers, but may be experiencing a variety of cost pressures, including an aging workforce. Efforts to loosen the current income requirements for MIA programs will certainly mean higher enrollment and increased costs to local programs.

Echoing the predicament of other counties, Contra Costa County officials identified its major challenge as sustaining program caseloads in the face of declining revenue. Contra Costa County officials know they need to provide care for the newly uninsured, such as new county residents who lack insurance, but also for existing residents who are losing coverage due to escalating costs and the loss of employer-sponsored insurance. The County Medical Services Program (CMSP) operates on a year-to-year budget and is dependent on a strong state economy for continuous levels of funding. Funding for the CMSP is derived entirely from state and county realignment funding, specifically sales taxes, and vehicle license fees. However, the growth rate of realignment revenue does not keep pace with actual medical cost inflation and caseload increases. In robust economic times, there is relatively more money available and relatively less need, because caseloads are flat or trend

downward. Conversely, in poor economic times, caseloads increase while revenues decline. This dynamic affects all county indigent care programs, because all rely in whole or in part on realignment funding.

San Francisco County officials have expressed the same uncertainty about future medical costs and affordability as they embark on a system redesign to meet their Section 17000 obligation and create an integrated health care system to provide comprehensive health care benefits to all uninsured adults. San Francisco’s financing structure takes into account local and state revenues, in addition to funding from program participants, and employer contributions that select Healthy San Francisco to meet the employer-spending requirement.

As earmarked state funding has decreased, a greater proportion of indigent care funding must come from local funding. As a result, county medical care competes directly with other local, non-health-related needs. Plumas County, a rural county participating in the CMSP, is an example of a county wanting to expand coverage to the uninsured but is hamstrung by competing needs. Because anticipated federal funding for roads and schools has not materialized, the Board of Supervisors is requiring county departments to reduce discretionary spending to replace lost funding for non-health-related projects.

For some counties, demographic trends may thwart efforts to expand programs serving the low-income uninsured. Program managers in Alameda and Los Angeles counties cited the growth of funding needed for expanding health insurance coverage to IHSS workers as that workforce ages. Contrary to initial cost and utilization assumptions, the actual health care use by IHSS workers exceeds what a similar Medi-Cal population would use. The challenge is how to influence service-use patterns so that intervention takes place earlier, and primary care replaces the need for more costly, crisis-oriented interventions later.

Reducing or restricting eligibility by tightening income and other criteria is no guarantee that program costs can be contained proportionately. San Mateo County has made recent program changes, which have resulted in a reduction in the number of indigent program participants, yet overall county costs to provide medical care have not declined. Negotiated salaries and benefits continue to grow, including retirement contributions and retiree health benefits, as do other costs to operate the county hospital and affiliated clinics service system. A Blue Ribbon Task Force on Adult Health Care Coverage, appointed by the Board of Supervisors, has been examining how to improve the indigent care program in order to serve more of the county's uninsured more efficiently.

Certain counties, notably Fresno, have entered into multiyear financial arrangements with local hospitals to furnish outpatient and inpatient services to enrollees of the county's medically indigent services program. These long-term contracting arrangements often include an automatic payment adjustment based on an inflation rate set forth in the contract. Such contracts have been good financial strategies for some counties, because they protect the counties against rapidly rising health care costs that exceed expected inflation. If Fresno County decides to increase the family income threshold and expand enrollment, the contracting hospital could experience an increase in medical costs and might seek a renegotiation of the agreement. Fresno County's agreement also requires the contracting hospital to provide specialty and inpatient health care services to inmates, not a mandate of Welfare & Institutions Code Section 17000.

The effort to expand health care access and find new revenue streams becomes controversial when new financial obligations are imposed on businesses and individuals. In San Francisco County, there are still differences of opinion regarding the fairness and financial impact of the mandated employer spending requirements for businesses with more than 20 employees. In recent years, San

Francisco has enacted a series of mandates on business, including mandatory sick leave, a higher minimum wage known as the living wage, and now a health care spending requirement. Some have sued the county, challenging its legal right to impose these spending mandates.

Using Local Managed Care Plans to Administer Programs for the Indigent

Since the expansion of Medi-Cal managed care in the mid-1990s, there has been a significant increase in publicly sponsored, state-licensed health plans throughout the state. These managed care plans, now with a decade or more of experience, have proven to be valuable local partners with counties in finding solutions to the challenge of extending health care coverage to uninsured residents.

Several counties are using or have considered using local health plans to administer programs for the medically indigent. Contra Costa County has been using its local county-operated health plan, the Contra Costa Health Plan, to administer its Basic Health Care program. San Francisco County expects the San Francisco Health Plan be a key player in the Healthy San Francisco program. San Mateo County is considering an expanded role for the Health Plan of San Mateo in administering both the WELL program and the program that is likely to emerge from its Blue Ribbon Task Force on Adult Health Care Coverage. Counties such as Alameda and Los Angeles rely on local health plans for the operations of their IHSS caregivers' health insurance programs.

A local health plan has to consider the infrastructure demands when it is solicited to play a role in administering an indigent or low-income coverage program in addition to its core Medi-Cal business. In Los Angeles County, a growing IHSS caseload has exacerbated the need for Community Health Plan, Los Angeles County's own licensed health plan, to replace its information system. The selection and implementation of a new health plan information system can be disruptive to

workflow, in addition to generating significant software, hardware, and consulting costs.

Changing Program Benefits to Improve Care and Contain Costs

The scope of benefits offered in programs serving low-income uninsured adults takes into account factors such as cost, county history, services offered in county facilities, and the overall quality of care.

In Los Angeles County's IHSS caregivers' health insurance program, adding benefits can be a collective bargaining issue. For example, the union has wanted a dental benefit separate from the county dental services already offered to workers. Additionally, vision care and hearing aid services are not covered, and are not provided by the county. By paying outside vision providers, county funds flow outside the county system. This runs contrary to the county's initial expectations that the IHSS caregivers' health program would increase the net use of county facilities.

Counties usually find that reducing or tightening benefits is a method of cutting program costs. For example, when the CMSP was faced with growing costs and caps on state funding, the CMSP governing board eliminated eyeglass coverage, reduced dental services, and capped mental health benefits, in addition to cutting provider payment rates and capping eligibility. It also saved costs when it contracted for management of its prescription drug formulary. As counties face dwindling funding, there is little incentive to add benefits—especially if any available funding could be used to increase the number of covered residents with a less comprehensive scope of benefits. Some counties have attempted to fix the costs of programs for medically indigent adults by entering into multiyear contracts with community hospitals. There are no incentives for the contracting hospital to add benefits if its revenue from the county is capped.

Special care management programs can function as an added benefit and serve as a means to improve the

delivery of care to individuals with complex health care needs, while at the same time serving as a cost containment measure to avoid service duplication. Contra Costa County's Basic Health Care Program takes advantage of the care management services offered by Contra Costa Health Plan to assist enrollees with designated medical conditions. Timely management of complex conditions can provide early intervention and avoid more costly, crisis-oriented care later. San Francisco County is building case management into its Healthy San Francisco program. Planners are exploring medical management and chronic care management in primary care with a focus on how to improve the efficiency and effectiveness of specialty consultations to better address the needs of chronically ill residents.

Screening Applicants and Determining Eligibility

Screening of candidates for public programs is essential if counties want to maximize the use of federal and state funding before county funds are expended. At the same time, counties bear the costs of eligibility determination. Some counties have used improved technology to make the eligibility screening and enrollment process more effective and efficient.

The principle of maximizing the use of federal and state funds first is not pursued equally in all counties. In Alameda County, the Public Authority does not screen IHSS workers for other public health coverage. There is some indication that workers would rather have nominal out-of-pocket costs in the IHSS insurance program than receive Medi-Cal at no cost. Nevertheless, the county provides tobacco tax funds to subsidize IHSS's premiums. Funding would go further if federal and state funding were used to cover eligible IHSS workers.

While tightening eligibility criteria may move a county closer to controlling its financial obligation under Section 17000, there are administrative and other costs that must be absorbed. In its efforts to eliminate self-declaration and improve verification of eligibility for its

medically indigent care program, San Mateo County has shifted some eligible residents into an expanded cost-sharing program. This, however, required changes to the county's billing and payment collection system. The result has been delays in eligibility determination due to the new screening and verification process for adults and a decrease in community trust. Collection practices have received greater emphasis as the collection of an annual "up-front" enrollment fee has become a priority. Other methods are being used to improve the level of collections.

The CMSP's efforts to simplify and control eligibility and redirect eligible applicants to other public programs, whenever possible, reflects the imperatives of managing county indigent care programs within available revenues. In an effort to make better use of funds, the CMSP is working with its benefits administrator, Blue Cross Life & Health Insurance, and county welfare departments to identify disabled participants, who tend to be high-cost participants, and facilitate their application for the Medi-Cal program. In another eligibility-related measure, the CMSP simplified eligibility processing and moved eligibility to defined terms of enrollment based upon the category of aid—a six-month period of eligibility for participants who do not have a share of cost and a three-month period of eligibility for participants with a share of cost.

One-e-App, a Web-based system designed to enroll applicants in multiple publicly funded health plans, has proved useful to counties during the process of screening and referring low-income families to the most appropriate public program for which an individual qualifies. San Mateo County has been using One-e-App to screen across multiple public coverage programs serving children and adults, as well as to support the multiplicity of programs serving low-income residents and steer them to the most appropriate program. The advantages of One-e-App are magnified when community-based organizations also use it. San Francisco County plans to use One-e-App for

its Healthy San Francisco program. In Fresno County, community-based organizations and safety net providers are using One-e-App to enroll children into Medi-Cal, Healthy Families, and the local Healthy Kids health care coverage initiative. The local contracting hospital is responsible for determining eligibility for the adult medically indigent care program, but the hospital has not implemented One-e-App to enroll patients into the medically indigent adult services program.

Supporting Safety-Net Providers and Other Provider Network Challenges

Each county faces the challenge of securing provider participation in different ways, depending on the presence of county clinics and hospitals, community clinics, support by the provider community, and the resources available in the county. Some counties have a scarcity of physicians, or a scarcity of physicians in particular medical specialties. Community providers may choose not to participate in medically indigent adult care programs. The challenge is exacerbated by typically low provider reimbursement. Consequently, some providers do not welcome medically indigent adults into their practices.

Fresno County's contracting hospital furnishes inpatient and outpatient services to patients who qualify for the medically indigent services program. If the hospital cannot furnish the required medical care, it will refer the patient to another hospital or specialist in or outside the county. When Fresno County patients are referred to hospitals or specialists outside the Central Valley, they may experience prolonged appointment wait times and inconvenient travel arrangements.

The problem of access to providers presents an even more significant challenge in the state's small rural counties, where specialist physicians are not available. The stability of the provider network and access to specialists in its 34 member counties is an ongoing concern for the CMSP. The CMSP relies on its benefits administrator, Blue Cross Life & Health Insurance, to organize and manage the

provider network. However, there are two drawbacks to this arrangement: the CMSP's provider reimbursement rates are generally below Medi-Cal levels, and second, medically indigent adults are not a desirable patient population for most community providers. For high-need specialties, the governing board has authorized Blue Cross to propose alternative rates, subject to the approval of the Board. The CMSP is considering other enhancements to improve specialty care, including securing provider coverage in contiguous areas, improving the availability of telemedicine, and other regional approaches.

In addition to the systemic issues facing CMSP counties, there are also county-specific problems. For example, the stability of local health care facilities and providers in a county affects all users of health care services, insured or uninsured. Until recently, Plumas County had four hospitals, each operating independently. The hospitals are contemplating a program of shared services to reduce costs. However, such cooperation, if it comes to pass, will arrive too late for one district hospital, which was forced to close recently. Another is now in bankruptcy. Of Plumas County's three hospitals, Seneca District Hospital, East Plumas District Hospital, and Plumas District Hospital, two, East Plumas District Hospital and Plumas District Hospital, are designated "critical access" facilities. The Board of Supervisors has encouraged the three hospitals to enter into cooperative planning. Also at stake is stability of the working environment for the community's physicians who are all directly linked to the hospitals.

IHSS workers' health insurance programs use the provider networks belonging to local health plans, which administer the programs. Counties such as San Mateo, Contra Costa, and Los Angeles, which operate extensive ambulatory clinic and hospital systems, have a financial incentive to encourage use of county facilities and discourage the use of outside health care providers in providing care to medically indigent adults. For example, in Los Angeles County, the IHSS workers' insurance

program is operated through the county's Community Health Plan. Its provider network, dominated by county facilities and providers, is supplemented in a very limited way by two community medical groups and their affiliated hospitals. Marketing efforts are underway to enroll as many IHSS workers as possible. Community Health Plan may need to bring more non-county providers into the county network to attract enrollment, yet at the same time find a balance that isn't a net draw of funds from county clinics and hospitals. Other counties face similar challenges. Management has not yet found effective methods of communicating with prospective and existing enrollees. Communication is essential in persuading IHSS workers to enroll in the insurance program. Once workers are enrolled, the health plan must effectively communicate how to use the system and discourage out-of-network use by enrollees.

Lessons Learned

The California counties interviewed for this issue brief have confronted a variety of issues in addressing the needs of low-income, uninsured residents. These counties provide lessons for other counties and policymakers in understanding how, with a myriad of constraints, counties respond to the medical needs of their indigent residents.

Leadership and Political Will Are Required

Local leadership from county health departments and support by the local Boards of Supervisors have led to new insurance products in Alameda and Los Angeles counties targeting the low-wage IHSS workers who would be unlikely to qualify for coverage under existing public programs.

San Francisco and San Mateo counties have moved forward with comprehensive reforms that aim to address the lack of available health insurance. The San Francisco Board of Supervisors and the mayor of San Francisco have injected "political will" into the reform drive. The board and mayor brought together a broad coalition to fashion solutions and passed a county ordinance to establish

the Healthy San Francisco program. This is noteworthy because the county adopted a controversial “employer spending requirement” obliging some employers to spend a minimum amount per hour on health care for their employees. The San Mateo County Board of Supervisors has appointed a Blue Ribbon Task Force on Adult Health Care Coverage to make recommendations as to how the county can organize and finance services for uninsured residents. In both counties, political leadership has been instrumental in tackling a major county problem requiring broad community consensus.

Episodic, Crisis-Oriented Medical Services Are Costly

Indigent adults typically wait until a medical crisis before seeking county health care. Consequently, the first contact with these residents is often during an acute episode. Whether MIA programs require an existing medical need in order for the patient to qualify for care, or the financial consequences of a medical episode leads to an application for care as a MIA, most MIAs come to the program after a medical condition has become exacerbated, since they are far less likely to have received primary care, prevention, or early intervention. San Mateo County’s task force is studying how alternative clinical models can reduce this prevalence of crisis-oriented health care. Counties receiving funds under the Coverage Initiative will be attempting to organize services for the indigent to focus on prevention and early intervention to reorient the conventional delivery of services to indigent adults.

The Coverage Initiative projects are likely to point to additional ways to avoid episodic and crisis-oriented interventions. Several projects propose to assign each enrollee to a “medical home” responsible for providing preventive care, primary care, and early intervention services. Some counties have designed care management programs to provide more intensive services to indigent patients with certain chronic conditions, such as diabetes or hypertension. The objective is to reduce more costly

services by reducing disease risk factors through early intervention and coordination of services.

Local Collaborations and Partnerships Are Productive

Successful collaborations can be forged between local publicly sponsored health plans, counties, and in some circumstances, organized labor. Local publicly sponsored health plans have been key partners in helping counties provide operational know-how and infrastructure support for expanded coverage programs. This knowledge and support has ranged from offering licensed health care products to providing administrative services, such as claims processing. Counties that use local health plans either to offer licensed insurance products or administrative services benefit from the plans’ experience under Medi-Cal managed care and Healthy Families.

Counties such as Alameda and Los Angeles have developed health insurance products for low-income In-Home Support Services home care workers. The local publicly sponsored health plan offers a state licensed product. In the case of Los Angeles County, the coverage product is offered through Community Health Plan, a county-operated plan, with a subcontract through L.A. Care, which provides administrative services. These collaborations have depended on the willingness and intent of local health plans to expand their portfolio of products beyond Medi-Cal, Healthy Families, and Healthy Kids.

Local plans must also rely on the good relations developed with participating providers, the local community, and regulators to expand successfully. In Contra Costa County, the county-owned licensed health plan administers the covered benefits to the medically indigent enrollees. In San Mateo County, the local Medi-Cal managed care plan, the Health Plan of San Mateo, is seen as a partner in helping the county address the problem of adult residents without health insurance.

Under the Coverage Initiative, Contra Costa, San Francisco, and San Mateo counties will be using local managed care plans to expanding health care options and coverage to uninsured residents. In Orange County, CALOPTIMA, the local county-organized health system established to serve those eligible for Medi-Cal, will be a partner with the county in developing a system to measure quality of care. These efforts offer lessons to other counties with local, publicly sponsored managed care plans.

Regional Efforts Face Barriers

Regional solutions and opportunities for intercounty collaboration have not been the rule, because Section 17000 focuses on the statutory obligation of each county. Except in the case of the CMSP, which is, by charter, a multicounty entity, counties have viewed administration and responsibility for programs for the medically indigent as county-specific ventures. There is some recognition that efficiencies of administration could be achieved through multicounty efforts.

IHSS Workforce Coverage Targets Uninsured, Low-Wage Earners

Insurance expansion to cover low-income In Home Support Services home care workers presents different issues than those facing programs for the medically indigent. Two lessons can be offered to counties considering health insurance plans to cover IHSS workers. First, counties with IHSS workers' health insurance programs are facing an aging workforce and an increase in health care costs. According to program managers, IHSS worker demographic and utilization data suggests that these trends lead to the use of higher-cost medical services, such as oncology and organ transplantation. This leads to increased pressure for care coordination and other prudent cost containment strategies.

A second lesson is that counties must develop effective ways of communicating with IHSS workers. While the local sponsorship of health care coverage for low-

income IHSS home care workers (and similar workers in San Mateo County) has resulted in an affordable insurance product, market penetration rates are still low. Effective communication is vital because the IHSS workers' insurance program depends on voluntary enrollment. Thus far, counties have not been as successful as anticipated in reaching enrollment targets, even with the offer of extensive benefits and nominal premiums. Counties are studying the reasons for the apparent reluctance to purchase this coverage. Another important reason to improve communication is to encourage appropriate use of health care services once workers have enrolled. Los Angeles County, for example, reports that out-of-plan use by IHSS workers could be better controlled with improved communication and education of both enrollees and out-of-network providers.

Technologies Have Benefited Indigent Care Programs

The use of One-e-App provides a unifying, technological link across a range of public programs, promoting efficiencies in screening and steering the uninsured to the most appropriate public program. Although One-e-App has been used primarily for children's programs, such as Healthy Kids, it can be used in conjunction with programs targeting the medically indigent adult population. San Mateo County has been using One-e-App to screen across indigent coverage programs serving children and adults, to support the multiple programs serving low-income residents. The advantages of One-e-App are magnified when community-based organizations also adopt its use. San Francisco County plans to use One-e-App for its Healthy San Francisco program.

Under the Coverage Initiative, several counties will use information technology to improve the exchange of medical data among providers both within county systems of care and among independent providers, non-county clinics, and hospitals. The electronic exchanges will include clinical information, as well as support information such as appointment scheduling.

Coverage Initiative

The federal Centers for Medicare & Medicaid Services granted the California Department of Health Services a Section 1115 Medicaid Demonstration waiver for hospital financing. The waiver allots \$180 million per year in federal funding for three years to expand care to low-income, uninsured Californians not eligible for Medi-Cal, Healthy Families, or Access for Infants and Mothers (AIM). Projects must comply with the Deficit Reduction Act of 2005 and verify that those enrolling in programs under the Coverage Initiative are U.S. citizens or nationals. Table 1 summarizes the ten successful proposals.

The elements for evaluating a successful proposal under the Coverage Initiative included attention to establishing a medical records system; designating a medical home and assigning eligible applicants to a primary care provider; offering a benefit package that includes preventive and primary care services and case management designed to treat those with chronic health conditions; monitoring the quality of care; promoting preventive care and early intervention through education for both eligible residents and participating providers; screening and enrolling processes that make priority use of other federal and state funds; demonstrating that the proposal will promote the viability of the existing safety net health care system; and documenting that project implementation can begin on September 1, 2007.

Table 1. Successful Coverage Initiative Proposals

AWARDEE	ANNUAL AWARD	PROJECT GOAL
Alameda County Health Care Services Agency	\$8,204,250	Coverage program for those with chronic disease and history of frequent use of health care services. Includes medical home assignment, condition appropriate care management and targeted specialty care improvements.
Contra Costa County Health Services	\$15,250,000	Expands Basic Health Care (BHC) program, a Contra Costa Health Plan managed temporary health coverage program for low-income uninsured residents who need care. Provides additional slots and expands provider network to include community clinics.
Kern Medical Center (KMC)	\$10,000,000	Creates a comprehensive benefit program for chronically ill uninsured and indigent patients to maintain health and minimize hospitalization.
Los Angeles County Department of Health Services	\$54,000,000	Targets patients who are chronically ill and frequent users of health services to help them shift from episodic to continuous care. Establishes a medical home and provides care management for chronic conditions.
Orange County Health Care Agency	\$16,871,578	Expands and improves the existing program to shift from an episodic care model to primary and preventive services. Widens scope of services from urgent/emergent care to include primary/preventive, links enrollees to a medical home, and provides care management.
County of San Diego Health and Human Services Agency	\$13,040,000	Chronic care model program targeting individuals diagnosed with diabetes, hypertension, or related condition. Provides disease management and primary care through a medical home, as well as related specialty and inpatient services.
San Francisco City and County	\$24,370,000	Managed care coverage model that seeks to deliver more coordinated and efficient services to adult uninsured by providing a medical home, health plan participation and services, and improved quality monitoring.
San Mateo County / San Mateo Medical Center	\$7,564,172	Expands the WELL program to ensure a medical home to reduce episodic care and emphasize primary and preventive care. Includes medical home assignment, health plan as third-party administrator, and redesigned chronic disease services.
Santa Clara Valley Health & Hospital System	\$20,700,000	County coverage program for low-income uninsured that are self-employed or employed by small businesses. Participants eligible for a benefit package that includes primary, inpatient, specialty, pharmacy, and other medical services.
Ventura County Health Care Agency	\$10,000,000	Seeks to provide comprehensive coordinated coverage through a pre-defined benefits package, expanded provider network, coordinated information systems, preventive care incentives, and targeted case/care management. Also includes employer component targeting farm workers.

AUTHORS

Bobbie Wunsch, M.B.A., Tim Reilly, M.S., Steven Krivit,
M.P.A., Pacific Health Consulting Group

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FOR MORE INFORMATION CONTACT

California HealthCare Foundation
1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org

Appendix: County Program Descriptions

ALAMEDA COUNTY

For the past five years, the Alameda Alliance for Health, the county's locally operated Medi-Cal managed care plan, has administered, on behalf of the Alameda County Public Authority for In Home Supportive Services, a comprehensive medical, dental, and vision plan for IHSS homecare workers called Alliance Group Care. Members' monthly cost is \$8 to \$15, with copayments of \$5 for most services. There are no copayments for preventative care, pregnancy and maternity care, and inpatient hospital services. To qualify for the program through the Public Authority, IHSS homecare workers must be paid for two consecutive months and for an average of 45 working hours in those two months. Eligibility determination and enrollment are conducted by the Public Authority. Health care services are provided through the Alliance's extensive public and private provider network. The administration of the dental and vision benefit will be turned over to Public Authority at the beginning of fiscal year 2007–2008.

COUNTY MEDICAL SERVICES PROGRAM (CMSP)

The County Medical Services Program (CMSP) was established in 1983, when the state was required to assist small, usually rural counties in financing and administering their medically indigent adult programs. Beginning in 1991, the State's General Fund contribution to the CMSP was capped each fiscal year. Subsequently, another legislative change limited CMSP funding solely to realignment revenue (motor vehicle license fees and sales tax) and county general revenue. In April 1995, another state law was passed requiring that the CMSP be self-governing. In 2005, the Governing Board selected Blue Cross Life & Health Insurance to perform administrative services for the CMSP, including the development of a provider network and negotiation of provider reimbursement levels.

CMSP eligibility criteria require that qualifying individuals be from 21 through 64 years of age, reside in a participating county, have incomes at or below 200 percent of the FPL (federal poverty level), and not be eligible for Medi-Cal benefits. In calculating income eligibility for the CMSP, there are monthly liquid asset limits per household size. One home, one car, and personal effects are exempt. No current medical need is required to qualify. To receive full benefits, the county resident must be a United States citizen or have legal immigration status. If the applicant's net income is above a maintenance need level but below 200 percent FPL, s/he must share in the cost by paying or obligating that amount toward medical expenses before the CMSP will assume financial coverage. Residents of CMSP counties who have undetermined immigration status may receive coverage limited to emergency services only. The applicant screening and eligibility determination process is administered by the respective county's social services department, according to CMSP criteria. Enrollment duration varies depending on eligibility status: two months for emergency-only coverage; three months for share of cost; six months for no share of cost. Reenrollment requires a reapplication in the month coverage ends to ensure uninterrupted eligibility. To receive CMSP benefits other than emergency care, the enrolled individual must go to a contracted CMSP/Blue Cross Life & Health Insurance network provider. Plumas County, one of the 34 member counties participating in the CMSP, was interviewed for this issue brief.

CONTRA COSTA COUNTY

Basic Health Care (BHC) is a health coverage program intended to meet Contra Costa County's Section 17000 obligation. To be eligible for BHC, county residents must have household income no greater than 300 percent of the FPL (federal poverty level) and may not be eligible for any other public or private health insurance program. Assets are considered in eligibility determination and any housing, food or utilities provided free or as work

exchange are considered income. The applicant may not have any other residency outside the county. There is no age restriction for BHC; both adults and children can qualify. In addition, BHC is open to undocumented immigrants. Depending on actual household income, the cost to participants is \$0 to \$15 per quarter for children (under 19 years of age) and \$0 to \$225 per quarter for adults. Those with family incomes at or below 150 percent of the FPL have no out-of-pocket cost. An initial eligibility period of six months is granted with an opportunity for subsequent renewal. County financial counselors determine eligibility. The BHC program is administered by Contra Costa Health Plan and operated by the county. Medical care is provided only at Contra Costa Regional Medical Center or one of the county's health centers, unless prior authorization is obtained.

FRESNO COUNTY

The Fresno County Medical Indigent Service Program (MISP) serves county residents between the ages of 21 and 64 years who are undocumented, legal permanent residents, or United States citizens. Each must meet the income and property criteria. The eligibility threshold is based on the Medi-Cal Maintenance Need formula, a superseded Medi-Cal standard, which is set at or below 63 percent of the FPL (federal poverty level) in Fresno County. The county's Temporary Assistance Department screens applicants for Medi-Cal eligibility. If a person does not qualify for Medi-Cal coverage, the county refers the patient to the hospital under contract to the county that will accept the MISP application and determine eligibility. No medical need is required to qualify. The initial period of MISP coverage is three months, if income is steady. If income varies, MISP coverage is for one month. Renewal can be accomplished by reapplication and re-qualification. MISP medical services are provided by a local, non-profit, private medical center and its affiliated hospitals and clinics under a 30-year agreement with the County of Fresno. Nearly all required inpatient and outpatient services are provided by these facilities. In the event that these contracted hospitals and clinics cannot provide the

necessary medical care, the medical center will refer the patient to an outside provider, either in Fresno County or outside the county.

LOS ANGELES COUNTY

The Personal Assistance Services Council (PASC), a public authority, was created by Los Angeles County to administer the IHSS program. In April 2002, PASC, in collaboration with the homecare workers' union, began offering medical benefits to qualified IHSS homecare workers through Community Health Plan (CHP), a county-operated, state-licensed health plan. The monthly premium for homecare workers is \$1, with the balance of the premium covered by federal, state, and county matching funds. CHP has subcontracted to L.A. Care Health Plan, the locally operated Medi-Cal managed care plan, various administrative services, such as claims processing, information system support, and member services. In 2004, the hours-worked eligibility requirement was reduced from 112 hours to 80 hours per month. By 2006, the liberalization of the working hours requirement increased the total number of IHSS workers eligible to enroll in the health insurance program to approximately 73,000, including the 24,170 enrolled as of December 2006.

SAN FRANCISCO COUNTY

Created by county ordinance, the Healthy San Francisco program is a coverage program designed to make health care services accessible and affordable to uninsured San Francisco residents, regardless of employment, immigration status, or pre-existing medical condition. Healthy San Francisco is overseen and administered by the San Francisco Department of Public Health in conjunction with the San Francisco Health Plan. Healthy San Francisco is not characterized as insurance, but a restructuring of the county's Section 17000 obligation that includes the creation of an integrated health care safety net delivery system comprised of both public and non-profit providers. To be eligible for the program, an individual must be uninsured, a resident of San

Francisco, between the ages of 18 to 64, and ineligible for other government-subsidized health benefits programs, such as Medi-Cal and Medicare. Healthy San Francisco participants are required to pay monthly participant fees and point-of-service fees when obtaining services. However, if the Healthy San Francisco participant has an annual household income at or below 100 percent of FPL, there is no monthly participation fee or point-of-service fee.

The county ordinance also requires medium and large-sized employers in the county to spend a minimum amount per hour on health care for their employees, a controversial provision referred to as the “employer spending requirement.” Nonprofit organizations with fewer than 50 employees are exempt from the employer-spending requirement. The employer has five options: purchase coverage for employees, open a Health Savings Account, pay the employee’s health care bills, open a clinic to care for employees, or participate in Healthy San Francisco. If the employer selects the city coverage program, the employer contribution (i.e., employer spending requirement) is made toward Healthy San Francisco. The employer contribution takes into account the employee’s income and employer contribution.

SAN MATEO COUNTY

The WELL Program provides a basic level of health care to low-income and uninsured adult residents regardless of ability to pay, to fulfill the County’s Section 17000 obligation. To be eligible, residents may be United States citizens, legal residents, or undocumented immigrants. They must be 21 to 64 years of age (19 and over for undocumented immigrants). Applicants are screened for existing health care coverage and may not be eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party payers. The WELL program income level is set at 200 percent of FPL. For residents who earn incomes that are at or below 100 percent FPL, there is no enrollment fee. However, above 100 percent FPL but below 200 percent FPL, there is a \$250 annual fee,

as well as point of service copayments. For qualifying residents with incomes above 200 percent of FPL, there is also a program to discount billed charges by the San Mateo Medical Center (SMMC), the county hospital. Assets are considered in eligibility determination and homeownership in the county disqualifies an individual from WELL eligibility. An initial eligibility period of 12 months is granted, though the county may set shorter periods. Eligibility is evaluated annually and before inpatient stay and surgery. All WELL program services are provided through SMMC and its affiliated county clinics. Certain specialty services unavailable at SMMC can be accessed outside the county system only with prior authorization.

Over the past four years, the County of San Mateo has been expanding insurance and coverage for low-income residents through a series of new programs. In 2003, it launched a program to provide health insurance to all children in the county at or below 400 percent of the FPL. The county, in conjunction with AFSCME (American Federation of State County and Municipal Employees), SEIU (Service Employees International Union), and the Health Plan of San Mateo, created a voluntary health insurance product to cover IHSS homecare workers and county temporary, extra-help workers, on a voluntary basis at a premium below market rates. Most recently, the County Board of Supervisors named a Blue Ribbon Task Force on Adult Health Care Coverage Expansion to explore options for providing comprehensive health care coverage or insurance to uninsured adults living at or below 400 percent of the FPL.