California's Health Care Coverage Initiative:
County Innovations Enhance Indigent Care

California HealthCare Foundation

ISSUE BRIEF

Overview

More than 100,000 low-income Californians have begun to benefit from county-level innovations aimed at expanding access to health care, transforming provision of services, and maximizing limited resources. The innovations are supported by the Health Care Coverage Initiative (CI) component of California's Medicaid hospital financing waiver,[1] which is intended to help counties expand coverage to medically indigent adults. Ten California counties—Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura—are using CI funding to work toward specific improvements in their indigent care systems, with a focus on patients with complex, chronic medical conditions. Significantly, the CI counties have moved beyond coverage expansion to transform the way care is provided, replacing fragmented, episodic care limited to urgent and emergency services to more organized, efficient, and financially sustainable systems that include primary and preventive care.

To support these counties' efforts and to learn from their experiences, the California HealthCare Foundation (CHCF) and The California Endowment (TCE) engaged Health Management Associates (HMA) to create a comprehensive program of technical assistance for the CI counties working on the transformation of indigent care. Based on the counties' experiences, this issue brief describes common elements of the county programs that are critical to reforming local health systems.

As required by the state law that enacted the CI, all ten programs include the following components:

- An identification system that demonstrates enrollment of the uninsured person into the program (enrollees also must be ineligible for other public programs);
- A medical records system;
- Assignment of each enrollee to a medical home;[2]
- A benefits package that includes preventive and primary care as well as care management;
- Promotion of preventive and primary care; and
- A quality monitoring process.

Because the CI programs provide unique sets of services to individuals and not comprehensive insurance, coverage is only available within the county's provider network and is not portable outside the resident's county.

The historic structure of each county's delivery system has impacted the design of its CI program. For example, some of the counties (e.g., Contra Costa and Ventura) have existing systems that include both a county-owned public hospital as well as county-owned clinics. Other counties (e.g., Alameda and Santa Clara) have CI networks that include both county-based and private providers. Two counties' networks—Orange and San Diego—are comprised solely of private hospitals and clinics.

September 2009

The counties also differ in terms of where they fall along the continuum of health system redesign. Prior to the CI, San Francisco and San Mateo counties had already invested heavily in redesign as part of a larger push to expand access and coverage to all local residents. Other counties have used participation in the CI to begin the process or to test new methods for providing access for indigent populations. For example, Alameda's CI program is testing a comprehensive chronic care model, with the goal of expanding it countywide. (See Appendix A for an overview of county initiatives.)

Common Program Elements and Issues

The counties' approaches and implementation experiences highlight common elements and issues that are critical to effective system reform.

Provider Networks

To address the complex health needs of the enrollees, the CI counties have developed networks that include both primary and specialty providers, with the primary care physicians serving as enrollees' medical homes. To avoid both duplication and gaps in services, the counties have found it useful to analyze enrollees' clinical needs, identify service gaps in their existing networks, and partner with providers around specific service needs.

Ensuring sufficient access to specialty care has been a challenge for the majority of the CI counties, particularly where the number of CI enrollees with multiple chronic conditions is greater than expected. Many of the CI counties with county-based systems developed or expanded partnerships with non-county specialty providers. Alternatively, Orange and San Diego counties, which do not have county-based systems, developed contractual arrangements with a wide range of private specialty providers. In general, the counties with more comprehensive county-based health systems have reported fewer issues with specialty access than those that rely more heavily on private providers.

Systematic coordination and close communication between providers have been found to be crucial for the CI-mandated medical home model to succeed. Some counties have implemented IT solutions to facilitate provider communication, but others continue to seek assistance and information on best practices in supporting good communication. Coordination across providers also appears more difficult for counties with provider networks that include a higher proportion of private providers.

Financial Sustainability

The CI programs are working to achieve financial sustainability through the economic downturn. Many are focusing on strategies to increase efficiency in practice management, use of specialty services, and chronic care management. Counties also are seeking to maximize every source of funding available for local systems and making the business case for their CI programs to maintain local support.

The counties' efforts have been affected by a long delay in reimbursement for the first year of CI health care and administrative expenditures. This was due to lengthy negotiations between the California Department of Health Care Services (DHCS) and the federal Centers for Medicare and Medicaid Services (CMS) regarding federal approval of reimbursement mechanisms for claiming federal funds. As of this writing, the CI administrative funds still have not been paid to counties. The delay has stressed county fiscal capacity to sustain care management and continue to invest in administrative improvements.

The CI counties are concerned about their ability to sustain their programs over the long term if federal funding is eliminated or reduced. Consequently, they are exploring ways to create efficiencies, generate savings from existing programs, and identify opportunities to secure additional federal funding. This often requires a detailed understanding of federal and state reimbursement mechanisms.

Enrollment Processes and Systems

The development of a formal, centralized enrollment process and system has allowed the CI counties to track and manage care for their enrollees. By tracking eligibility, the county enrollment systems also assist with the renewal process, helping to maintain continuity of care. Alameda, San Francisco, and San Mateo counties use One-e-App[3] to manage the CI enrollment process. Other counties, including Contra Costa and Orange, have developed their own enrollment systems.

During the first year of the CI, counties struggled with the requirement to verify CI applicants' citizenship using original documentation, as required by the federal Deficit Reduction Act of 2005. This slowed the eligibility process considerably as the counties worked with applicants to obtain the necessary documents. To assist applicants, a number of CI counties purchased vital statistics data from the state (a valid birth certificate can be used to prove citizenship), and Orange County granted CI enrollees an extended grace period to produce their documentation.

The counties also have become interested in improving their practices for eligibility, enrollment, and retention, including strategies for assuring timely identification of individuals who qualify for Medi-Cal.

Chronic Care Management

The CI counties are implementing a variety of strategies to better manage chronic care, which is critical to improving CI enrollees' health status and shifting care from costly emergency and inpatient settings to outpatient settings. To be effective, care management requires close collaboration between primary care and specialty providers, as well as between clinicians and social service providers.

Some counties focus on specific conditions. San Diego, for example, is targeting diabetes and hypertension. Others have introduced chronic care management tools—such as evidence-based practice guidelines, patient self-management tools, and disease registries—to all enrollees eligible for CI. In general, the CI counties indicate there is a continuing need for training, resources, and information about how best to serve populations with multiple chronic conditions.

Information Technology

Information technology (IT) offers important infrastructure for a county-based indigent health care system. It is used to support coordination of care across providers by facilitating shared access to patient information, and can also be used to implement an enrollment system and disease registries.

A number of counties have implemented IT tools and systems as the underpinning of their system redesign. Orange County, for example, has contracted with an outside vendor to develop MSI Connect, an electronic health information exchange that is available to all medical home and emergency department providers. Orange is now developing an e-referral tool to streamline the specialty referral process. Many counties, however, continue to seek assistance with identifying, financing, and implementing effective IT solutions.

Strong Leadership

The counties found that committed senior-level executives and policymakers have played an important role in their reform efforts. Leadership in the CI counties has been relatively stable over the first two years of the CI, which has likely helped the counties maintain their momentum in the face of the economic downturn and delay in accessing federal funds.

Looking Ahead

The CI county experiences to date suggest there is strong potential for similar initiatives in other counties. But they also point to larger issues that bear consideration in view of the upcoming renewal of the state's hospital waiver.

System Redesign and Financing

In California, as elsewhere, the flow of money has shaped the way care is delivered, contributing to heavy reliance on emergency and inpatient care. To offset this influence, the funding streams need to be tapped in ways that reinforce the financial sustainability of more efficient and organized systems of care over the long term. Administrators will need to look for opportunities to maximize available funding in one area (public health, for example) to offset the costs of providing services in another area, such as indigent care.

Clear Guidance from Federal Government

The CI was a new program for both DHCS and CMS. As a result, it took time to develop key parameters, such as the final protocols for claiming federal funds. CMS also changed its guidance on certain eligibility parameters after the counties had been selected. For example, CMS imposed an income limit of 200 percent of the federal poverty level and required the counties to adhere to the Medicaid requirement to document enrollees' citizenship as part of the eligibility process. The CI counties were frustrated by these changes to the eligibility rules and lack of guidance regarding the claiming protocols, as well as delays in receipt of federal reimbursement. Going forward, clear and timely guidance and reimbursement from CMS will be important, particularly if California seeks to expand the CI in the next waiver.

Strong Partnership Between State and CI Counties

While the state has not allocated new funding for CI, the counties have indicated the need for DHCS to champion their efforts and to provide support to ensure the CI's success. DHCS has played a key role in implementing the CI by serving as the intermediary between the counties and CMS and interpreting federal guidance regarding eligibility requirements and financing mechanisms. The counties, however, have expressed frustration that DHCS may not fully understand the operational challenges of running a health care delivery system, as well as with DHCS's limited ability to administratively support all of the county-initiated efforts at system redesign. To expand their knowledge of health system operations and management, DHCS leadership and staff have attended several CI-related convenings sponsored by CHCF and TCE over the last 18 months. State staff should continue to seek opportunities to expand their knowledge of county-based delivery systems and the operational parameters.

Options for Additional Technical Assistance

If the CI is expanded in the upcoming renewal of California's waiver, DHCS may want to include funding to provide technical assistance for participating counties. This could allow the counties to contract directly for the kinds of assistance that are most relevant to each county's reform strategy. In particular, counties are interested in acquiring enhanced information technology to support more efficient systems of care. DHCS also could gather and synthesize the lessons learned and facilitate information-sharing across the counties.

Authors

Caroline Davis, M.P.P., is a senior consultant with Health Management Associates (HMA), a national health policy research and consulting firm. Barbara Coulter Edwards, M.P.P., is a principal with HMA.

Appendix A: Coverage Initiative Overview*

COUNTY	ANNUAL FEDERAL ALLOTMENT	YEAR ONE EXPENDITURES — FEDERAL MATCH	YEAR ONE EXPENDITURES — COUNTY FUNDS	TARGET ENROLLMENT	ENROLLMENT AS OF MARCH 2009
Alameda	$8,204,250	$7,614,175	$7,614,175	5,500	6,393
Contra Costa	$15,250,000	$15,250,000	$22,060,358	9,600	11,446
Kern	$10,000,000	$10,000,000	$12,415,736	3,500	5,704
Los Angeles	$54,000,000	$20,830,612	$20,830,612	94,000	34,429
Orange	$16,871,578	$16,871,578	$33,029,042	17,000	31,440
San Diego	$13,040,000	$620,411	$620,411	3,260	3,651
San Francisco	$24,370,000	$11,053,828	$11,053,828	10,000	10,963
San Mateo	$7,564,172	$5,907,394	$5,907,394	2,100	6,977
Santa Clara	$20,700,000	$20,700,000	$23,730,376	12,500	21,828
Ventura	$10,000,000	$10,000,000	$11,956,953	12,500	12,520

*For more information about the CI, see: R. Pizzitola, "California's Coverage Initiative: Year One Challenges and a Forecast for Year Two," Insure the Uninsured Project, December 2008 (www.itup.org/Workgroups/PublicPrivate/Pizzitola.pdf).

Source: California Department of Health Care Services, personal communication, August 24, 2009.

Endnotes

1. Created as part of California's Medicaid Section 1115 hospital financing waiver, the CI provides $180 million in federal funding for each of the last three years of the waiver period (September 1, 2007 to August 31, 2010). It was enabled through California Senate Bill 1448.

2. SB 1448 defines the medical home as "a single provider or facility that maintains all of an individual's medical information."

3. One-e-App is a Web-based tool that screens and submits eligibility data for a variety of public health coverage and insurance programs.