

## Overview of the Health Care Coverage Initiative

### Background

The Health Care Coverage Initiative (CI) allows the expansion of health care coverage to eligible, low-income uninsured persons in California. The CI is a component of the five-year federal section 1115 Medicaid Demonstration<sup>1</sup> for hospital financing and provision of uninsured care. The Demonstration provides \$180 million in federal funds annually during years three, four and five of the Demonstration (from September 1, 2007 through August 31, 2010) for the implementation of the CI.

State law (Chapter 76, Statutes of 2006, Kuehl) provides the statutory framework for California to utilize the \$180 million in federal funds, allocated annually, to provide health care services to eligible, low-income, uninsured persons. The implementation of the health care coverage programs funded under the CI contributes to the following three key Legislative objectives:

- Expand critical health services to low-income, uninsured individuals in California through programs that are designed by local governments that have the unique ability to develop the health service delivery models that meet the needs of their diverse populations and build on local infrastructures.
- Strengthen and build upon the local health care safety net system which includes disproportionate share hospitals, county clinics, and community clinics, and create efficiencies in the delivery of health services that could lead to savings in health care costs.
- Promote the use of preventive services and early interventions to improve the health outcomes of low-income, uninsured individuals.

---

<sup>1</sup> Medi-Cal Hospital/Uninsured Care (Waiver 11-W-00193/9) effective September 1, 2005 and as amended October 5, 2007

The ten CI programs are:

<b>Contractors</b>	<b>Allocation</b>
Alameda County Health Care Services Agency	\$ 8,204,250
Contra Costa Health Services	15,250,000
County of Kern, Kern Medical Center	10,000,000
Los Angeles County Department of Health Services	54,000,000
County of Orange	16,871,578
County of San Diego, Health and Human Services Agency	13,040,000
San Francisco Department of Public Health	24,370,000
County of San Mateo	7,564,172
County of Santa Clara, DBA Santa Clara Valley Medical Center	20,700,000
Ventura County Health Care Agency	10,000,000

The CI program goals are to:

1. Expand the number of Californians who have health care coverage.
2. Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics.
3. Improve access to high quality health care and health outcomes for individuals.
4. Create efficiencies in the delivery of health care services that could lead to savings in health care costs.
5. Provide grounds for long-term sustainability of the programs funded under the CI program beyond August 31, 2010, when the annual federal allocation for the CI program ends under the current waiver.
6. Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

### Evaluation of the CI Programs

State law requires the Department of Health Care Services (DHCS) to perform an evaluation of the CI program and to submit an evaluation report to the appropriate policy and fiscal committees of the Legislature. The CI programs are required to participate in the program evaluation and to collect and provide data for the evaluation. DHCS entered into an Interagency Agreement with the University of California, Los Angeles (UCLA), Center for Health Policy Research to perform the program evaluation.

The evaluation is intended to provide information on the ten CI programs and their long-term success and potential for inclusion in the next negotiated Demonstration. UCLA has gathered preliminary information and completed site visits of all ten CI County programs. During these site visits each County provided a comprehensive overview of the program to date and UCLA examined issues such as enrollment and program implementation challenges and successes.

The Special Terms and Conditions (STCs) of the Demonstration require DHCS to submit an evaluation report to the Centers for Medicare & Medicaid Services (CMS). Since DHCS has submitted a request to CMS to renew the Demonstration beyond August 2010, UCLA will prepare an interim evaluation report for DHCS to submit to CMS by April 2010 for consideration of the renewal of the CI program component of the Demonstration. If CMS approves renewal of the Demonstration, UCLA will prepare the final evaluation report of the CI programs by August 2012 for submittal to CMS.

### CI Program Contract and Reimbursement Process

The ten CI counties contract with DHCS to provide health care services to enrollees through their county provider network and/or through subcontracts with private and community providers. The CI counties are reimbursed solely through the use of the certified public expenditure (CPE) mechanism specified in federal regulations (42 C.F.R 433.51). CPEs are the allowable total funds expenditures that are certified by the CI counties as eligible for claiming federal financial participation under the Demonstration. This reimbursement mechanism involves establishing CI program costs to be used to calculate quarterly interim payments which are reconciled through an audit and settlement process, and quarterly invoices for reimbursement of actual subcontract expenditures. The reimbursement mechanism for allowable expenditures for administrative activities involves the use of quarterly time studies to capture staff time associated with allowable categories of administrative costs. The reimbursement mechanism for the start-up, prior period, and close-out administrative costs are currently being developed by DHCS.

### CI County Reimbursement

The CI counties began receiving reimbursement for health care services provided during program year one in October 2008, when the cost claiming protocol was approved by CMS. As of February 17, 2010, the total amount of reimbursement to the ten counties is:

Program Year One (September 1, 2007 – August 31, 2008): \$171,402,339  
Program Year Two (September 2, 2008 – August 31, 2009): \$163,734,403

## Reallocation of Federal Funding

State law provides the authority for DHCS to reallocate the amount of federal funding available to each of the participating counties, if necessary, to ensure that the available federal funding is maximized. DHCS provided reallocations for program year one during program year two for five of the ten counties that had certified public expenditures in their CI programs that exceeded their annual federal allotment. The total amount of funds reallocated to the recipient counties was \$15,185,444.

## Enrollment

The unduplicated enrollment for program year one is approximately 101,254 and represents approximately 60 percent of the annual statewide enrollment goal of 167,960 enrollees. The unduplicated enrollment for program year two is approximately 161,273 and represents approximately 95 percent of the annual statewide enrollment goal of 169,760 enrollees. As enrollees are determined eligible their enrollment becomes effective the first day of the month in which they applied. This results in continual adjustments to the enrollment figures for each program year.

## CI County Program Accomplishments

Prior to implementation of the CI program in the ten select counties, low-income, uninsured adults residing in these counties received episodic care for urgent or emergent services with limited primary care. Now these individuals enrolled in the CI programs have access to a comprehensive delivery system with primary and preventive services coordinated within an established network of providers.

The CI programs provide preventive services included, but were not limited to, allergy testing, prescription drugs, vision and hearing exams, treatment and serum injections, immunizations, inoculations, dental treatment, flu vaccine, bone density screening, diabetic retinal screening, tobacco screening, smoking cessation programs, and provision of cancer screening services, such as mammograms, pap smears, and colonoscopy screening.

Selected examples of strategies for the promotion and provision of preventive services and early intervention implemented in the CI programs are: assignment and use of medical homes; a 24-hour nurse advice line;

patient education; health assessments; group education; tracking and monitoring enrollee compliance with care plan goals; monitoring of medications and lab results; use of electronic health information technology; and case management.

### CI County Program Issues

After months of negotiations with CMS, the amendment to the STCs of the Demonstration that provides the cost claiming and reimbursement methodology, program eligibility requirements, and program evaluation requirements for the CI program, was approved by CMS on October 5, 2007. The amendment included the following:

- Disallowed a three-month retroactive eligibility;
- Required a new income limit of 200 percent of the federal poverty level for enrollees;
- Required that the Deficit Reduction Act of 2005 (DRA) for U.S. citizenship and identity must be met by eligible individuals prior to enrollment;
- Limited direct cost claiming to five of the nine administrative cost categories and the cognizant agency's approved indirect cost rate must be used for the four remaining cost categories.

The amendment changed the eligibility requirements for the CI program and caused difficulties for the counties that were in the process of enrolling individuals into their programs. The amendment also limited the direct cost claiming for program administrative activities expenditures which impacted county budgets for program implementation.

The delayed approval of the STCs impacted the CI program implementation as follows:

- The county planning and development period for the program was abbreviated. The CI program was designed to include a six-month, start-up period from March 2007 through August 2007, to develop networks and implement systems of care prior to program enrollment beginning September 1, 2007.
- The CI program contracts between the counties and DHCS were not fully executed until after the CI program was implemented.

- The contracts between the counties and local providers were not executed until after the CI program was implemented and the DHCS contracts between the counties were executed.
- The county systems for enrollment, eligibility, and reporting were delayed or required additional changes.
- The county systems for documentation of U.S. citizenship and identity were not available or fully developed by September 1, 2007. This has been the largest barrier to patient enrollment.
- Program eligibility determinations were prolonged due to difficulty or inability to obtain required citizenship, identity, and income documentation.

DHCS did not receive CMS approval for essential cost claiming protocols for health care services until October 2008. This created cash flow difficulties for counties because the counties did not receive any reimbursement for health care services provided under the CI program until October 2008. Subsequent delays in implementing the time study required to calculate the costs associated with allowable administrative activities, and certain CMS dictates regarding the application of the Coverage Initiative Percentage (which reduces federal participation in county costs for certain CI administrative activity categories), and the rules for grouping counties' time studies for purposes of claiming for CI administrative costs, created additional intricacies in the CI administrative activities claiming process which have complicated, and delayed, the claiming for counties' CI administrative costs.

Additionally, DHCS must negotiate with CMS separate reimbursement protocols for start-up, prior period, and close-out costs. The counties will not receive reimbursement for these costs until after CMS approves the protocols.

### Federal Flexibilities Amendment to the STCs

DHCS completed negotiations with CMS for an amendment to the STCs effective February 1, 2010, which authorizes among other things, some changes to the U.S. citizenship and identify requirements and program enrollment requirements in the final year of the CI program. These changes will enable the CI programs to continue enrollment in their programs

through the final year of the program and to enroll eligible individuals into the program pending completion of the U.S. citizenship and identify certifications.