HMA

HEALTH MANAGEMENT ASSOCIATES

HCCI Interim Assessment for CHCF: Lessons Learned, Options for the Future

PREPARED FOR CALIFORNIA HEALTH CARE FOUNDATION

SEPTEMBER 29, 2009

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

AUSTIN, TEXAS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN
NEW YORK, NEW YORK • SACRAMENTO, CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Introduction

California's Health Care Coverage Initiative (HCCI) is a demonstration project implemented under California's Section 1115 Hospital Financing waiver (hereinafter referred to as the waiver) that is showing significant early promise in extending effective health coverage to low-income, uninsured adults not otherwise eligible for Medi-Cal. Ten counties - Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara and Ventura - were selected through a competitive process to share in $180 million a year in federal funds during the last three years (September 1, 2007 – August 31, 2010) of the five-year waiver.

The HCCI supports the development and implementation of strategies to move medically indigent adults from fragmented, episodic and reactive care, which is often hospital-based and limited to urgent and emergency services, to a more efficient, effective and organized system that centers on primary and preventive services delivered through a medical home. Through the HCCI demonstration, participating counties are focused on improving how care is delivered in the safety-net, with a particular emphasis on providing more effective care to patients with complex, chronic medical conditions.

The HCCI counties enroll individuals into a program of health coverage, but they do not provide insurance to enrollees. The counties provide a wide range of health care services to HCCI enrollees, but the coverage is not portable outside the resident's county or outside of the county's designated provider network. Under the HCCI, the participating counties provide the non-federal matching funds through Certified Public Expenditures (CPEs).

The waiver which authorizes HCCI expires on August 31, 2010. In preparation for the development of a renewal or replacement waiver, the state is engaged in a process that includes obtaining public input regarding options for the future. The state plans to submit a concept paper to the federal Centers for Medicare and Medicaid Services (CMS) in October 2009 that will outline the state's approach to a new waiver. The California HealthCare Foundation has supported the development of a two-part interim assessment of the HCCI demonstration to provide input to the state regarding the early results from the ten county HCCI projects. As one part of this effort, UCLA provided an analysis of available data from the first 18 months of the demonstration projects.[1],[2] This issue brief, which is the second part of the effort, provides a qualitative assessment of early lessons learned from the HCCI projects and assesses options the state may consider regarding an extension or expansion of HCCI within a new waiver.

---

[1] N. Pourat, PhD, G. Kominski, PhD, D. Roby, PhD, A. Diamante, MD, MPH, Y. Meng, DrPH, C. Reifman, MPH, A. Davis, MPH, *Interim Evaluation of Health Care Coverage Initiative in California*, August 1, 2009.

[2] UCLA will perform a formal evaluation of the HCCI program, following the end of the waiver period, under a contract with the California Department of Health Care Services.

Methodology

CHCF contracted with Health Management Associates (HMA) to provide a qualitative review of HCCI's early impact. HMA conducted in person or telephone interviews with officials in current HCCI counties, as well as with officials in selected counties which had applied for but did not win an HCCI grant. HMA also met with officials at the Department of Health Care Services and with other stakeholders with an interest in HCCI. (See Appendix A for a list of counties and other stakeholders interviewed.) HMA asked HCCI counties to reflect on the implementation process, to describe results to date, and to comment on the impact that HCCI is having or expected to have on county programs for medically indigent adults and other populations served. All counties were asked about their interest in and recommendations regarding an extension or expansion of HCCI in the context of a new waiver. State officials and other stakeholders were asked to discuss the impact of HCCI, as well as to comment on the potential for a continued, expanded or modified coverage initiative under a new Medi-Cal waiver.

Putting HCCI in Context

Waiver Authority

The basic premise of a Section 1115 waiver is that the state asks for special permission to use federal Medicaid funds for purposes not specifically authorized under Title XIX of the Social Security Act (e.g., to cover individuals or services not otherwise coverable) or in a way not contemplated under the federal law and regulations (e.g., an alternative delivery system model) to demonstrate a more effective approach to achieving program goals. Section 1115 waivers are typically granted for a five-year period. Before the current waiver expires, California must decide on the goals of a new waiver program and whether the state will request to extend the current hospital financing strategies or seek a more comprehensive set of system reforms.

Important issues will shape how California designs a renewal or replacement waiver and how a new waiver might incorporate a continuation or expansion of the HCCI demonstration. These include the reality of California's on-going economic and budget struggles and the impact that federal health reform might have on the need for coverage expansion and other health system reform initiatives. Each of these is discussed in more detail below.

The Environment in California

Under Section 1115 waivers, states generally seek to draw new federal funds to use for proposed reforms. Because HHS requires that total federal spending under a waiver not exceed what would have been spent without the waiver, California must identify strategies to reduce costs within the existing Medi-Cal program and/or negotiate advantageous assumptions regarding growth trends on what the state might otherwise have spent under traditional Medi-Cal. The state's ability to gain access to federal funding through these mechanisms will determine the amount of funding available under the waiver for reimbursement to safety net and other hospitals but also for activities such as the HCCI. The state's need for short term reductions in the cost of Medi-Cal to help close the budget shortfall may dominate the state's interest under a

waiver program. An equally important consideration, however, is that the health system and financing reforms possible within a comprehensive approach to a Section 1115 waiver could be essential to creating a sustainable Medi-Cal program for the future. The HCCI program is currently testing important elements of more cost-effective health care delivery system design.

Since California operates the second lowest cost Medicaid program (on a per capita basis) in the country, obtaining additional savings within the current Medi-Cal program is challenging. Many believe the best opportunities for additional savings may be found in improved care coordination for beneficiaries with chronic and disabling conditions. HCCI, with its focus on more effective service delivery to these high-cost populations among medically indigent adults, may provide valuable lessons as well as a potential foundation for broader system reforms.

To take full advantage of a Section 1115 waiver, California must identify sources of allowable local or state matching funds sufficient to draw the new federal funds to the state. States often seek the ability to use new sources of matching funds, including existing public funds spent on health care that are not currently matched under Medicaid. In the foreseeable future, it appears unlikely that California will have general fund dollars to support new spending under a waiver. As a result, identifying alternative financing options will be an important part of waiver design. One obvious strategy for the state is to explore options, including a renewed or expanded HCCI, for partnering with counties to leverage currently unmatched local funds.

Given the nature of the current recession, county governments in California also are under considerable stress. County revenues are reduced by the recession, which has also resulted in growing numbers of uninsured indigent adults seeking county-funded health services. Counties anticipate further stress on local health systems, as the state's economic woes reduce the state's ability to adequately fund the costs of treating Medi-Cal enrollees at county-run health provider sites. For example, the 2009-2010 state budget reduces by 10 percent the funds that will be paid to California's public hospitals and clinics from the Safety Net Care Pool. In addition, counties may be concerned over the level of new fiscal commitments that might be created (in terms of expanded services or individuals enrolled in county-sponsored coverage) under a new Section 1115 waiver reform strategy.

Federal Health Reform

Clearly, the potential for federal health reform has to be factored into the state's development of a waiver concept, especially since a basic goal of most Section 1115 waivers is to use federal flexibility to cover the uninsured. For example, current federal reform proposals would expand Medicaid eligibility and provide enhanced federal financing (up to 100 percent) for newly eligible groups. In addition, federal reform would likely include Maintenance of Effort (MOE) provisions, perhaps requiring that states continue to cover higher income groups that were voluntarily added to Medicaid prior to any new federal reform, but without the advantage of enhanced federal financial support. It is not clear whether MOE would apply to populations added under

a Section 1115 waiver. Finally, federal reform would likely not be implemented until at least 2013, well after the effective date of a new California waiver.

One of the challenges of universal coverage is the need to assure sufficient health system capacity to serve large numbers of newly-insured individuals. Another point of uncertainty is how universal coverage may impact traditional safety net providers. County partners in California's HCCI initiative will be critical to ensuring sufficient access and system capacity under a reform scenario. While many would face significant challenges in accommodating increased demand for access, these counties are generally well-positioned to be part of the solution. They are already engaged in the types of delivery system and service reforms that will be key to providing sustainable access to newly insured populations. The growing imperative of federal reform, to create a more cost-effective health care system, is a goal which may align with California's opportunity to build on the county HCCI programs.

Promising Early Results from HCCI

Expectations

Under Section 17000 of the California Welfare and Institutions Code, California's counties have an obligation to provide a safety net of health services to medically indigent adults. Traditionally, health care for this population has been highly fragmented, with services provided most often in response to urgent or acute episodes. Prior to the HCCI, some counties had begun to implement delivery system improvements to address these challenges; however, there generally has been little care coordination for chronic health conditions for medically indigent adults, and access to specialists and, in some systems, to primary care, has often been limited.

HCCI gave California counties the opportunity to compete to receive federal matching funds to support and build upon efforts to create more comprehensive, organized and efficient systems of care for medically indigent adults. California Senate Bill 1448, which provided statutory authority for HCCI, required that county coverage initiatives include the following components:

- An enrollment process with an identification system to demonstrate enrollment of the uninsured into the program (enrollees also must be ineligible for other public programs);
- A medical records system;
- Assignment of each enrollee to a medical home;[3]
- 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.

[3]The authorizing legislation for HCCI (Senate Bill 1448, Ch. 76 Stats. 2006, Kuehl) requires designation of a medical home (i.e., a single provider or facility that maintains all of an individual's medical information) and assignment of eligible individuals to a primary care provider from which the individual can access primary and preventative care.

The California Department of Health Care Services received 17 HCCI applications and selected ten counties to participate in HCCI on the basis of each county's commitment to: expand the number of adults with coverage; strengthen and build upon local health care safety net systems; improve access to high-quality health care and health outcomes; create efficiencies in delivery of services that could lead to savings in health care costs; provide the foundation for long-term sustainability of the HCCI programs; and implement their program expeditiously to maximize their annual federal allocation.

Within the established parameters, counties had the flexibility to design their own demonstration project, and there is significant variation across the counties in terms of goals, benefits and strategies. Projects reflect differences in county health system infrastructure and historical approaches to serving the medically indigent. Some counties placed a particular emphasis on reaching and enrolling individuals who had not previously used county services; other counties were more focused on implementing improved service systems for high-need individuals who were already known to the system.

Early Challenges and Successes

The start-up for HCCI was slower than the state and counties had hoped for, with much of the delay due to unforeseen difficulties in obtaining federal approval for key elements of the initiative. As a result of this delay, federal reimbursement for health care services did not commence until December 2008. Although reimbursement was retroactive to the start of HCCI (September 2007), counties waited to receive federal funding for more than one year after they had begun to enroll individuals into their HCCI projects. At the time this report was written (August 2009), the administrative reimbursement available under HCCI has still not been received by counties.

The most significant implementation challenge, which was cited by all counties, was the federal requirement that counties had to apply the federal Deficit Reduction Act's (DRA's) Medicaid citizenship and identity documentation provisions to medically indigent adults enrolled under HCCI.[4] The DRA requirements slowed the enrollment process considerably as the counties worked with applicants to obtain the necessary documents. A number of HCCI counties purchased Vital Statistics data from the state to assist with documenting citizenship for applicants. Obtaining acceptable documentation of identity, however, is more challenging for many applicants, especially people who are homeless. One county reported having thousands of pending applications awaiting documentation of identity.

Despite start-up challenges, county project officials, county health system leadership and county political leadership remain enthusiastic supporters of the HCCI project. County officials, when interviewed for this interim assessment, reported the HCCI has expanded coverage to medically indigent adults, driven and supported innovation in county health systems, and supported health system reforms to develop more effective and efficient systems.

[4] The federal Deficit Reduction Act of 2005 required that individuals must provide acceptable documentation of U.S. citizenship and of identify to obtain Medicaid coverage. Under the Section 1115 waiver, these requirements were extended to HCCI enrollees.

Expanded Coverage to Medically Indigent Adults

In July 2009, counties reported 145,351 medically indigent adults enrolled. All counties except Los Angeles County were in excess of anticipated enrollment. Los Angeles County, at only 37 percent of projected enrollment, still had the largest number of enrollees (34,429 individuals), followed by Orange County, which, with 34,440 enrollees, was at 185 percent of projected enrollment. [5]

In addition to the expansion of coverage in terms of numbers of people served, most counties have expanded the scope of services available to the enrolled population. Orange County, for example, has included for the first time a primary care benefit to enable effective utilization of a medical home model and to begin to prevent or mitigate acute care episodes for people with chronic conditions. All counties have included disease and case management services to support self-management of targeted chronic conditions and to reduce inappropriate use of hospital emergency departments for non-emergency care.[6]

Driven Innovation

County officials were unanimous in their view that HCCI, with the availability of federal matching funds for administration and service delivery for medically indigent adults, has enabled counties either to build upon existing innovations in the design and operation of local health care financing and delivery or to develop and implement new innovations. HCCI has been a catalyst for implementation of health information technology tools to support improved system operation and has energized local system administrators and providers – with both resources and publicly-established goals – to create improved clinical processes.

Supported System Reform

Some counties had invested heavily in redesigning local delivery systems, prior to participation in HCCI, as part of a larger strategy to expand access and coverage to all local residents. In these counties, HCCI provided the opportunity to build on the existing system and implement improvements that complemented the larger county initiatives. Other counties have used participation in HCCI to begin the process of re-organizing how care is delivered or to test new methods for providing access to care for indigent populations.

HCCI has resulted in counties, often for the first time, officially enrolling medially indigent adults into an organized system of care that offers a medical home, with defined primary and acute care benefits and chronic care management services. This, in itself, is a singular achievement. Most counties reported these system improvements, once tested, were expected to be rolled out across all populations being served locally, including Medi-Cal. Counties also reported that HCCI has enabled counties to strengthen network arrangements and improve the efficiency of local delivery systems.

---

[5] California Department of Health Care Services, personal communication, August 24, 2009.

[6] For more detail on scope of services offered through HCCI, see N. Pourat, et al, *Interim Evaluation of Health Care Coverage Initiative in California*, August 1, 2009.

Promising Results and Recommendations for Improvement

While it is still too early to fully evaluate the impact of the reforms implemented by HCCI counties, early indicators show significant improvements in access to quality services and local system operations.[7] Counties have adopted a number of policies and new approaches that, taken together, promise to be a strong foundation for over-arching system redesign and improved care delivery for indigent populations. Key strategies are highlighted below, along with ideas and recommendations that county officials and other stakeholders offer for consideration regarding how to improve or further support the goals of the HCCI.

Eligibility and Enrollment

Developing and implementing a formal enrollment process for HCCI, with membership or identification cards issued to individuals who are enrolled, has been identified by counties as critical to the transformation of a fragmented system of episodic care for indigent populations into an organized system of health coverage. A centralized enrollment system in each county has allowed counties to track and manage care for their enrollees. It has also enabled some counties to improve identification of individuals eligible for Medi-Cal and other public insurance programs. By tracking program eligibility, the county enrollment systems also assist with the renewal process, helping to improve continuity of coverage and care for enrollees. Ventura County is using the enrollment process to obtain a medical profile of new enrollees. Los Angeles County reports using HCCI to implement a Web-based application to access existing system data at enrollment to identify a new enrollee's usual source of care and prior use of services, and to assist with linking the enrollee to a medical home. San Francisco reports that the use of a single, transparent eligibility and enrollment system across all coverage programs offered in the county (e.g., Medi-Cal, Healthy San Francisco) has been an efficient tool to improve coverage in the county.

Alameda, San Francisco and San Mateo use One-e-App to manage the HCCI enrollment process. Other counties, such as Contra Costa and Orange, have developed their own enrollment systems.

Recommendations for the future

The following recommendations were suggested by county officials and other stakeholders based on county HCCI experience and innovation in eligibility and enrollment practices:

- Allow all residents to enter through a single eligibility and enrollment process, regardless of source of coverage or payer; consider creative options for increasing enrollment in coverage programs;
- Adopt alternative options for satisfying DRA documentation requirements or do not apply these requirements to medically indigent/waiver groups;

[7] For more details on early results as reported by HCCI counties, see N. Pourat, et al, *Interim Evaluation of Health Care Coverage Initiative in California*, August 1, 2009.

- Streamline and make eligibility determination more efficient. For example, allow community partners to approve eligibility, partner with county health plans to conduct eligibility and enrollment processes, or integrate more effectively with Medi-Cal, Healthy Families and other health care program eligibility and enrollment systems; and
- If HCCI models are expanded or rolled out into new parts of the state, consider standardizing eligibility and enrollment.

Organized Systems of Care

Each of the HCCI counties has created a more integrated way of delivering care to a target population of medically indigent adults. The effort to emphasize primary and preventive services has centered on the development of medical homes to serve medically indigent adults and the introduction or expansion of disease management care models for individuals with chronic disease conditions. For example, the Santa Clara HCCI has added to its primary care approach to by contracting with 12 clinics that serve as community-based medical homes, with each site demonstrating specific service capacity for an assigned group of HCCI covered enrollees. Orange County has expanded its covered benefits to included primary and preventive care to facilitate more effective care for people with chronic conditions. San Diego (and many other counties) has adopted evidence based disease management protocols to improve outcomes and reduce costs of care for target populations. A few counties, including San Francisco, Ventura and Santa Clara, had adopted a broad philosophy of managed care service delivery within their local delivery systems and have expanded this approach to include HCCI enrollees. In San Mateo, HCCI provided funds for the county to continue a "best practices" Innovation Clinic to provide comprehensive services and supports to covered populations.

Counties report they have modeled their HCCI projects on best practices, tested in California and throughout the country, on the development of medical homes and the design of chronic care or disease management strategies. All the HCCI counties have gone beyond the minimum requirements of providing enrollees with a usual source of care for primary and preventive services to initiate many of the elements of a patient-centered medical home. For example, all counties are using a physician-directed team-based approach in the delivery of care and have augmented teams to provide case managers or health educators to support chronic care management, care coordination, and linkage to community resources. All counties also have adopted quality assurance processes and are monitoring utilization, adherence to protocols and other measures. In addition, some counties have provided access to 24-hour nurse advice lines and even implemented patient satisfaction surveys.

Health information technology tools and systems are being used as a foundation of system redesign in several counties, with counties investing in improved coordination and information sharing between providers. Orange County has contracted with an outside vendor to develop an electronic health information exchange that is available to all medical home and emergency department physicians to support referrals to specialty

care and to provide access to pharmacy, lab and other clinical data. Other counties are using information technology to support patient tracking and care management.

The HCCI program has served as a catalyst to consolidate and spread earlier efforts to improve health system operations. Several counties noted the ability to implement new strategies with a smaller, target population has allowed the testing of improvements to clinical operations and improved accountability. Many counties cited the importance of HCCI in enabling the implementation of long-sought system improvements, with newly available federal funds supporting investments in new health information technology, clinic redesign, staff training and enhanced staff resources (e.g., care coordination staff). For example, Los Angeles County cited examples of long-stalled strategies for information sharing across providers that have been implemented under HCCI.

All counties described HCCI as resulting in newly engaged and enthusiastic clinical and administrative staff, from across the organizations within the delivery system, with a renewed focus on delivering improvements in system outcomes, efficiency and costs. All counties also noted the improvements being designed and tested under HCCI had important implications for other populations served within the county health system; some counties have already adopted HCCI strategies for other populations, while others anticipate doing so if final evaluations demonstrate the cost-effectiveness of strategies.

Recommendations for the future:

The following recommendations were suggested by county officials and other stakeholders based on county HCCI experience and innovation in organizing systems of care, including development of a medical home and chronic care management:

- Allow additional counties and all public hospitals to participate in an expansion of the HCCI program;
- Preserve county design flexibility within a framework of coverage expansion and delivery system reform (based on lessons learned in HCCI) that is more clearly defined by the state;
- Implement payment reform to better align reimbursement with overall system reform goals and eliminate current incentives that favor higher-cost settings such as inpatient hospitals without undermining the viability of the overall safety net;
- Combine all coverage programs and populations (including Medi-Cal) under a single strategy or organizational umbrella;
- Recognize the reality of federal approval and program start-up timeframes in designing a next phase;
- Consider options to address need for portability of coverage outside the county network;
- Encourage regional strategies (which might help with portability and reduce administrative costs);

- Provide more state/federal support for health information technology implementation and encourage that these investments be made in a systematic way, perhaps within a more standardized, statewide framework;
- Encourage counties, through program design parameters and increased resources, to include important services (e.g., mental health) as part of HCCI coverage design;
- Develop a more standardized, but practical, definition of a medical home model for HCCI;
- Integrate training regarding the medical home model into medical education;
- Expand best practices for chronic care management to more disease conditions; and
- Apply best practices from HCCI to other covered populations, including Medi-Cal, Healthy Families and California Children's Services.

Network Enhancement

Most HCCI counties have included a focus on enhancing the capacity and the operation of the local provider network. The most sophisticated approaches have involved an examination of enrollees' clinical needs, identification of service gaps in existing networks, and targeted expansion of networks to address specific service needs. Some counties have developed additional capacity in primary care. San Francisco, Orange and other counties have implemented information technology tools to improve the efficiency and effectiveness of referrals for specialty care.

Ensuring sufficient access to specialty care has been a particular challenge for counties, particularly as HCCI initiatives have focused on high-need populations with chronic health conditions. To improve access to both primary care and specialty care, many HCCI systems have developed or expanded on partnerships with non-county providers. For example, Ventura County relies heavily on publicly-operated clinics but also contracts with a private physician corporation to assure expanded primary care access. San Diego has enhanced funding to primary care clinics to enable them to establish referral relationships with targeted specialty providers. The expansion of public-private network arrangements raises questions about how to develop the most effective approaches to network governance and increases pressures for systems to enhance efficiency of resource utilization.

A more subtle change in network design was noted in some counties, where the focus on creating an organized system of care for medically indigent adults has resulted in the locus of care shifting from hospitals to community or outpatient sites of care. This shift has resulted in increased focus on and engagement of community health centers, clinics and other providers, and more of a "bottom up" approach to system design.

Recommendations for the future:

The following recommendations were suggested by county officials and other stakeholders based on county HCCI experience and innovation in network development and enhancement:

- Develop models of network governance to maximize efficiency, clarify responsibilities and increase collaboration among otherwise competing providers; and
- Identify additional models to offer improved access to lower cost primary care and preventive services, including "low touch, easy access" options for those who do not need full medical home supports (to counter concerns that local systems will not be able to develop sufficient capacity if the only model is "medical home").

Sustainability

One of California's goals for HCCI was for counties to develop strategies that would provide the grounds for long-term sustainability of the programs funded. Accordingly, the interim assessment process explored the issue of sustainability with the HCCI counties.

Several counties suggested that certain system reforms, for example, new health information technology tools to improve patient tracking and information sharing across providers, would likely be retained and used in the broader county health care system if the HCCI is not continued under a new waiver.

In addition, county officials reported that they expect to find many of the care management strategies being implemented under HCCI will prove cost-effective. Early results in some counties already are demonstrating changes in utilization that are consistent with more cost-effective care. For example, Ventura County reported a marked reduction in emergency department utilization for patients receiving nurse case management.[8] Similarly, Kern County has recorded a dramatic drop in the number of emergency room visits for patients receiving care management, and Orange County has experienced an increase in the percentage of generic prescription medication use. San Diego has measured improvements in the percentage of enrolled individuals who meet or exceed county goals for improved blood pressure, HbA1 measures and cholesterol (LDL) levels. Several counties report reduced inpatient days per member month.[9]

Yet county officials all cautioned that, without an on-going source of funding, efforts to formally enroll medically indigent adults into comprehensive coverage programs cannot be sustained. They explained that the level of previously unmet medical need in the medically indigent population, coupled with growing numbers of uninsured individuals relying on county services during difficult economic times, means the added costs of providing comprehensive coverage to larger numbers of uninsured adults simply cannot be fully paid for out of savings from reduced emergency room utilization or shorter inpatient stays.

Many of the county officials interviewed for this assessment expressed the belief that the system reforms being implemented or strengthened under HCCI, especially reforms that result in improved efficiencies in system operation and improved quality of care

---

[8] Diana Casey, Ventura County Medical Center, personal communication, September 11, 2009.

[9] N. Pourat, PhD, G. Kominski, PhD, D. Roby, PhD, A. Diamant, MD, MPH, Y. Meng, DrPH, C Reifman, MPH, *Interim Evaluation of Health Care Coverage Initiative in California*, June 2009.

(including the avoidance of preventable hospitalizations and other high cost services), are critical to the development of a health care system that has a reduced, more sustainable rate of cost growth over time. While, the health care system will be more cost-effective, the need for a predictable funding stream to assure coverage will remain.

Recommendations for the future:

The following recommendations were suggested by county officials and other stakeholders based on county HCCI experience:

- Develop a funding strategy to extend coverage to medically indigent adults that is sustainable and predictable;
- Recognize that HCCI is reaching only a small portion of the uninsured population and that California has a particular challenge regarding immigrant populations, many of whom cannot be included as covered populations for federal funding, even under a waiver.[10]

Options for a New Waiver

The state has three basic options in considering how it might incorporate HCCI into a renewal or replacement waiver and build on the foundations being laid under the current initiatives to cover medically indigent adults and develop more efficient and cost-effective local delivery systems. These options are discussed below.

Option #1: Provide funding to Continue Current HCCI Projects

There is strong interest in continuing or expanding the HCCI demonstrations under a renewal or replacement waiver. Current HCCI counties and other stakeholders argue the three-year demonstration period will simply not be long enough to fully leverage all that can be learned from the county initiatives being tested. Given the level of investment already made, and the promising results from the first eighteen months of operation, counties and other stakeholders recommend that, at minimum, the state could continue HCCI funding under the next waiver to gain the full benefit of the current demonstrations.

Option #2: Provide Additional Funding to Expand Current HCCI Projects to Cover More Indigent Individuals and Advance System Reforms

Current HCCI counties appear to have significant interest, if additional funding is made available, to extend the pilots to cover more individuals and, especially, to include additional conditions (including behavioral health) in the chronic care management protocols. Counties cite significant reform momentum in their local systems and believe the state as a whole would benefit from more fully leveraging the HCCI experience.

Option #3: Provide Waiver Funding to Expand HCCI Statewide

---

[10] P. Harbage, T. Sachs, S. Rosenstein, *California Medi-Cal Waiver Options*, prepared for California Department of Health Care Services, 2009. Available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA_Medi-Cal_Waiver_Options.pdf

Most local officials and stakeholders interviewed expressed the opinion that, as current HCCI programs demonstrate effectiveness, the state has the opportunity to broaden this effort into statewide reform. The interim assessment found strong interest among non-HCCI counties, both those with public hospitals and those without, in having the opportunity to implement reform pilots under an expanded HCCI demonstration. Counties were particularly interested in the development of medical home models, the implementation of chronic care management, and the development of health information technology to support more efficient information sharing.

An expanded HCCI could further leverage county health care funding to improve care and access for the uninsured. While only 10 of California's 58 counties are currently participating in the coverage initiative, these counties are home to over 64 percent of California's uninsured adults between the age of 19 and 64. Five non-HCCI counties – Riverside, San Bernardino, Fresno, Sacramento and San Joaquin – are home to another 19 percent of the state's uninsured adults; the majority of these counties applied to participate in HCCI under the current waiver but failed to win one of the limited number of pilot opportunities. In addition, another 34 of California's counties are already organized into a single collaborative, the County Medical Services Program (CMSP), for purposes of serving the medically indigent under Section 17000. CMSP also applied for the HCCI pilot in 2007, but was not selected. If these five counties and CMSP were added to HCCI, California could implement coverage reforms that could more than 90 percent of the uninsured in the state with only six additional pilot sites (fewer if more counties were interested in regional collaboratives).[11]

HCCI Refinements and Reforms

Under any of the options outlined above, the state has the opportunity to incorporate design reforms and enhancements to reflect lessons learned in the initial HCCI projects and to encourage enhancements that will improve outcomes and effectiveness of future coverage expansion efforts by the counties. Some recommendations include:

1. Within a new HCCI, the state could establish a more standardized framework for county initiatives, but should continue to allow county-level design flexibility.
    - Designate an extended, standardized set of chronic conditions that should be addressed, with flexibility to include additional conditions based on local priorities;
    - Take the lead in sharing best practices across counties with regard to chronic disease management;
    - Work with counties and experts to develop a more comprehensive yet realistic set of characteristics to guide medical home development;
    - Encourage/incentivize the inclusion of mental health or dental care benefits in benefit design; and

[11] Authors' analysis of 2007 California Health Interview Survey (CHIS) data (http://www.chis.ucla.edu/).

- Establish statewide parameters for the adoption of electronic supports for improved information sharing, including specialty care referrals, electronic medical records, and patient registries.

2. A new HCCI design could encourage regional as well as county-specific coverage and system reform models.
3. A new HCCI design could encourage counties to test streamlined eligibility and enrollment strategies that encourage enrollment in health coverage programs and maximize enrollment in Medi-Cal and Healthy Families.
4. The state could encourage HCCI projects to test alternative payment mechanisms (including episode of care or capitated methodologies) that create improved incentives to provide services in the most appropriate and cost-effective settings.
5. A new HCCI design could encourage projects to develop coverage and reform strategies with applicability to broader populations, including but not limited to Medi-Cal enrollees, immigrant populations and other groups that rely on local health systems for access to care, with a goal of creating efficiencies across payers and administrative entities and increased sustainability of reforms.
6. A new HCCI design could encourage projects with increased focus on effective network design and operation and could allow creation of alternative strategies to increase access to both primary and specialty care.
7. An expanded HCCI could establish a clear set of performance measures that focus on increased numbers of individuals enrolled in coverage and the cost-effectiveness of care management strategies. These measures would be most effective if incorporated into initial project design to accommodate more complete reporting.

Conclusion

HCCI has provided the opportunity for California counties to play a leadership role in designing and testing fundamental health system reforms that offer comprehensive coverage through organized delivery systems for medically indigent populations. HCCI has driven innovation at the county level, providing participating counties, local public hospitals and local public-private partnerships with the opportunity to design and implement more effective systems of care for medically indigent adults in California.

California has the opportunity to more fully realize the value of current county efforts by extending the opportunity for county participation statewide, leveraging local public funds and thereby increasing the availability of federal funds to cover more people and more chronic conditions. Through an extension of HCCI, counties can continue to serve as laboratories for developing, testing and institutionalizing elements of comprehensive health system improvements in county indigent care systems. These improvements, in turn, also can benefit Medi-Cal and other populations served by local health systems, especially those with chronic and disabling conditions. Perhaps more importantly, these improvements in the efficiency of health care systems will be critical to the long-term sustainability of national health reform strategies.

Appendix A: Interviews Conducted

HCCI Counties

Alameda County

Contra Costa County

Los Angeles County

Orange County

San Diego County

San Francisco County

San Mateo County

Santa Clara County

Ventura County

Other Stakeholders

California Health and Human Services Agency

California Department of Health Care Services

California State Association of Counties

County Medical Services Program

Fresno Healthy Communities Access Partners

Insure the Uninsured Project

Riverside County

The California Endowment