

REPORT

Health Access Foundation

November 2013

California's Uneven Safety Net: A Survey of County Health Care

*Expanded Coverage, But Big Disparities for Those Left Without Coverage
Counties About To Decide the Future of their Health Care Safety Net*



HEALTH ACCESS FOUNDATION

CAPITAL

1127 11th Street, Suite 234, Sacramento, CA 95814 (916) 497-0923

NORTHERN CALIFORNIA

1330 Broadway, Suite 811, Oakland, CA 94612 (510) 873-8787

SOUTHERN CALIFORNIA

1930 Wilshire Blvd., Suite 916, Los Angeles, CA 90057 (213) 413-3587

www.health-access.org

blog.health-access.org

www.facebook.com/healthaccess

www.twitter.com/healthaccess@HealthAccess

INTRODUCTION

The historic expansion of coverage under the Affordable Care Act in 2010 will provide new and more affordable coverage options for millions of Californians, and dramatically reduce the number of uninsured by one-third to half and maybe more. California can and should continue to lead efforts to maximize the benefits of the new law, including maximizing eligibility and enrollment in Medi-Cal, Covered California, and employer-based health coverage.

But for the many Californians who are left uninsured, there needs to be a robust safety net to provide basic care and coverage, to prevent the devastating health and financial consequences to individuals and families and prevent the public health and economic repercussions in our communities. By most estimates, a few million Californians will remain uninsured, with a majority who will be citizens or lawfully present residents, and those who remain uninsured disproportionately Latino and also include the diversity of California, including African American, and Asian-Pacific Islanders. Some will not be eligible due to income or immigration status or for missing deadlines or open enrollment periods, or otherwise exempt from the requirement to maintain coverage.

Counties will continue to be responsible for providing care to the medically indigent in their communities, but, as in the past, they have considerable discretion as to who they serve and the level of care they provide. Health Access and community partners surveyed the counties to better understand how they plan to respond to changes in financing and coverage under the ACA. **The survey found that despite dramatic and exciting progress in key counties in providing a medical home to the remaining uninsured, California will continue to have a highly variable patchwork of indigent care and safety-net programs and services. More critically, depending on upcoming decisions at the county level, in some counties consumers may have less access to care than before.**

California is at a pivotal moment in the next month and next year in deciding how we continue to care for all our residents and families. California can decide to simply implement the minimal expectations of the Affordable Care Act, but allow many to be left out, relying on a remaining safety-net struggling with reduced capacity and support. Or our counties and ultimately our state can fulfill the full promise of the law, and embrace a vision that this effort to cover everyone truly includes everyone.

Key decisions will be made by counties throughout the state in the next couple of months, and in the next year, on both whether they are maximizing the opportunities in the law to enroll Californians in federally-funded coverage, and what kind of safety-net will exist for the remaining uninsured. This survey provides a quick snapshot of what counties are doing now, what they are thinking about doing in the future, and recommendations for action at both the county and state level.

CALIFORNIA'S CURRENT SAFETY NET

California has the largest number of uninsured residents in the nation, and one of the highest rates of uninsurance, seventh in the nation according to the U.S. Census Bureau. This has dramatic health and financial consequences for our fellow Californians: someone who is uninsured lives

sicker, dies younger, and is one emergency away from financial ruin. Having a high percentage of uninsured also has public health and economic consequences for the community as a whole.

People who are uninsured typically delay and are sometimes denied care because of lack of insurance. Paying medical bills out-of-pocket can get expensive quickly, especially for those without much to begin with. While many consider hospital emergency rooms as the nation's safety net, the only requirement is that a hospital must stabilize a patient in an emergent situation. So while an ER will treat the heart attack or gunshot wound, a private hospital has the ability to turn away a patient with cancer or diabetes. Without insurance, a severe asthma attack will be treated, but care to manage asthma is not necessarily provided. Also, in these emergency situations, hospitals bill uninsured patients, and these charges quickly run in the thousands of dollars even if the patient is not admitted to the hospital.

For care to the uninsured outside the hospital emergency room, there is a private safety-net of community clinics in many but not all locations, and hospitals that sometimes (and unevenly) provide "charity care," sometimes in recognition of the nonprofit tax status that some of them benefit from.

Counties have an obligation to provide care and coverage for low-income Californians left uninsured, particularly the "medically indigent adults" that do not qualify for Medi-Cal or other state or federal programs. This is often referred to as the counties' "17000" obligation, named after the Welfare and Institutions Code section of the state requirement. Counties have interpreted and responded to this requirement widely and wildly, reflecting each county's specific circumstances, demographics, politics, and resources. Court cases and litigation have provided some guidelines for specific instances.

Counties have interpreted and responded to this requirement widely and wildly, reflecting each county's specific circumstances, demographics, politics, and resources.

Twelve counties run public hospital systems, in most cases accompanied by a network of county clinics. These typically large and urban counties, which include Alameda, Contra Costa, Kern, LA, Monterey, Riverside, San Bernardino, SF, San Joaquin, San Mateo, Santa Clara, and Ventura, thus provide a range of services, from an emergency room to primary and preventative services.

Another twelve counties are known as "payer" counties, which contract with a private health care providers, like clinics and community hospitals, to fulfill their indigent care obligation. These counties are Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and until recently, Yolo.

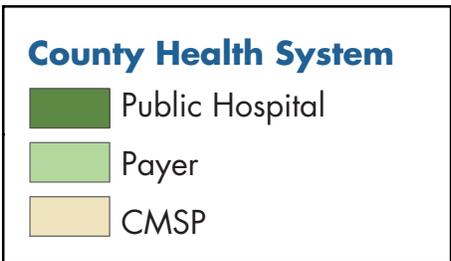
Finally, the remaining 34 small, often rural, counties belong to the County Medical Service Program (CMSP) consortium, which offers basic enrollment-based coverage for those who qualify. Yolo County recently joined CMSP's Low Income Health Program earlier this year.



PUBLIC HOSPITAL: Alameda, Contra Costa, Kern, LA, Monterey, Riverside, San Bernardino, SF, San Joaquin, San Mateo, Santa Clara, Ventura;

PAYOR: Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare.

CMSP: All others



The range of services provided by these counties varies, as does who is eligible for free or reduced-cost help. Our survey indicates a highly uneven safety net around the state, where it is even hard to make apples-to-apples comparisons between what the counties offer, given the details of each counties' programs. Much of this information is hard to come by, often not put on websites or publicly available sources—perhaps intentionally.

Counties have income-based eligibility requirements to get free or low-cost care, although they range in terms of what the threshold is and that threshold is usually tagged to a percentage of the federal poverty level. Virtually all counties will consider assets when considering eligibility. Some counties like Santa Clara, San Francisco or Ventura have programs that go past three times the poverty level (although with cost-sharing expected at these higher incomes), where other counties like Fresno have programs at or below the poverty level. Some counties require co-payments even for relatively low-income residents, and in other cases, more onerous cost-sharing in order to get care.

The range of services also varies among counties. For instance, Alameda County provides mental health services through its indigent care program while Fresno County does not. Similarly, San Bernardino County provides for vision services while Sacramento County does not.

In addition to an income-based eligibility requirement, some counties like Santa Cruz, Merced, and Monterey require an individual to have a current medical need in order to be eligible for services, and have a very short period of eligibility to get such services. Other counties will provide primary and preventative care, and have a year's eligibility to get services before re-applying.

Some California counties provide their safety net health services without regard to immigration status, but a majority of counties restrict who they serve to only those immigrants with legal documentation.

Those that offer such services to all their residents include Alameda, Fresno, Kern, Los Angeles, Riverside, San Francisco, San Mateo, Santa Clara, and Santa Cruz. (Contra Costa covers undocumented children but not adults.) Those that restrict who they serve to citizens and immigrants lawfully present in include the 35 counties in CMSP as well as Merced, Monterey, Orange, Placer, Sacramento, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Tulare and Ventura County.

The survey highlights the fact that this information is not readily available to policymakers, the press, or the public. There is no one or two variables that determine a county's performance: there are counties that provide robust services, but not for the undocumented; others that offer good benefits, but to a low income threshold before onerous cost-sharing kicks in; yet others that are fully inclusive in who they cover but have limitations in what they offer.

Prior to the Affordable Care Act, any uninsured Californian had dramatically different access to basic care based on what county they lived in. The ACA provides a new expectation and right for the California adult without children at home with an income around or below the poverty level. Before, she would find herself not eligible for Medi-Cal, thus at the mercy of what the county she lived in did—or did not—provide. Now, she and over a million other Californians like her have ac-

cess to full Medi-Cal coverage, regardless of where she lives. And more have access to private health insurance with financial help, through Covered California.

A BRIDGE TO HEALTH REFORM: LOW INCOME HEALTH PROGRAMS

With the enactment of the Affordable Care Act in March, 2010, many of the uninsured have new options and benefits. In 2014, Medicaid (Medi-Cal in California) will expand to include all non-elderly lawfully present residents under 138% of poverty level, including adults without children at home, who were previously excluded. Those over 138% but at or below 400% will have access to subsidies for private coverage in the state's new health insurance marketplace or exchange, called Covered California.

California was one of only seven states in the nation to work to take advantage of this remarkable opportunity to expand coverage early, before 2014. As the state undertook this early expansion, the county safety-net got a big opportunity to improve and innovate. Under the Affordable Care Act and a Medicaid waiver with the federal government approved in 2010, California counties who provided Medicaid-like coverage to those adults under 133% of federal poverty level could get federal matching funds.

Through these Low Income Health Programs (LIHPs), counties get federal matching funds to provide coverage that go beyond providing episodic and emergency care, to providing a real medical home, one that offers preventive and primary care, as well as other services. Some counties have been able to serve more people, and have used these new resources to better innovate integrate this health care with others services like mental health. The LIHPs have been a source of innovation and improvement for the safety net.

Ultimately, 53 of 58 counties chose to set-up LIHPs: from the ten counties that started in 2011 having had earlier pilot programs for providing such coordinated care through a previous waiver, to a few that didn't start until earlier this year in 2013 (Monterey, Sacramento, Tulare).

Five counties declined to set up a LIHP, the biggest by far being Fresno, and also including Santa Barbara, Merced, Stanislaus, and San Luis Obispo. These counties lost out on federal matching dollars through 2013, and won't get the ongoing benefit of having residents already in systems of care, ready to be automatically covered under Medi-Cal for January 1, 2014 and beyond.

Counties with LIHPs had to abide by many federal standards in terms of benefits, which are similar what the new Medi-Cal expansion benefits will be. As a "bridge to health reform," LIHP eligibility criteria had to be aligned with those who would be newly eligible for Medicaid coverage, meaning they could only serve citizens or those with legal immigration status. Counties had the discretion to set eligibility levels, up to 133% of the poverty level for the LIHP Medicaid Coverage Expansion (MCE) program. (If counties go up to 133% of the poverty level, counties could set up separate program LIHP Health Care Coverage Initiative (HCCI) program for those from 133-200% of the poverty level—a handful of counties that had previous local initiatives sought this option.)

LOW INCOME HEALTH PROGRAM

Upper Income Eligibility Criteria by County

Counties	Started at 200% FPL	Started at 133% FPL	Increased to 133% FPL	Less Than 133% FPL	No LIHP
Alameda	X				
CMSP				X (100%)	
Contra Costa	X				
Fresno					X
Kern			X (from 100%)		
Los Angeles		X			
Merced					X
Monterey			X (100%)		
Orange	X				
Placer			X (100%)		
Riverside		X			
Sacramento				X (67%)	
San Bernardino				X (100%)	
San Diego		X			
San Francisco			X (25%)		
San Joaquin			X (80%)		
San Luis Obispo					X
San Mateo		X			
Santa Barbara					X
Santa Clara			X (75%)		
Santa Cruz				X (100%)	
Stanislaus					X
Tulare				X (75%)	
Ventura	X				

Notes:

- *Grey denotes counties with no LIHP*

MAXIMIZING ENROLLMENT

Beyond providing more coordinated and high-level care, another benefit of these LIHPs is that they have identified and enrolled over 600,000 Californians in coverage—just about half of the Medicaid expansion population. These Californians are then ready to be shifted to full state Medi-Cal on Day One, January 1, 2014. The goal and expectation when the LIHPs were created in 2010 was that enrollment would be about 500,000 so the LIHPs are already a success story.

In these final months of 2013, counties can use LIHPs to drive Medi-Cal enrollment even further and perhaps go beyond 750,000 Californians as a starting figure for the Medi-Cal expansion.

Some counties started out eligibility for the LIHP program at 133% of federal poverty level, including Alameda, Contra Costa, Los Angeles, Orange, Riverside, San Diego, San Mateo and Ventura/ Some counties actually started their LIHPs as pilot projects in the previous Medicaid waiver (Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura) and many went up to 200%, but at a capped amount of money. Many of them went to 133% to first take advantage of their uncapped resources, but four counties continue to aggressively enroll people above 133%: (Alameda, Contra Costa, Orange and Ventura).

Others began at lower income thresholds, typically at poverty level but a few even lower. The good news is that in their last year, six counties ramped up their eligibility, recognizing the health and financial benefit of getting more of their residents enrolled: Kern, Monterey, Placer, San Francisco, San Joaquin and Santa Clara.

Some counties are already doing aggressive LIHP enrollment, recognizing that everybody enrolled in a LIHP/Medi-Cal this year will be shifted into full federally-funded Medi-Cal in January 2014. In our survey, many county leaders recognized that a small investment in enrollment in these largely federally-funded efforts means relieving the county of financial obligations in future years.

As of this writing, the only counties with a LIHP that have not upped their eligibility to 133% of the federal poverty level are Sacramento, San Bernardino, Santa Cruz, Tulare, and the CMSP counties. In conversation, many of them claim that they have already hit the limit of the budget decided by their boards of supervisors.

DECIDING THE SAFETY-NET OF THE FUTURE

As Californians in Low-Income Health Programs will be transferred to Medi-Cal on January 1, 2014, counties are now determining what options and services are left for the remaining uninsured.

Some counties are taking advantage of the capacity and innovation that came from the LIHPs to serve the remaining uninsured. Other counties are considering retrenching, possibly reducing benefits, services, eligibility, and funding.

The next few months in the short term, and the next few years, will determine the future of California's safety-net.

THE REMAINING UNINSURED

Modeling by the University of California suggests that there will be three to four million remaining uninsured, after the first five years of ACA implementation in 2019. Of this remaining uninsured population, half will be eligible for a federally-funded coverage through either Medi-Cal or Covered California. The biggest challenge will be how to maximize enrollment, to get as many Californians signed up.

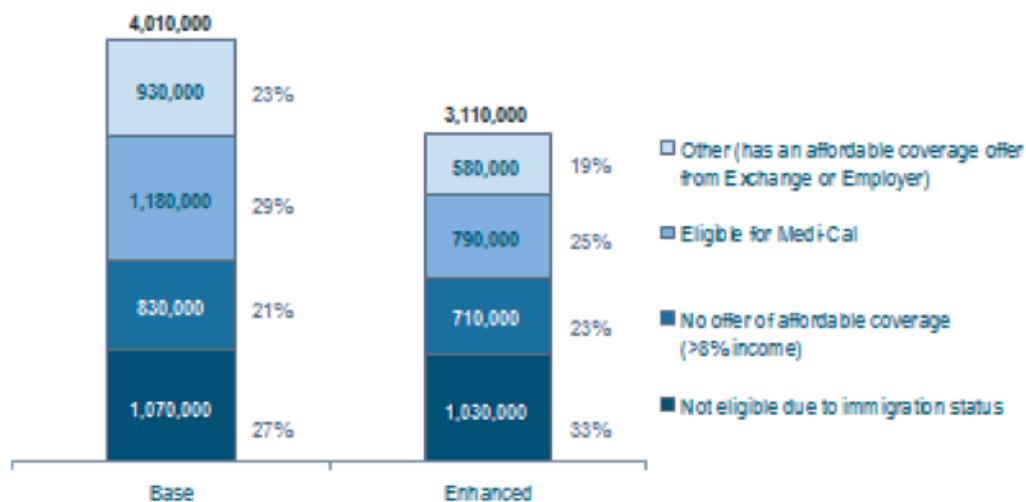
But there will be a remaining uninsured population without an affordable offer of coverage, one that will remain the responsibility of the counties to provide safety-net care and coverage.

For those under 133% of the poverty level, most Californians will be eligible for Medi-Cal coverage—with no premiums or open-enrollment periods as a barrier.

- Most left uninsured under 133% of the poverty level are those who are eligible for Medi-Cal but not enrolled. These could be citizens who lack awareness of the program or their eligibility or have trouble with the enrollment process.
- Another group under 133% of the poverty level who will be uninsured will be undocumented, who are explicitly excluded from federally-funded health coverage under the ACA.

3-4 Million Californians are Predicted to Remain Uninsured in 2019

Uninsured Californians under age 65, 2019



Source: UC Berkeley-UCLA CalSIM model, v1.8

For those over 133% of the poverty level, in addition to undocumented immigrants, there are other Californians who may remain uninsured and unable to get subsidized coverage:

- For those who may be eligible for subsidized coverage in Covered California (those over 133% of the poverty level), there may still be barriers of affordability. About a fifth to a quarter of the remaining uninsured will be exempt from the individual mandate for reason of lack of an affordable coverage option.
- Some of the remaining uninsured will be family members of workers with job-based coverage, but who don't get or qualify for family coverage or Exchange subsidies. (This has been known as the "kid glitch" or "family glitch.")
- Because of the barrier to individual insurance coverage created by open enrollment periods, some individuals will fail to take up coverage during the open enrollment and will need care when they lack coverage.
- Even with special enrollment periods, some will drop off coverage during transitions in life and work, not sign up for new coverage in time, and need care before the next open enrollment period.

THE REALLOCATION OF SAFETY-NET DOLLARS IN THE 2014 BUDGET

Starting in 2014, the number of the remaining uninsured—especially those that are not eligible for existing federal or state assistance with care and coverage—will be reduced sharply

Because of this fact, the state sought to reallocate health dollars that previously went to serve the remaining uninsured. In the 2013-14 state budget, the state requires counties to choose between two formulas that will determine how much the state will take back from the safety-net funding streams.

For 2013-14, \$300 million will return to the state. For 2014-15 and thereafter the share shifted to the state depends on the formulas chosen by the counties. The agreement gives most counties a choice of which formula to use:

- **The 60/40 split:** Counties can choose to give back 60% of health realignment dollars (including the county maintenance of effort contribution) to the state and retain 40% of the dollars for public health and indigent care. This was designed for the counties that do not operate public hospitals such as Fresno, Orange and San Diego but is available to counties that do operate public hospitals as well. This formula refers to "indigent" care, which is the language of long-standing law that speaks of the counties' obligation to "relieve the indigent lawfully resident therein." CMSP counties, made up of the small rural counties, will choose this formula as a group, and will go from an enrollment-based program

of \$225 million in state funds to, after the counties' public health programs are protected, about \$35 million or so to provide care for the remaining uninsured.

- **The 80/20 “Hospital” or “cost-based” formula:** Counties can choose a more complicated formula that is intended to ensure the viability of public hospitals post-ACA. The formula is based on actual costs, including costs of care for the uninsured (within a cost cap based on historical spending to limit any expansions of service), as well as actual revenue—including that of Medi-Cal, Covered California, and other private-pay patients. After accounting for actual costs and actual revenue, any savings are split 80/20 between the state and the counties. For most counties with a public hospital, this will be a better deal financially than simply handing back 60% of the health realignment dollars. The legislation defines “uninsured patients as individuals who have no source of third-party coverage for the specific service furnished.”

These funding streams have traditionally funded both public health and the safety-net for indigent care. The public health work includes tracking of diseases as well as broader preventative efforts against tobacco use, youth smoking, teen pregnancy, and much more. This public health work also includes the new efforts that the Affordable Care Act encourages, centered on community transformation grants to encourage walking and active lifestyles, to promote healthy eating, and to engage in other efforts that are policymakers' best shot at improving health and reducing health care costs. From emergency preparedness capacity to advancing key public health goals, public health funding is also crucial alongside indigent care.

As counties make these decisions about funding and formulas in the next two months, they are likely to also decide what kind of safety net they will continue to provide for the remaining uninsured.

FULFILLING THE FULL PROMISE OF THE LAW

Some counties see the opportunity, using the ACA coverage expansions as a platform, to ensure access to care and coverage for all of their residents, so everyone is eligible for something, and to efficiently use the safety-net resources that remain to provide primary and preventative care for the remaining uninsured as well as those insured through Medi-Cal or other sources.

Los Angeles, Alameda, San Francisco, Santa Clara, San Mateo, and other counties are using the infrastructure developed under their LHPs to provide coverage to the remaining uninsured including the undocumented. These successor programs will have different enrollment criteria (since most current enrollees will have Medi-Cal), and often slightly differ-

ent benefits and costs—but the counties have built up enrollment and appeals systems, contractual relationships with providers, staffing of help centers, policies and procedures, and are now dedicating these built-up resources to the remaining uninsured population.

This is an exciting development, where counties are building upon their previous success to provide safety-net services in a better and more integrated way. One county has a brochure entitled “Now We Can Say Yes,” which implies that as opposed to being gatekeepers, the county’s main task is to be a facilitator of enrollment in whatever of a range of coverage options. And in these counties, if someone comes in and isn’t eligible for either Medi-Cal or Covered California, there is a third option offered by the county—not everybody is eligible for everything, but everybody eligible for something.

RETRENCHMENT

Other counties, seeing the reductions of safety-net funding streams from both federal and state sources, are discussing cutting services and capacity for the remaining uninsured. CMSP has voted to reduce the period during which an individual is covered from 6 months to 3 months, and is considering cutting benefits like dental, vision, mental health and substance abuse. Fresno and Merced need to renegotiate contracts with private providers. News reports indicate that public health systems in Riverside and Kern are facing financial deficits.

Other counties were threatening certain cuts, but seem inclined at this point to not make decisions to cut services, eligibility, or benefits—they are waiting to see what happens with Covered California enrollment and their own experience in the first year. Health and community advocates need to be involved in these discussions over the next year as counties revisit these issues when they review budgets and goals in spring 2014.

THE SURVEY

This survey reveals that while California makes great strides in expanding coverage under the Affordable Care Act expansions and additional county efforts, for the remaining uninsured population, we will be left with an uneven safety-net.

The methodology of the survey was that Health Access asked that key community partners approach their county administrators and/or health department to ask them a series of question about their existing safety-net, and their plans in the future. We greatly thank both our community partners and the county staff and leaders for their time and candor. Inevitable, there will be some misheard or misunderstood information, or problems in translating as Health Access compiled the data. Finally, the reason we are doing this survey is because we are in a time of transition, and some decisions are being made as we

speak, so the information is also changing.

So while we tried to fact check against other sources, Health Access takes full responsibility for any errors, and will welcome corrections. We consider this “draft one” of an evolving document, will post updated versions on our website when appropriate, and that we plan to revisit and reissues the report after we pass this initial implementation period in early 2014.

Health Access remains indebted to two studies before us, by the California Health Care Foundation in 2009, and another by the Public Policy in California (PPIC) more recently, which provided a framework of the California safety-net. In many ways, this is an attempt to update those studies during a crucial period of transition.

The appendix devotes a page to each of the non-CMSP counties, detailing their LIHPs and their remaining uninsured group. It is important to remember that the benefits and eligibility for the LIHPs were largely determined by the federal government. So the LIHPs could not include the undocumented, for example. Counties had discretion to set the eligibility level in terms of the federal poverty level, and to see how much they wanted to enhance and integrate a service like mental health. Where counties have more leeway is the medically indigent program, for the remaining uninsured. The survey details the rough outlines of the existing program.

Again, we offer the strong caveat that no one or two variables can be representative of a counties generosity or symbol of investment in public health. The survey does not capture a lot of detail about required cost-sharing, level of need requirement or other factors that sometimes make it very hard to get the care that may be available on paper.

That said, the survey shows the great diversity in what counties do and don't do for the remaining uninsured, as well as their initial thinking as they decide about funding formulas and what their safety nets look like in the future.

Health Access hopes this survey spotlights the decisions that counties are about to make, and spur community organizations and the public to engage with their counties ASAP about their interest in having a safety net that survives and thrives into the future.

CALIFORNIA'S CONDITIONAL COMMITMENT TO COVERING IMMIGRANTS

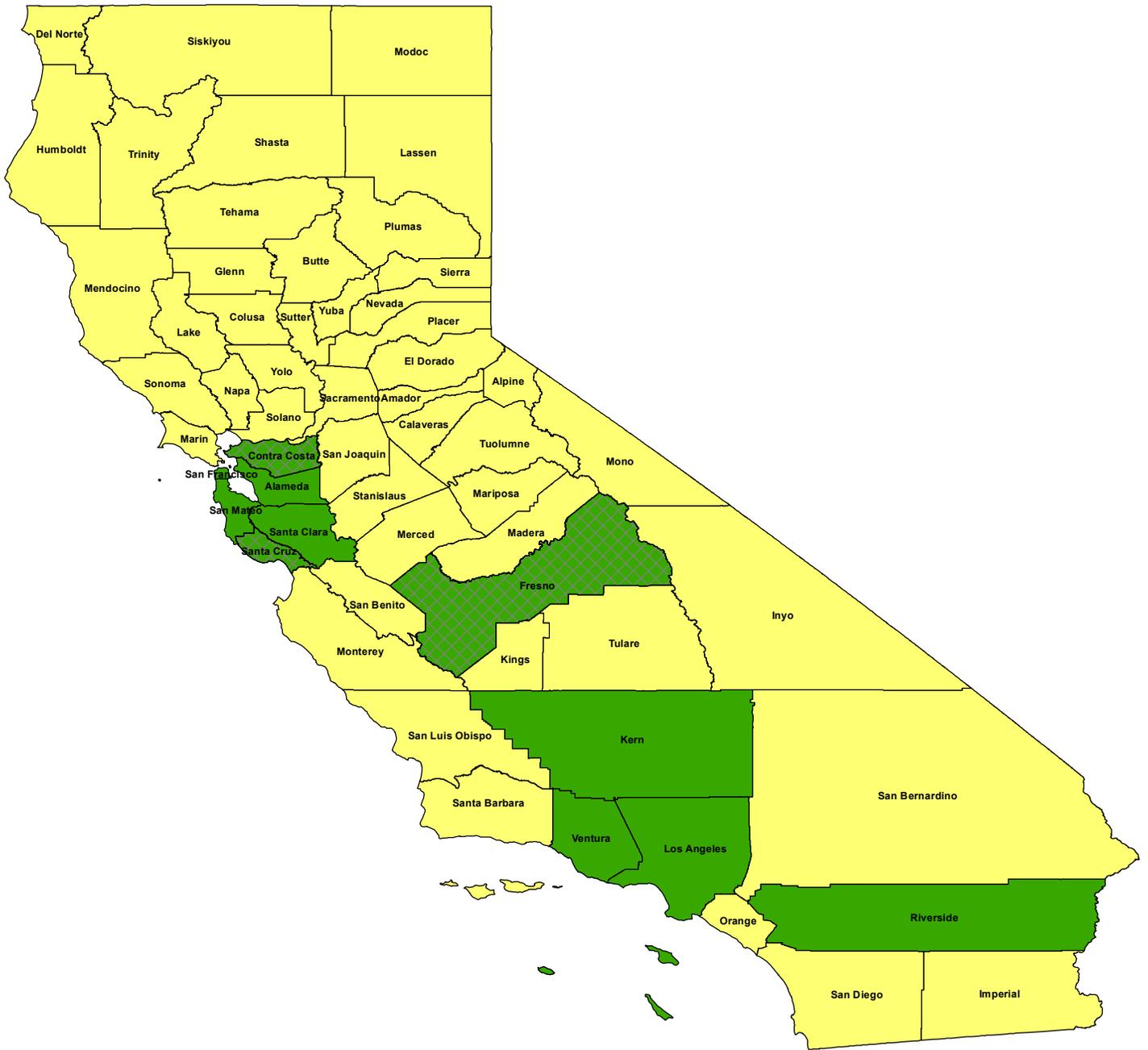
Nowhere is the California safety-net more uneven than in its treatment of undocumented immigrants. Some counties include all their residents in the safety-net services they provide, including coverage with a medical home. Other counties do not consider the undocumented immigrants as residents of their state and county, and thus not their responsibility. In those counties, the undocumented must rely on private clinics or providers, or face the financial burden of going to an emergency room as a self-pay patient. Study after study indicates that the long-term uninsured (including the undocumented) simply go without care and that when they receive care, the financial burden of that care is great.

While not a majority of the remaining uninsured now or even after ACA implementation, the undocumented are a sizable population. According to the UCLA-UC Berkeley CalSIM model, about 1 million of the remaining uninsured will be immigrant Californians who are not lawfully present; federal law expressly and unfortunately excluded these Californians from Medicaid and the Exchange by the federal law. The undocumented, now about 20% of the uninsured, are estimated to be 27-33% of the remaining uninsured after full implementation of the Affordable Care Act.

California has already taken steps at statewide solutions for specific immigrant populations. For example, federal Medicaid law has traditionally excluded recent legal immigrants who have been in the country for less than five years, but California (and New York) have included them in Medi-Cal using state funds without the federal match. In the Affordable Care Act, these recent legal immigrants continue to be barred from Medicaid coverage, but are able to get subsidies in the Exchange, including those at or around the poverty. In implementing the Medicaid expansion, California decided to continue state-only Medicaid for those recent lawfully present immigrants who are already eligible. Those newly-covered legal immigrants without children who are barred from Medicaid would get subsidies in Covered California, but California would provide “wrap-around” coverage to protect them from the higher premiums and cost-sharing in the Exchange for this low-income population. In this way, this group will get Medi-Cal levels of benefits and cost-sharing.

California has continued and extended similar coverage to immigrants who are designated as PRUCOL (Persons Residing Under the Color Of Law), those who may not have a green card but who are in this country and who there is not an intention to deport. This category has included refugees, and more recently, DREAM Act students that have applied for deferred action for childhood arrivals (DACA), who are otherwise not eligible for subsidies.

These efforts for lawfully present immigrants do not provide assistance to undocumented im-



County Funding for Undocumented Immigrant Health Care

- Provides a Medical Home
- Does Not Provide a Medical Home
- Restricted Eligibility

Date: 11/1/2013

migrants. While neither Medicaid nor the Affordable Care Act provides federal subsidies for coverage for undocumented immigrants, Medicaid does provide limited reimbursement to providers for emergency services provided to low-income residents who don't otherwise qualify for Medi-Cal. Under the ACA, this reimbursement is extended to include emergency care for low-income childless adults. This is a significant new funding source for safety-net health providers who provide emergency care to undocumented persons.

Such policies still leave a huge gap for California's undocumented immigrant population being able to access and afford basic care and coverage.

The most obvious solution is comprehensive immigration reform that allows undocumented immigrants to come out of the shadows and to accept both the rights and responsibilities of citizenship, including those about health care and coverage. Yet the immigration reform proposals currently being considered in Congress would require a "path to citizenship" of over a decade, and those on this path would be barred from any federal assistance for health coverage.

So immigration reform is unlikely, by itself, to resolve the issue of health care for the undocumented. Passage of immigration reform at best will force the question to a more local level: will the health of newly aspiring citizens under reform be the responsibility of the state, the counties, or some combination?

Even without reform, there will be a strong interest from the health care sector and immigrant communities to find a resolution for the remaining uninsured population, rather than ensure an unsustainable situation for many more years.

Statewide solutions are preferable, perhaps building off state-only programs provided to recent legal immigrants. Like with any coverage expansion, financing presents a challenge. (Yet unlike past state proposals for health reform, the comparatively smaller size of the remaining uninsured population is a smaller financing hurdle than past efforts.) For those over 138% of poverty, who are excluded from the Exchanges regardless of subsidy, the question is whether the state can offer some of the options under the Exchange, if not the subsidies.

With the absence of a statewide solution, the only hope for undocumented immigrant families lies with the counties. Many counties do provide basic primary and preventative services to the undocumented, but many do not. (Some also had "Healthy Kids" and other commitments to cover all children including undocumented children, but many of those programs were suspended in recent years due to lack of funds).

Three counties that don't provide coverage to undocumented adults (Contra Costa, Sacra-

mento, and Yolo) made that decision relatively recently, in 2009, at least partly as a result of the severe recession. Those and other counties can and should now look to revisit the question of covering the undocumented in the next year or two.

For a county not providing care to the undocumented, they have virtually no financial obligation for anybody under 138% of poverty level since anybody who is not undocumented can be presumptively enrolled in Medi-Cal. If those counties do have eligibility levels over 138%, they may not get much take up— if that region does a great job in enrolling people in Covered California, because some counties impose a fairly onerous share-of-cost above 138% of poverty level, or because by definition this would be a population that is hard to reach. The fiscal flexibility resulting from these facts, even considering state and federal reductions in funding, may mean that there are resources to direct to the remaining uninsured population of these counties.

Health Access urges counties that do not cover the undocumented to reconsider, and to look closely at the financial experience to see what flexibility is available.

RECOMMENDATIONS

Ultimately, California needs to have a strong safety-net and ultimately ensure that all Californians have access to basic care and coverage.

- **California is stronger when every person has access to care and coverage**, creating healthier and more financially stable families and communities. While preserving the flexibility and diversity of different counties and regions, every Californian should be have the dignity and security to access basic care and coverage, so they are best able to thrive and contribute to their community.
- Consumers who are left uninsured will eventually, by age or accident, find themselves in our emergency rooms and health system. **California has an interest in providing primary and preventative care early, rather than more expensive and intrusive care when it is too late.**
- California has always seen immigration as a source of strength and pride—and accordingly has made investments in our future. A portion of the remaining uninsured will be new American immigrants who will be on a roadmap to citizenship. California has a stake in their health and success. **Including immigrants in safety-net care and coverage is an investment in the future of California.**

We recommend that the state and county work to **maximizing ACA enrollment and federal funds:**

- Counties should actively engage to ensure that the Californians in LIHP are smoothly switched into Medi-Cal coverage for Day One, January 1, 2014.
- Counties should conduct aggressive outreach and enrollment in their LIHPs for the remainder of the year.
- As six counties have done, counties should lift any enrollment caps and expand eligibility up to the 133% level, so they may get as many people in the system to be transferred to full federally-funded Medi-Cal on January 1, 2014.
- Counties should take advantage of new funds from The California Endowment and the state to conduct Medi-Cal education and enrollment. (As of this date, X counties have.)
- Counties should also explore how to use existing human services and other programs as ways to identify potential populations for outreach and enrollment
- Counties should select the new option to suspend redeterminations in order to retain their enrolled LIHP populations throughout the transition period, and avoid confusion. (As of this writing, all counties who are eligible—those that started their LIHP at least a year ago—have taken up this option.)

California can, and should, fully expand the coverage options in the Affordable Care Act *and* ensure access to care and coverage to the remaining uninsured, including the undocumented aspiring to be citizens.

We urge consideration of state solutions, including expanding state-only Medicaid, partnerships with willing counties, and the provision of Exchange-like options.

In the absence of a state solution, and we recommend that counties commit and **plan for how they can provide care and coverage for all their residents.**

First, Health Access recommends that the state collect and publish this information, from the counties on a regular basis, about who of the remaining uninsured they serve, how many they serve, and what services they provide. This was exceedingly hard to get good, comparable data from many counties; this is basic information that should be public and available as a matter of course, and not something that requires an advocacy group, foundation, or think tank to have to recreate.

Health Access does not have a recommendation for what health realignment funding formula each county chooses. But most counties, concurrently with that decision, will be making decisions in the next month the funding and their overall vision for their safety-net.

We believe funding should be preserved for public health, and for indigent health care.

Counties should follow the lead of many of their peers in providing medical home coverage for the uninsured, extending the lessons learned and infrastructure built up with their Low Income Health Programs (LIHPs), but directing those efforts to the remaining uninsured. To let that safety-net capacity expire would be a missed opportunity. Counties like LA, Alameda, Santa Clara, and others are seizing this opportunity for a more robust indigent care program, to more efficiently and effectively manage safety-net resources, including providing primary and preventative services.

The county would fund it with state realignment dollars and their own resources. Unlike the LIHPs up to 2013, there would be no federal matching dollars available. With more limited dollars, the focus is on providing cost-effective care and treatment beyond just emergency or episodic care. Counties doing this are not duplicating the benefits of the LIHPs exactly, and reorienting their eligibility for the newly remaining uninsured.

Some counties are debating how their LIHPs and indigent care programs integrate with Medi-Cal and Covered California.

- It makes sense that every person who seeks care at a county facility be first screened for Medi-Cal and Covered California, and that counties actively facilitate enrollment in these federally –funded health options. Even if a consumer is not immediately eligible for one of these programs, almost everybody is eligible for something.
- As a facilitator of enrollment, the county program should be seen as a “bridge” to Covered California whenever possible. Counties should not deny someone for county care because they are eligible for Covered California subsidies if they are frozen out between open enrollment periods and should cover them until their Covered California coverage begins.
- What the appropriate cost-sharing should be needs further discussion, so that people are not tempted to decline Covered California because of the existence of a county program with lower cost sharing or share of premium. Other incentives could be that the cost-sharing starts below Covered California levels (to acclimate a family to premiums and co-pays as a bridge), but then it goes up if there is a failure to sign up a second year in a row.
- Some counties may also be exploring other options, like helping residents pay premiums in Covered California for the county-based plan—which might be still more financially efficient than letting them not be covered for the financial burden.

Even counties that don’t extend or build upon their LIHP programs should maintain their medical indigent care programs and keep them intact. No

county should be reducing or scaling back eligibility or benefits in their medically indigent programs in 2013 and 2014. While counties are concerned about the financial uncertainty during this transition, it is premature to make such decisions without the experience after implementing the ACA. In many cases, we think counties are overestimating the financial risks while underestimating the financial benefits. While counties are understandably concerned about the state's reclaiming of significant health realignment dollars, it was the stated intent of the Brown Administration to claim savings, but not to have any group worse off. That should be tested before counties actually take steps to make such patients worse off—and if there is a problem, then consumer advocates and counties should work together to make the case to the state and legislature.

For counties that choose not to set-up or continue a LIHP or cover the undocumented, **California should create other funding streams**, at the state level or from private providers to support statewide safety-net providers to ensure some help for the remaining uninsured.

California has had funding streams for community clinics and health centers, including Expanded Access to Primary Care (EAPC), Rural Health Services, Seasonal Agricultural Migration Services, and Indian Health Programs that have served to support safety-net providers of the uninsured, and a portion of any state savings should go to those or similar program. While we prefer that counties take this responsibility and commitment, California should have a basic commitment to a safety-net throughout the state.

Health Access also supports detailing the basic obligations of private providers in taking care of the remaining uninsured, especially nonprofit hospitals that enjoy significant tax benefits. **In conclusion**, the implementation of the Affordable Care Act is a transformational leap and improvement of coverage. But for those left out, including but not exclusively the undocumented immigrants, the safety-net is a wildly divergent patchwork—and threatens to become more so. The next few weeks and months will determine if the state and counties allow this uneven system to go further apart, or whether California and its counties fulfill the full promise of health reform, that all our residents have access to affordable care and coverage.

For more information about this report, contact Anthony Wright, executive director, Health Access California, at awright@health-access.org, or Sawait Hezchias-Seyoum at sseyoum@health-access.org. After its official release, the latest version will be available on our website at www.health-access.org.

Authored by Jirayut Latthivongskorn, Sawait Hezchias-Seyoum, and Anthony Wright, Health Access Foundation.

Health Access greatly appreciates the many partners and experts who have reviewed the several working drafts of this paper and made substantive edits, suggestions and comments: Beth Capell, Health Access California; Shannon McConville, PPIC; Richard Figueroa, The California Endowment; Laurel Lucia, UC Berkeley Labor Center; Ronald Coleman, CA Immigrant Policy Center.

We would like to thank our community partners, **California Partnership, Alliance of Californians for Community Empowerment, SEIU (Local 521), Legal Services of Northern California, Capitol Health Network, Congress of California Seniors, California Rural Legal Assistance Foundation, and the California Endowment** for their support and contributions to the survey.

We would also like to thank the following individuals across the various counties for their willingness to have conversations regarding each county's indigent care programs.

Amy Luftig-Viste, Deputy Director, Department of Human Services, Los Angeles; David Luchini, Assistant Director, Department of Public Health, Fresno; Srija Srinivasan, Director of Strategic Operations, San Mateo County Health System, San Mateo; Jan Remm, Assistant Hospital Administrator, Riverside County Regional Medical Center, Riverside; Kathleen Grassi, Public Health Director, Department of Public Health, Merced; Jill Cook, Director of Health, Yolo County Health Department, Yolo; Danice Cook, HealthPAC Administrator, Health Care Services Agency, Alameda; Rachel Metz, Policy Director, Health Care Services Agency, Alameda; Leslie Goodfriend, MediCruz Advantage Manager, Health Services Agency, Santa Cruz; Theresa Deem, Patient Account Officer, Riverside County Regional Medical Center, Riverside; Ron Boatman, Assistant Hospital Administrator, Arrowhead Regional Medical Center, San Bernardino; Sandy Damiano, Deputy Director, Primary Health Services Division, Health & Human Services, Sacramento; Lee Kemper, Director of Policy and Planning, CMSP Governing Board, CMSP; Colleen Chawla, Director of Policy and Planning, Department of Public Health, San Francisco; Rick Wanne, Director for Eligibility, San Diego County Health Department, San Diego; Amy Carta, Assistant Director, Valley Health and Hospital System, Santa Clara; Harry Weiss, CEO, Natividad Medical Center, Monterey; Dr. William Walker, Contra Costa Health Services, Contra Costa; Ken Cohen, San Joaquin Medical Center, San Joaquin

Alameda County

Population (total)	–	1,529,838
Population (uninsured)	–	190,093
% Uninsured	–	12%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	HealthPAC (MCE & HCCI)	HealthPAC (County)
<i># Enrolled</i>	48,603	42,000
<i>Department</i>	Healthcare Services Agency	
<i>Phone</i>	510-618-1923	
<i>Website</i>	http://achealthcare.org/health-insurance-info/low-income-coverage-options/healthpac/	

Eligibility

<i>Income</i>	200% FPL	200% FPL
<i>Ages</i>	19-64	All ages
<i>Undocumented?</i>	No	Yes
<i>Other</i>	12 month eligibility, asset test	

Services

<i>Primary care</i>	Yes	Yes*
<i>Emergency care</i>	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/No	Yes*/No*
<i>Dental</i>	Emergency Only	Emergency Only*
<i>Vision</i>	No	No*
<i>Prescription Drugs</i>	Yes	Yes*
<i>Share of Cost/Co-pay</i>	No/Yes	No/Yes*. Co-pays between 100%-200% FPL

*(*also for undocumented)*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Likely the 80/20 cost-based formula.
- *What is the public process for these decisions?* The County Board of Supervisors plans to finalize decision by November 2013.
- *Is there a medical home for the remaining uninsured?* HealthPAC will continue to provide care for those not eligible for Medi-Cal or any other coverage. However, some services through HealthPAC may be scaled back to pre-LIHP years: the county will decide whether to exclude out-of-network benefits and perhaps medical transportation; cost-sharing is being discussed.
- *Additional Comments* – Alameda has the second largest LIHP in the state, with the most enrollees per capita. The LIHP enrollment rate is 85-90% which is relatively high. They continue to promote and maximize enrollment through training of enrollment counselors. They are also in the process of developing a strategy and plan for outreach to individuals who may be eligible for Medi-Cal under the ACA.

Thirty-Five County Medical Services Program (CMSP) Counties

Population (total)	–	3.5 million
Population (uninsured)	–	Unknown
% Uninsured	–	Unknown

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Path2Health	County Medical Services Program (CMSP)
<i># Enrolled</i>	62,571	10,000-12,000
<i>Department</i>	Anthem Blue Cross & CMSP Governing Board	
<i>Phone</i>	Anthem Blue Cross: 800-670-6133 CMSP Governing Board: 916-649-2631	
<i>Website</i>	www.mypath2health.org	www.cmspcounties.org

Eligibility		
<i>Income</i>	100% FPL	200% FPL
<i>Ages</i>	19-64	21-64
<i>Undocumented?</i>	No	No
<i>Other</i>	3-6 month eligibility, asset limit	

Services		
<i>(*also for undocumented)</i>		
<i>Primary care</i>	Yes	Yes
<i>Emergency care</i>	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/Yes	Yes/Yes
<i>Dental</i>	Yes	Yes
<i>Vision</i>	Yes	Yes
<i>Prescription Drugs</i>	Yes	Yes
<i>Share of Cost/Copay</i>	No	Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 60/40 formula. Counties will keep their resources for public health, scaling back CMSP from a \$225 million to a \$35 million program.
- *What is the public process for these decisions?* CMSP Governing Board Meetings.
- *Is there a medical home for the remaining uninsured?* Yes, excluding the undocumented. CMSP eligibility will be limited to individuals who are otherwise not eligible for coverage under Medi-Cal or Covered California.
- *Additional Comments* – As of this writing, the CMSP Board was scheduled to vote this November on whether to eliminate specified benefits, including optometry, dental, mental health and substance abuse disorder services.
- CMSP estimates there are roughly 155,000 persons with incomes up to 138% of the FPL that will qualify for the Medi-Cal expansion in their counties. There is likely to be few people left under 138% eligible for CMSP services who aren't undocumented. The demand above 138% is uncertain, given Covered California enrollment and CMSP share-of-cost.

Contra Costa County

Population (total)	–	1,066,262
Population (uninsured)	–	127,587
% Uninsured	–	11%

Program Type	Low-Income Health Program		Indigent Care Program
<i>Program</i>	Medical Expansion Program (MCE)	Health Care Coverage Initiative (HCCI)	Basic Health Care (BHE)
<i># Enrolled</i>	10,012	2,172	1,200
<i>Department</i>	Health Services Department		
<i>Phone</i>	1-800-771-4270		
<i>Website</i>	http://cchealth.org/insurance/lihp.php		www.cchealth.org/insurance/adults.php#basic

Eligibility

<i>Income</i>	133% FPL	134-200% FPL	300% FPL
<i>Ages</i>	19-64	19-64	All
<i>Undocumented ?</i>	No	No	Undocumented children under 19 only.
<i>Other</i>	No enrollment cap		6 month eligibility, asset test

Services

<i>Primary care</i>	Yes	Yes	Yes*
<i>Emergency care</i>	Yes	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/No	Yes/No	No*/No*
<i>Dental</i>	Emergency Only	Emergency Only	No*
<i>Vision</i>	No	No	Limited*
<i>Prescription Drugs</i>	Yes	Yes	Yes*
<i>Share of Cost/Co-pay</i>	Yes (quarterly fee/No)	Yes	Yes* (quarterly fee)/No*

*(*also for undoc kids)*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 80/20 cost-based formula.
- *What is the public process for these decisions?* Stakeholder group comprised of community clinics, hospitals and other groups started in 2009 and meets quarterly.
- *Is there a medical home for the remaining uninsured?* Yes, the Basic Health Program (BHE) will continue to be available, similar to LIHP in services.

- *Additional Comments* – The county health services department is working with the employment human services department on outreach to both the Medi-Cal eligible and subsidy eligible populations. County may weigh options on any changes until after the 80/20 cost-based formula is implemented.
- Contra Costa has long-standing policy to provide coverage to undocumented children; suspended such care for undocumented adults in 2009. There is limited funding that goes to community clinics to provide some care. In the short term, they are exploring working with the private hospitals to provide additional financial assistance to the clinics to serve the remaining uninsured population.

Fresno County

Population (total)	–	942,642
Population (uninsured)	–	188,847
% Uninsured	–	20%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	N/A	Medically Indigent Services Program (MISP)
<i># Enrolled</i>		18,841
<i>Department</i>		Department of Public Health
<i>Phone</i>		559-459-3848
<i>Website</i>		www.co.fresno.ca.us/DivisionPage.aspx?id=48797
Eligibility		
<i>Income</i>		67% FPL
<i>Ages</i>		21-65
<i>Undocumented?</i>		Yes
<i>Other</i>		1-3 month eligibility, asset test
Services		
		<i>(*also for undocumented)</i>
<i>Primary care</i>		Yes*
<i>Emergency care</i>		Yes*
<i>Mental Health & Substance Abuse</i>		No*/No*
<i>Dental</i>		Emergency Only*
<i>Vision</i>		No*
<i>Prescription Drugs</i>		Yes*
<i>Share of Cost/Co-Pay</i>		Yes*/No*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of this survey. Leaning towards 80/20 cost-based formula.
- *What is the public process for these decisions?* County Board of Supervisors meetings.
- *Is there a medical home for the remaining uninsured?* No.
- *Additional Comments* – Fresno County declined to start up a LIHP and is California’s largest county not to do so. Fresno has contracted with Community Hospital to provide indigent care services to very limited income residents, inclusive of the undocumented. There are concerns about what would be the impact on the safety-net if/when the contract with the Community Hospital is re-negotiated.

Kern County

Population (total)	–	852,217
Population (uninsured)	–	188,620
% Uninsured	–	22%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Kern Medical Center Health Plan (KMCHP)	Medically Indigent Program (MIA)
<i># Enrolled</i>	8,760	361
<i>Department</i>	Health and Human Services Agency	
<i>Phone</i>	661-326-2392	
<i>Website</i>	www.kernmedicalcenter.com/	
Eligibility		
<i>Income</i>	133% FPL	200% FPL
<i>Ages</i>	19-64	19-64
<i>Undocumented?</i>	No	Yes
<i>Other</i>	12 month eligibility, asset test	
Services		
<i>(*also for undocumented)</i>		
<i>Primary care</i>	Yes	Yes
<i>Emergency care</i>	Yes	Yes
<i>Mental Health & Substance Abuse</i>	Limited/No	No/No
<i>Dental</i>	No	Limited
<i>Vision</i>	No	Limited
<i>Prescription Drugs</i>	Yes	Limited
<i>Share of Cost/Co-pay</i>	Yes/No	Yes/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* Board of Supervisors Meetings.
- *Is there a medical home for the remaining uninsured?* No official decision about changes to the indigent care program.
- *Additional Comments* – Media reports indicate that the Kern Medical Center is planning hiring freezes and voluntary furloughs as it seeks to cut \$6.5 million from the hospital budget.

Los Angeles County

Population (total)	–	9,891,877
Population (uninsured)	–	2,227,896
% Uninsured	–	22%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Healthy Way L.A.	Healthy Way L.A. Unmatched; Ability-to-Pay Plan (ATP)
<i># Enrolled</i>	282,026	
<i>Department</i>	Department of Health Services	
<i>Phone</i>	877-333-HWLA	800-472-8700
<i>Website</i>	www.ladhs.org/wps/portal/ /HWLA	dhs.lacounty.gov/wps/portal/d hs/healthcoverageoptions/lacou ntynocost/abilitytopay

Eligibility		
<i>Income</i>	133% FPL	HWLA: 133% FPL ATP: >133% FPL
<i>Ages</i>	19-64	All
<i>Undocumented?</i>	No	Yes
<i>Other</i>		12 month eligibility, asset test, medical need required

Services		
		<i>(*also for undocumented)</i>
<i>Primary care</i>	Yes	Yes*
<i>Emergency care</i>	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/No	No/No
<i>Dental</i>	No	Limited
<i>Vision</i>	No	Limited
<i>Prescription Drugs</i>	Yes	Yes*
<i>Share of Cost/CoPay</i>	No/No	HWLA (<133% FPL): No ATP (>133% FPL): Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 80/20 cost-based formula.
- *What is the public process for these decisions?* County Board of Supervisors, etc.
- *Is there a medical home for the remaining uninsured?* Yes. In addition to their LIHP program called Healthy Way LA, Los Angeles has also enrolled tens of thousands of those not eligible for Medi-Cal or LIHP into a program internally called "Healthy Way LA Unmatched." ("Unmatched" signifies that the program is funded by the county indigent care funds and does not get federal matching funds.) While the LIHP will expire in January, Healthy Way LA Unmatched will continue into 2014, and is likely to be relaunched, perhaps under another name, in September 2014, to provide coverage-like medical home for the remaining uninsured. LA County will retain the enrollment, help, and support staff from Healthy Way for this new "unmatched"

program. Los Angeles historically has had several different and intersecting programs for the medically indigent, such as Ability to Pay (ATP), which vary in what services and experience they provide patients. Those programs are expected to continue initially but the new “unmatched” program will seek to provide a capitated, managed care medical home.

- *Additional Comments* – The county’s goal is to enroll 300,000 individuals in LIHP by Dec. 31, 2013. County is hosting major enrollment events throughout the county, mailing applications to people they think might be eligible, and simplifying enrollment.

Merced County

Population (total)	-	258,609
Population (uninsured)	-	56,928
% uninsured	-	22%

Program Type	Low-Income Health Program	Indigent Care Program
Program	N/A	Medical Assistance Program
# Enrolled		14,000
Department		Department of Public Health
Phone		
Website		http://www.co.merced.ca.us/index.aspx?NID=611

Eligibility	
Income	200% FPL
Ages	21-64
Undocumented?	No
Other	1-6 months enrollment, asset test, medical need required

Services	<i>(*for undocumented)</i>
Primary care	Yes
Emergency care	Yes
Mental Health & Substance Abuse	N/N
Dental	Limited
Vision	Limited
Prescription Drugs	Yes
Share of Cost/Co-Pay	No/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* Partnership with Golden Valley FQHC's and Social Services Agency to encourage, enroll folks. A "Healthcare Consortium" that has been meeting since January 2013 and will last through to the transition period. The focus of this group is broader than indigent care, but also 1) those eligible for Medi-Cal but are not enrolled, and 2) helping consumers understand healthcare and ACA. Group is made up of county residents, pastors, agencies, etc. Focus is to share updated information, who's receiving what grants, how to coordinate together to, keep messaging simple and no convoluted, how to try to get consumers into service.
- *Is there a medical home for the remaining uninsured?* The MAP program will likely continue with limited services.
- *Additional Comments* – All individuals under 133% enrolled in MAP will automatically be enrolled into Medi-Cal since they're already in the system and approved, ready for Day 1.

Monterey County

Population (total)	–	421,494
Population (uninsured)	–	101,158
% Uninsured	–	24%

Program	Low-Income Health Program	Indigent Care Program
<i>Program</i>	ViaCare	Monterey County Medical Services Program (MCMSP)
<i># Enrolled</i>	1,092	400 per month
<i>Department</i>	County Health Department	
<i>Phone</i>	831-783-2400	
<i>Website</i>	www.viacaremc.com	

Eligibility

<i>Income</i>	133% FPL	250% FPL
<i>Ages</i>	19-64	21-64
<i>Undocumented?</i>	No	No
<i>Other</i>	1-3 month eligibility, asset limit, medical need required	

Services

		<i>(*also for undocumented)</i>
<i>Primary care</i>	Yes	Limited
<i>Emergency care</i>	Yes	Limited
<i>Mental Health & Substance Abuse</i>	Yes/No	No/No
<i>Dental</i>	No	Emergency only
<i>Vision</i>	No	Limited
<i>Prescription Drugs</i>	Yes	Limited
<i>Share of Cost/Co-Pay</i>	Yes/Yes	Yes/Yes (100-250% FPL)

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* No decision as of the date of this survey.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* Undecided on potential changes to the County Medical Services Programs.
- *Additional Comments* – Undocumented folks can receive many services at Natividad hospital, clinics and health department clinics, but they are not eligible for the County Medical Services Program. They can apply for the sliding scale at the Health Department and/or one of the discount programs at Natividad Medical Center.

Orange County

Population (total)	–	3,055,065
Population (uninsured)	–	534,002
% Uninsured	–	17%

Program Type	Low-Income Health Program	HCCI/Indigent Care Program
<i>Program</i>	Medical Services Initiative (MSI)	Medical Services Initiative (MSI)
<i># Enrolled</i>	44,319	9,959
<i>Department</i>	Health Care Agency	Health Care Agency
<i>Phone</i>	714-796-0260	714-796-0260
<i>Website</i>	www.ochealthinfo.com/about/medical/msi	

Eligibility

<i>Income</i>	133% FPL	200% FPL
<i>Ages</i>	21-65	21-65
<i>Undocumented?</i>	No	No
<i>Other</i>	12 month eligibility	12 month eligibility

Services

	<i>(*also for undocumented)</i>	
<i>Primary care</i>	Yes	Yes
<i>Emergency care</i>	Yes	Yes
<i>Mental Health & Substance Abuse</i>	Limited/No	Limited/No
<i>Dental</i>	Limited	Limited
<i>Vision</i>	Limited	Limited
<i>Prescription Drugs</i>	Yes; co-pays vary by income	Yes; co-pays vary by income
<i>Share of Cost/Co-Pay</i>	No/Yes	No/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* Board of Supervisor hearings before December 4th, 2013. Hearings are unscheduled pending negotiations between CSAC and the state Administration.
- *Is there a medical home for the remaining uninsured?* Yes, MSI will continue, but services will be modified.
- *Additional Comments* – Orange County was one of four counties that continued to enroll people in LHPs from 133-200% of FPL. County expects that all folks of 0-138% FPL will transfer to Medi-Cal and those of 138-400% FPL will be in Covered California. They are working with community-based organizations to set patients up with live enrollment assistants. County is focusing on those who would remain uncovered, to be mostly those between 138-200% FPL who do not take part in the exchange.

Placer County

Population (total)	–	357,930
Population (uninsured)	–	33,655
% Uninsured	–	9%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Medicaid Coverage Expansion (MCE)	Medical Care Services Program (MCSP)
<i># Enrolled</i>	3,406	20
<i>Department</i>	Department of Health and Human Services	
<i>Phone</i>	888-385-5160	
<i>Website</i>	www.placer.ca.gov/department/s/hhs/public_assistance/health_care/medicaidcoverageexpansion	www.placer.ca.gov/department/s/hhs/public_assistance/health_care/mcsp

Eligibility

<i>Income</i>	133% FPL	100% FPL
<i>Ages</i>	19-64	21-64
<i>Undocumented?</i>	No	No
<i>Other</i>		2 months eligibility, asset test, medical need required

Services

<i>Primary care</i>	Yes	Limited
<i>Emergency care</i>	Yes	Limited
<i>Mental Health & Substance Abuse</i>	Yes/No	Yes/No
<i>Dental</i>	Emergency Only	Emergency Only
<i>Vision</i>	No	No
<i>Prescription Drugs</i>	Yes	Yes
<i>Share of Cost/Co-pay</i>	Yes/No	No/Yes

*(*also for undocumented)*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* The county's indigent care program MCSP will continue to provide care for those not eligible for Medi-Cal—but unclear how big that population will be with the low eligibility level and the exclusion of the undocumented.
- *Additional Comments* – The County is waiting on state guidance and taking proactive steps to make sure LIHP transition is smooth. Big obstacle is the fact that they are a fee-for-service Medi-Cal county and are supposed to go to managed care but implementation keeps being pushed back in these counties. They are hiring a significant number of new staff to deal with Medi-Cal enrollment and plan to get 90% of the uninsured enrolled. They are working with CBOs to identify the uninsured.

Riverside County

Population (total)	–	2,239,636
Population (uninsured)	–	451,860
% Uninsured	–	20%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Riverside County Health Care	Medically Indigent Services Program (MISP)
<i># Enrolled</i>	27,000	10,000
<i>Department</i>	Riverside County Regional Medical Center	Riverside County Regional Medical Center
<i>Phone</i>	951-486-4655	951-486-5375
<i>Website</i>	www.riversidecountyhealthcare.org	www.rcrmc.org/home/index.php?Itemid=19

Eligibility

<i>Income</i>	≤133% FPL	≤ 200% FPL
<i>Ages</i>	19-64	19-64
<i>Undocumented?</i>	No	Yes
<i>Other</i>		12 month eligibility, asset test

Services

Services	Low-Income Health Program	Indigent Care Program <i>(*also for undocumented)</i>
<i>Primary care</i>	Yes	Limited
<i>Emergency care</i>	Yes	Limited
<i>Mental Health & Substance Abuse</i>	Yes/No	No/No
<i>Dental</i>	Emergency Only	Extractions Only
<i>Vision</i>	No	No
<i>Prescription Drugs</i>	Yes	Yes
<i>Share of Cost/Co-Pay</i>	Yes/Yes	Yes/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* No decision as of the date of this survey.
- *What is the public process for these decisions?* Unknown.
- *Is there a medical home for the remaining uninsured?* The remaining uninsured will be able to get coverage through MISP, which is more limited than the LIHP.
- *Additional Comments.* Media reports a \$54 million projected deficit for the operation of Riverside County Regional Medical Center, which is also undergoing a leadership change. The hospital's patient mix currently is over 70 percent Medi-Cal and the uninsured.

Sacramento County

Population (total)	–	1,434,454
Population (uninsured)	–	213,930
% Uninsured	–	15%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Medicaid Coverage Expansion (MCE)	County Medically Indigent Services Program (CMISP)
<i># Enrolled</i>	12,320	14,000
<i>Department</i>	Health and Human Services, Primary Health Services	
<i>Phone</i>	916-875-1985	
<i>Website</i>	http://www.dhhs.saccounty.net/PRI/Pages/Low-Income-Health-Program/GI-LIHP.aspx	http://www.dhhs.saccounty.net/PRI/Pages/CMISP/GI-CMISP-Main.aspx

Eligibility		
<i>Income</i>	67% FPL	67% FPL
<i>Ages</i>	19-64	19-64
<i>Undocumented?</i>	No	No
<i>Other</i>	12 month eligibility, asset test, medical need required	

Services	<i>(*also for undocumented)</i>	
<i>Primary care</i>	Yes	Yes
<i>Emergency care</i>	Yes	Limited
<i>Mental Health & Substance Abuse</i>	Yes/No	Yes/No
<i>Dental</i>	Emergency Only	Emergency Only
<i>Vision</i>	No	No
<i>Prescription Drugs</i>	Yes	Yes
<i>Share of Cost/Copay</i>	Yes/No	Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 60/40 formula.
- *What is the public process for these decisions?* The county's indigent care program CMISP will continue to provide care for those not eligible for Medi-Cal or other coverage, and goes above 67% FPL, but with a share-of-cost.
- *Additional Comments* – Currently, individuals who are ineligible for CMISP or LIHP can go to a FQHC clinic, emergency rooms or Loaves and Fishes, which provides services to the homeless. Sacramento was one of the last counties to start a LIHP, operated by Molina, a GMC plan. People will be defaulted into Molina MCP if they do not choose a plan. They are considering doing some outreach/enrollment activities in conjunction with their homeless CBOs. Changes to the level of services to remaining uninsured is unclear. The county stopped providing medical services to the undocumented in 2009.

San Bernardino County

Population (total)	–	2,064,674
Population (uninsured)	–	440,193
% Uninsured	–	21%

Program Type	Low-Income Health Program	Indigent Care Program
Program	ArrowCare	MISP
# Enrolled	31,837	800
Department	Arrowhead Regional Medical Center	
Phone	1-877-410-8829	
Website	http://www.arrowcare.org/	
Eligibility		
Income	100% FPL	200% FPL
Ages	19-64	21-64
Undocumented?	No	No
Other	12 month eligibility, asset test	
Services		
	<i>(*also for undocumented)</i>	
Primary care	Yes	Yes
Emergency care	Yes	Yes
Mental Health & Substance Abuse	Yes/No	No/No
Dental	Yes	Limited
Vision	Yes	Yes
Prescription Drugs	Yes	Limited
Share of Cost/Co-Pay	Yes/Yes	Yes/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 80/20 cost-based formula.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* The remaining uninsured will be able to get coverage through MISP. Undocumented individuals will continue to be excluded.
- *Additional Comments* –The county is actively working to transition individuals into Medi-Cal. They are experiencing challenges related to cost and changes in the state and medical transition plan. The county does not plan to enhance level of services to the remaining uninsured. The only avenue for undocumented individuals to get health care is through charity care or clinics.

San Diego County

Population (total)	–	3,139,065
Population (uninsured)	–	529,014
% Uninsured	–	16%

Program Type	Low-Income Health Program	Indigent Care Program
Program	Low Income Health Program	County Medical Services (CMS)
# Enrolled	39,664	2,000
Department	Health and Human Services Agency (HHSA)	
Phone	866-262-9881	800-587-8118
Website	www.sdlhip.org	http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/

Eligibility		
Income	133% FPL	350% FPL
Ages	19-64	21-64
Undocumented?	No	No
Other		1-6 month eligibility, asset limit, medical need

Services		<i>(*also for undocumented)</i>
Primary care	Yes	Yes
Emergency care	Yes	Yes
Mental Health & Substance Abuse	Yes/No	No/No
Dental	Emergency Only	Emergency Only
Vision	Yes	Limited
Prescription Drugs	Yes	Yes
Share of Cost/Co-pay	No/No	Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey. Recommendations will be made to the Board of Supervisors in the coming months.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* The County Medical Services program will continue and the county does not plan to decrease eligibility at this time.
- *Additional Comments:* To facilitate transition of individuals into Medi-Cal, county is putting more eligibility workers in the hospitals. They are also setting up a web portal. Undocumented individuals can get care at the 58 community clinics with sliding scale fees.

San Francisco County

Population (total)	–	812,411
Population (uninsured)	–	93,336
% Uninsured	–	11%

Program Type	Low-Income Health Program	Indigent Care Program
Program	SF PATH	Healthy San Francisco
# Enrolled	9,226	46,822
Department	Department of Public Health	
Phone	415-615-4510	
Website	www.sfpath.org	www.healthysanfrancisco.org

Eligibility

Income	133% FPL	500% FPL
Ages	19-64	18-65
Undocumented?	No	Yes
Other	12 month eligibility	

Services

*(*also for undocumented)*

Primary care	Yes	Yes*
Emergency care	Yes	Yes*
Mental Health & Substance Abuse	Yes/Yes	Yes*/Yes*
Dental	No	No*
Vision	No	No*
Prescription Drugs	Yes	Yes*
Share of Cost/ Co-pay	Yes/Yes	Yes*; Yes*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 80/20 cost-based formula.
- *What is the public process for these decisions?* City Council/Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* Yes, the county plans to maintain the groundbreaking Healthy San Francisco program and services and will not change eligibility.
- *Additional Comments* – The Department’s and Healthy San Francisco’s foray into the Affordable Care Act (ACA) preparation and implementation began in earnest on July 1, 2011, when the Department successfully transitioned over 10,000 participants from HSF into a new federally supported program, SF PATH, designed to help prepare uninsured adults for ACA implementation. It is estimated that 60% of the combined HSF and SF PATH populations will be eligible for health insurance beginning January 1, 2014.
- There are policy conversations about how to have the Healthy San Francisco program adjust to the Affordable Care Act. Also, advocates are concerned about an attack on a key financing component, the Health Care Security Ordinance, which requires that employers contribute to their workers’ health care, either by providing a health benefit or paying into Health San Francisco. Currently, there seems to be strong support for maintaining Healthy San Francisco benefits.

San Joaquin County

Population (total)	–	696,216
Population (uninsured)	–	118,132
% Uninsured	–	17%

Program Type	Low-Income Health Program	Indigent Care Program
Program	LIHP	Medical Assistance Program
# Enrolled	3,164	4,264
Department	San Joaquin County General Hospital	
Phone	209-468-7449	
Website	http://www.sjgeneralhospital.com/	
Eligibility		
Income	133% FPL	200% FPL
Ages	19-64	21-64
Undocumented?	No	No
Other	12 month eligibility, asset test	
Services		
	<i>(*also for undocumented)</i>	
Primary care	Yes	Yes
Emergency care	*Yes	*Yes
Mental Health & Substance Abuse	Yes/No	N/Limited
Dental		No
Vision		Limited
Prescription Drugs	Yes	Limited
Share of Cost/Co-Pay	Yes/Yes	No/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Has not decided, but potentially 60/40 formula.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* The Medical Assistance Program will continue. No changes were
- *Additional Comments* – San Joaquin was one of six counties that started with a low eligibility threshold but expanded it this year to maximize enrollment going into 2014. San Joaquin provides emergency care to the undocumented, but they fit in the “self-pay category at this moment.

San Mateo County

Population (total)	–	727,526
Population (uninsured)	–	82,536
% Uninsured	–	11%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Medicaid Coverage Expansion – Access and Care for Everyone (MCE-ACE)	Access and Care for Everyone (ACE)
<i># Enrolled</i>	9,090	22,000
<i>Department</i>	Health Plan of San Mateo	
<i>Phone</i>	650-616-2002	
<i>Website</i>	www.hpsm.org/members/mce/cos.ts.aspx	www.hpsm.org/members/san-mateo-ace/benefits-and-costs.aspx

Eligibility

<i>Income</i>	133% FPL	200% FPL
<i>Ages</i>	21-65	19-64
<i>Undocumented?</i>	No	Yes
<i>Other</i>	Asset Limit, 1,500 individuals on waiting list	

Services

Services	Low-Income Health Program	Indigent Care Program <i>(*also for undocumented)</i>
<i>Primary care</i>	Yes	Yes*
<i>Emergency care</i>	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/Yes	Limited*/Yes*
<i>Dental</i>	Emergency Only	Emergency Only*
<i>Vision</i>	Yes	Yes*
<i>Prescription Drugs</i>	Yes	Yes*
<i>Share of Cost/Co-Pay</i>	No/No	Yes*/Yes*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey. Leaning towards 80/20 cost-based formula.
- *What is the public process for these decisions?* Cost-sharing workgroup which consists of county leaders in safety net, from FQHC's and legal aid society. Workgroup has recommended to increase cost sharing for 138-200% FPL individuals to match Covered CA rates (to encourage move into Covered CA). This would increase cost from \$240 enrollment fee to match subsidized Covered CA premiums. Will apply this evenly to both Documented and Undocumented.
- *Is there a medical home for the remaining uninsured?* Yes, ACE will be maintained.
- *Additional Comments* – 81,000 are uninsured today, and 68,000 will remain

uninsured. Details below. (81,000 total uninsured - 13,000 eligible for MediCal = 68,000 remaining). County expects 13,000 will be eligible for MediCal Expansion and 34,000 will be eligible for tax credits in Covered CA (200-400% FPL). They estimate around 40% will take up coverage in first year and at least 34,000 are NOT eligible for ACA subsidies. This number includes: 1.) 18,000 = undocumented in Indigent Care Program already 2.) 11-12,000 are 400% FPL or more and Uninsured. Lastly, 4,000 are currently uninsured in ACE, but will be eligible for Covered CA. They will be encouraged to move to Covered CA, off county program. County expressed it would be great for counties, who serve undocumented, to be able to leverage CalHEERS' infrastructure to streamline the administrative end and data flow for enrolling people. For example, if a consumer applies to CalHEERS but is not eligible due to immigration status, it would be great if eligibility data be streamlined and leveraged so that it saves cost and the administrative work for counties.

Santa Barbara County

Population (total)	–	426,723
Population (uninsured)	–	81,117
% Uninsured	–	19%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	N/A	Medically Indigent Adult Program (MIA)
<i># Enrolled</i>		
<i>Department</i>		Public Health Department
<i>Phone</i>		805-681-5390
<i>Website</i>		www.countyofsb.org/phd/mia.aspx?id=20786
Eligibility		
<i>Income</i>		200% FPL
<i>Ages</i>		21-64
<i>Undocumented?</i>		No
<i>Other</i>		1-4 month eligibility, asset test, medical need required
Services		
		<i>(*also for undocumented)</i>
<i>Primary care</i>		Yes
<i>Emergency care</i>		Yes
<i>Mental Health & Substance Abuse</i>		No/No
<i>Dental</i>		No
<i>Vision</i>		No
<i>Prescription Drugs</i>		Yes
<i>Share of Cost/Co-pay</i>		Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* Undecided about potential changes.
- *Additional Comments* – Santa Barbara County was one of five counties that declined to set up a Low Income Health Program, and has had a limited indigent care program (medical need required and a short eligibility, for example).

Santa Clara County

Population (total)	–	1,809,736
Population (uninsured)	–	210,952
% Uninsured	–	11%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	Valley Care	Ability to Pay Determination Program (APD)
<i># Enrolled</i>	17,176	12,000
<i>Department</i>	Department of Health and Human Services	
<i>Phone</i>	408-885-4551	408-885-7470
<i>Website</i>	www.scvmc.org/valleycare	www.sccgov.org/ssa/opp2/15_health/15-5.html#apd
Eligibility		
<i>Income</i>	133% FPL	350% FPL
<i>Ages</i>	19-64	All ages
<i>Undocumented?</i>	No	Yes
<i>Other</i>		6 month eligibility, asset test, medical need required
Services		
		<i>(*for undocumented)</i>
<i>Primary care</i>	Yes	Yes*
<i>Emergency care</i>	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/Yes	Limited*/No*
<i>Dental</i>	Emergency Only	Emergency Only*
<i>Vision</i>	No	Emergency Only*
<i>Prescription Drugs</i>	Yes	Yes*
<i>Share of Cost/Co-Pay</i>	No/Yes	No*/Yes*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* No decision as of the date of this survey.
- *What is the public process for these decisions?* The county is currently drafting the proposed new 17000 program for the Health and Hospital Committee to take up in public and another opportunity for public engagement will come when the full BOS takes up the issue.
- *Is there a medical home for the remaining uninsured?* Yes, the county will continue its 17000 indigent care obligation though it will be modified as to not dis-incentivize enrollment in Covered CA. Out of the 12,000 APD patients this year it is estimated that about 6,000 are likely eligible for ACA benefits.

Santa Cruz County

Population (total)	–	264,306
Population (uninsured)	–	36,974
% Uninsured	–	14%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	MediCruz Advantage (MCA)	MediCruz Classic
<i># Enrolled</i>	1,260 (cap at 2,000)	1,300
<i>Department</i>	Health Services Agency (HSA)	
<i>Phone</i>	831-454-4313	
<i>Website</i>	www.santacruzhealth.org/mca/index.htm	www.santacruzhealth.org/adminstr/2benefits.htm#Medi-Cruz

Eligibility		
<i>Income</i>	100% FPL	100% FPL
<i>Ages</i>	19-64	19-64
<i>Undocumented?</i>	No	Yes
<i>Other</i>	1-3 month eligibility, asset test, medical need required	

Services		
<i>(*also for undocumented)</i>		
<i>Primary care</i>	Yes	Yes*
<i>Emergency care</i>	Yes	Yes; Life, limb or sight threatening emergencies only
<i>Mental Health & Substance Abuse</i>	Yes/Yes	No/No
<i>Dental</i>	No	No
<i>Vision</i>	No	No
<i>Prescription Drugs</i>	Yes	Yes*
<i>Share of Cost/Co-pay</i>	Yes/Yes	Yes*, Yes*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* An organized group will be created for the purposes of putting together a plan for outreach, communication, education, and plan to get individuals into Medi-Cal in 2014. Another group will educate community providers.
- *Is there a medical home for the remaining uninsured?* At this point, the county is not clear about the options for the remaining uninsured population.
- *Additional Comments* – In October 2012, LIHP peaked at 2200 people enrolled. However, in January 2013, an enrollment cap and redetermination were instated (if folks do not show up, they fall off the program). About 50% of enrollees fell off as a result, and an increase in the Indigent Care program increased as a result. Santa

Cruz instituted an enrollment cap, for 2,000 enrollees. More than 18,750 (11% of 170,787) are 137% FPL or less, and are eligible for Medi-Cal Expansion. There is another "Access to Care" program with cost-sharing for those under 200% FPL with no insurance. Transition of LIHP enrollees into Medi-Cal has been a very "painful" and difficult, primarily due to lack of funding and challenges around getting the necessary data to facilitate transition. While county is working on outreach and enrollment for Medi-Cal, they are not using LIHP (due to cap, and folks were falling off during redetermination). They are working with Dept. of Social Services to work out a system to transfer individuals who are waitlisted for LIHP services into Medi-Cal in 2014. County is using funding from Blue Shield to outreach to special populations, such as substance using, mentally ill, and recently incarcerated Californians.

San Luis Obispo County

Population (total)	–	272,066
Population (uninsured)	–	49,194
% Uninsured	–	18%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	N/A	County Medical Services Program (CMSP)
<i># Enrolled</i>		3,200
<i>Department</i>		Health Agency Services
<i>Phone</i>		805-781-4838
<i>Website</i>		http://www.slocounty.ca.gov/health/publichealth/lowincome/cmosp.htm

Eligibility

<i>Income</i>	250% FPL
<i>Ages</i>	21-64
<i>Undocumented?</i>	No
<i>Other</i>	Medical need required

Services

Services	<i>(*also for undocumented)</i>
<i>Primary care</i>	Yes
<i>Emergency care</i>	Yes
<i>Mental Health & Substance Abuse</i>	No
<i>Dental</i>	Emergency only
<i>Vision</i>	No
<i>Prescription Drugs</i>	Yes
<i>Share of Cost/Co-pay</i>	Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* There are two ACA planning groups that meet monthly, one on outreach and the other on care coordination for providers.
- *Is there a medical home for the remaining uninsured?* Yes, CMSP will cover the remaining uninsured and services will not be scaled back at this time.
- *Additional Comments* – SLO does not cover the undocumented, but they do refer to the Noor Clinic, a free clinic that started a year ago and provides health care services to uninsured and undocumented. County predicts that the majority of individuals covered under CMSP will be eligible for coverage under Covered California and by virtue of the dramatic decrease in enrollment in CMSP, the CMSP program will cover the remaining uninsured and services will not be scaled back.

Stanislaus County

Population (total)	–	518,474
Population (uninsured)	–	92,647
% Uninsured	–	17%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	N/A	Medically Indigent Program (MIA)
<i># Enrolled</i>		5,554
<i>Department</i>		Health Services Agency
<i>Phone</i>		(209) 558-7232
<i>Website</i>		http://www.schsa.org/pages/services/ihcp/index.html

Eligibility

<i>Income</i>	279% FPL
<i>Ages</i>	21-65
<i>Undocumented?</i>	No
<i>Other</i>	1-6 month eligibility, asset test

Services

Services	<i>(*also for undocumented)</i>
<i>Primary care</i>	Limited
<i>Emergency care</i>	Limited
<i>Mental Health & Substance Abuse</i>	No/No
<i>Dental</i>	Limited
<i>Vision</i>	No
<i>Prescription Drugs</i>	Limited
<i>Share of Cost/Co-pay</i>	Yes/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 60/40 formula.
- *What is the public process for these decisions?* County Board of Supervisor Meetings.
- *Is there a medical home for the remaining uninsured?* The MIA program will continue as a safety net program.
- *Additional Comments* – Stanislaus, which declined to set up a Low-income Health Profteam—was one of the few counties that explicitly did not want to participate in this survey.

Tulare County

Population (total)	–	449,377
Population (uninsured)	–	105,282
% Uninsured	–	23%

Program Type	Low-Income Health Program	Indigent Care Program
<i>Program</i>	TulareCare	Tulare County Medical Services (TCMS)
<i># Enrolled</i>	3,530	Unknown
<i>Department</i>	Health and Human Services Agency	
<i>Phone</i>	559-735-3892	
<i>Website</i>	http://www.tchhsa.org/hhsa/	
Eligibility		
<i>Income</i>	75% FPL	275% FPL
<i>Ages</i>	19-64	21-65
<i>Undocumented?</i>	No	N
<i>Other</i>	2-3 month eligibility, asset test	
Services		
<i>(*also for undocumented)</i>		
<i>Primary care</i>	Yes	Yes
<i>Emergency care</i>	Yes	Yes
<i>Mental Health & Substance Abuse</i>	Limited/No	No/No
<i>Dental</i>	Emergency Only	Limited
<i>Vision</i>	No	Limited
<i>Prescription Drugs</i>	Yes	Yes
<i>Share of Cost/Co-pay</i>	No/No	Yes/Yes

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* County Board of Supervisors.
- *Is there a medical home for the remaining uninsured?* The county is in the process of trying to determine who will be the remaining uninsured. At this point, the plan to maintain services.
- *Additional Comments* – LIHP enrollment is capped at 3,500 (current enrollment). In regards to outreach and enrollment, the county was awarded a grant from United Way to get individuals enrolled into Medi-Cal.

Ventura County

Population (total)	-	831,241
Population (uninsured)	-	146,400
% Uninsured	-	17%

Program Type	Low-Income Health Program		Indigent Care Program
<i>Program</i>	Access, Coverage Enrollment (ACE) – Medicaid Coverage Expansion (MCE)	Access, Coverage Enrollment (ACE) – Health Care Coverage Initiative (HCCI)	Self-Pay Discount Program
<i># Enrolled</i>	8,856	2,870	Unknown
<i>Department</i>	Health Care Agency		
<i>Phone</i>	805-981-5070		
<i>Website</i>	www.vchca.org/t/health-care-for-the-uninsured/ace-program-for-adults		www.vchca.org/t/health-care-for-the-uninsured/self-pay-discount-program

Eligibility

<i>Income</i>	133% FPL	134-200% FPL	700% FPL
<i>Ages</i>	19-64	19-64	19 or older
<i>Undocumented ?</i>	No	No	Yes
<i>Other</i>	3-6 month eligibility, asset test		

Services

<i>Primary care</i>	Yes	Yes	Yes* <i>(*also for undocumented)</i>
<i>Emergency care</i>	Yes	Yes	Yes*
<i>Mental Health & Substance Abuse</i>	Yes/No	Yes/No	No*/No*
<i>Dental</i>	No	No	No*
<i>Vision</i>	No	No	No*
<i>Prescription Drugs</i>	Yes	Yes	Yes*
<i>Share of Cost/Co-pay</i>	Yes/Yes	Yes/Yes	Yes*/Yes*

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* Undecided as of the date of this survey.
- *What is the public process for these decisions?* Board of Supervisor meetings.

- *Is there a medical home for the remaining uninsured?* Unclear. The county is in discussion about plans moving forward.
- *Additional Comments* – Ventura’s indigent care program goes up higher than many counties, but does include sliding-scale cost-sharing.
- There are an estimated 70,000-75,000 undocumented people in Ventura County. Undocumented immigrants who do not qualify for the self-pay discount program will make up the bulk of people who will remain outside of coverage. Other options undocumented individuals have for care are public hospital ERs, Clinicas del Camino Real (with minimal charges), and a few private providers who provide primary care clinics for the indigent.

Yolo County

Population (total)	–	202,277
Population (uninsured)	–	26,146
% Uninsured	–	12%

Program Type	LIHP Name	Indigent Care Program
Program Type	Path2Health	CMSP
URL		
Phone	(800) 670-6133	(916) 649-2631
Department	CMSP Governing Board	CMSP Governing Board
# Enrolled	1,945	400 a month
Website	http://mypath2health.org/index.html	http://www.cmspcounties.org/

Eligibility		
Income	100% FPL	200% FPL
Ages	19-64	21-64
Undocumented?	No	No
Other		6 month eligibility, asset limit, medical need required

Services	<i>(*for undocumented)</i>	
Primary care	Yes	Yes
Emergency care	Yes	Yes
Mental Health & Substance Abuse		MH
Dental	ER	Yes
Vision	Yes	Yes
Prescription Drugs	Yes	Yes
Share of Cost/ Co-Pay	Yes/Yes	Yes/No

Comments (2014, undocumented, and changes)

- *What realignment formula will the county choose?* 60/40 formula.
- *What is the public process for these decisions?* The Yolo County ACA Implementation Team is now convening to align efforts for the Exchange and Medi-Cal Expansion (experience has been that outreach efforts by those who received funding could be better aligned). They come together to do organizing efforts, meeting twice a month.
- *Is there a medical home for the remaining uninsured?* CMSP will continue.
- *Additional Comments* – Yolo joined CMSP’s LIHP earlier this year. Yolo covered undocumented services until 2009. Now, undocumented individuals can visit the emergency room or rely on sliding-scale fees at Federally Qualified Health Centers for other services.