

Introduction

Beyond the recent well-publicized expansions of coverage at the federal and state level, from the significant reductions in the number of uninsured under the Affordable Care Act to California-specific efforts to cover all children, there has also been a revolution at the local level as California counties have been busy building more inclusive and smarter safety-net programs. In just the last year, the counties of Sacramento, Contra Costa, and Monterey as well as a consortium of 35 rural counties created limited-benefit pilot programs that cover the remaining uninsured without regard to immigration status. Efforts in other counties are pending, joining counties like Los Angeles and Santa Clara that are improving existing indigent care programs to better provide primary and preventive care and a medical home.

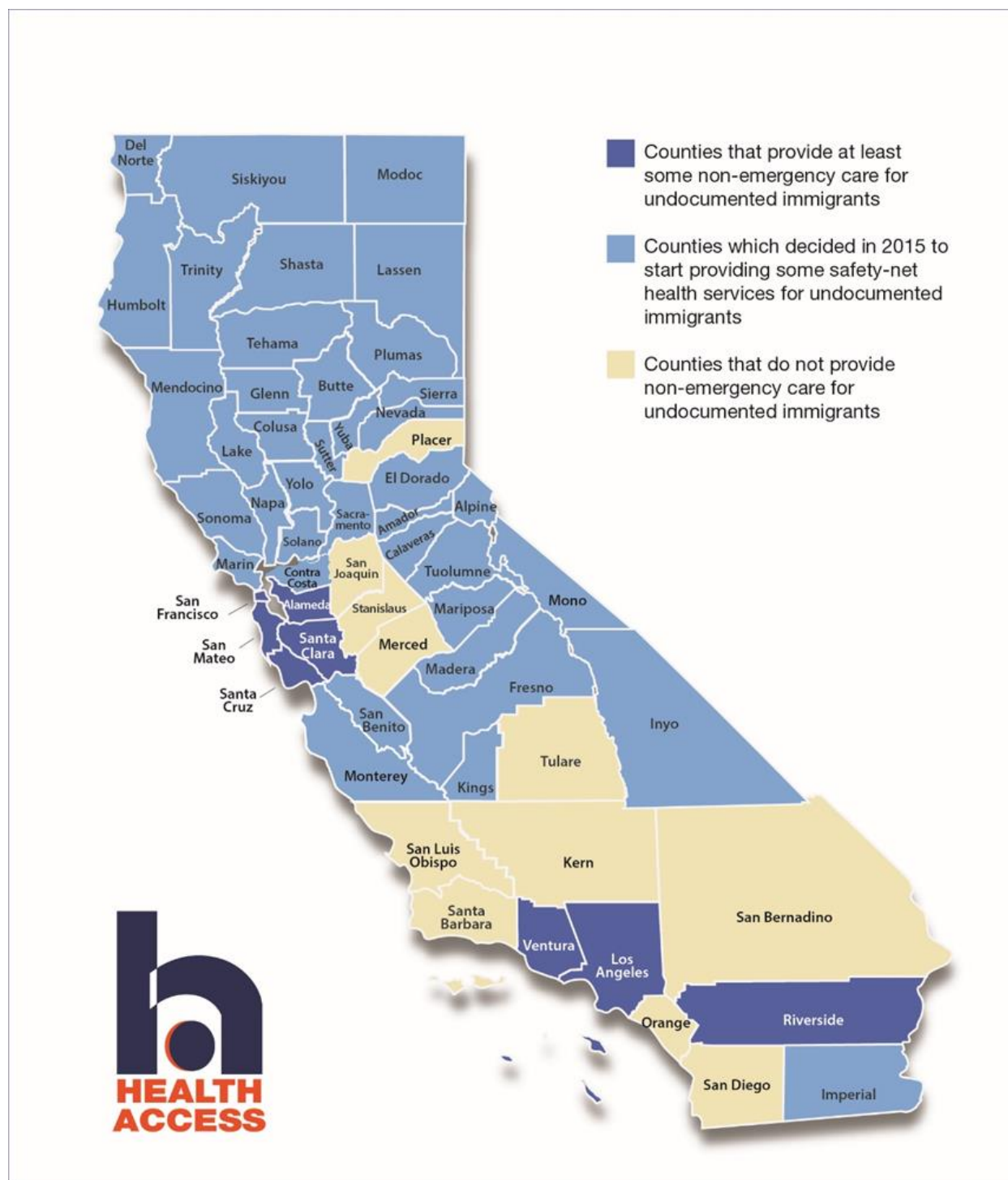
Each of these counties are profiled in this paper, which highlights these historic changes, helps provide context and analysis for the rationale for these reforms, and predicts additional advances in the near future. Ultimately, more counties can and should extend indigent care to the remaining uninsured, including undocumented immigrants, and provide more primary and preventive care that not only directly helps these families but is also more effective and efficient for our health system.

For decades, California counties have been the last resort to care for low-income uninsured residents who have no other options and who would otherwise live sicker, die younger, and are one emergency from financial ruin. Yet counties have dramatically different ways of meeting this responsibility, under what is known as their “section 17000” obligation.¹ As recent Health Access surveys² of county indigent health programs have shown³, counties interpret their responsibility widely with regard to who they serve (by income or immigration status), what services they provide, and even how they deliver the care.

Following the recent implementation of the Affordable Care Act, counties experienced a dramatic decrease in the number of people enrolled in county programs for the “medically indigent” population. The majority of individuals previously enrolled in county safety-net programs have successfully enrolled in Medi-Cal or Covered California, the state-based health marketplace. However, the need for these safety-net programs continues. Estimates suggest 2-3 million Californians will remain uninsured for various reasons, ranging from affordability challenges to explicit exclusions from health care coverage and financial assistance due to immigration status.

As a growing number of people take advantage of health care coverage options under the Affordable Care Act, an increasing number of counties are recognizing the need to re-orient their county indigent care programs to better meet the needs of the remaining uninsured that exist in their communities.

Access to Care for Undocumented Californians by County (2015)



More Counties are Recognizing Californians Need #Health4All

Counties and stakeholders, including community groups, have worked to improve access to care and ensure that everyone, regardless of immigration status, has access to affordable health care. In early 2015, there were just nine counties that provided health care services beyond emergency care to undocumented immigrants: Alameda, Los Angeles, Riverside, Fresno, San Francisco, San Mateo, Santa Clara, Santa Cruz, as well as Ventura, which provides discounted rates for its hospital care.^{4,5}

This year there are an additional 38 counties that provide health care coverage to undocumented immigrants through limited-benefit, capped pilot programs: Sacramento, Contra Costa, Monterey and the County Medical Services Program (CMSP), the consortium of 35 counties located in rural California.

Creating these programs were historic steps as counties recognized their responsibility for residents who have little recourse when seeking needed health care. But they have their limitations: providing limited benefits falls far short of full coverage, capping funding and enrollment increases the possibility of waiting lists, and renewal and additional financing is required in order to be sustainable.

Each county has its own unique financial, political, and policy context and has achieved a different level of success in serving the remaining uninsured. Some examples are:

- **Fresno**, after winning a lawsuit to not serve the undocumented and voting to discontinue its previous medically indigent program, ultimately decided to create a new referral system to fill a gap in specialty care with a \$5.5 million reimbursable budget with special flexibility.⁶ As of March 2016, the county had spent only \$260,000, referring only 69 people and serving 34.
- In 2015, **Sacramento, Contra Costa, Monterey** and the 35 rural counties in the **County Medical Services Program** (CMSP) decided to expand their eligibility, including offering capped, limited-benefit pilot programs to include the undocumented.
 - **Monterey**: Started program focused on providing lab tests and pharmacy in November 2015, with over 700 enrolled as of May 2016. Funded with an initial \$500,000; advocates are seeking another \$500,000 to renew the program.⁷
 - **Contra Costa CARES**: Started in November 2015 to focus on primary care, nearly 3,000 enrolled as of May 2016, nearing the enrollment cap of 3,000. Funded through June 2017, \$500,000 is provided by county and matched with \$500,000 by local providers. Advocates are seeking \$250,000 to receive additional match and extend the program for another year.⁸
 - **Sacramento Healthy Partners**: The new primary care program's enrollment is at around 2,003 for May 2016, picking up steam after the first few months of implementation; the program has an enrollment cap of 3,000.⁹
 - **CMSP**: After adopting a new strategic plan for the 35-member counties last year, eligibility expansions¹⁰ and a new primary care benefit¹¹ start in May 2016.
- Some counties like **Santa Clara** and **Los Angeles** are augmenting their safety-net in a smarter way, with programs like My Health LA and Healthy San Francisco.
 - **My Health LA**:¹² As of May 2016, almost 140,000 enrolled, approaching its current enrollment cap, but advocates are seeking added funding.¹³
 - **Santa Clara Primary Care Access Program**: Started in March 2016 with 159 enrolled, but rapidly increasing. The program is capped at 5,000 and funded through March 2017.

The counties of Sacramento and Contra Costa restored some of the access lost by county budget cuts in 2009, while Monterey and CMSP's actions were largely new for their region. Some counties focused on providing better access to primary and preventive care and adopting a medical home model while others worked to fill gaps in specialty care. Los Angeles and Santa Clara had traditionally served undocumented Californians but enhanced what services they provided. While all counties approached this decision somewhat differently, there were some common themes for the shifts in approaches.

Why Did Counties Undertake These Expenses?

Improved economy and budget situation: Until 2009, three additional counties offered safety-net health care services to undocumented residents. But faced with the biggest recession since the Great Depression, and the resulting reduction in revenue and the need for cuts, Sacramento, Contra Costa, and Yolo counties voted to roll back eligibility for undocumented Californians (Contra Costa continued its Healthy Kids program for undocumented children). As the California economy improved, counties had the opportunity to restore programs, services, and eligibility as before and take steps toward serving a broader slice of their community.

Health reform savings and other financial opportunities: The passage of the Affordable Care Act provided another financial opportunity for counties. As Health Access' 2015 county survey showed, many of the Californians previously served by county safety-net programs are now covered under the ACA by Medi-Cal or Covered California. Many of these counties with restrictive eligibility rules found virtually nobody left to serve after the ACA coverage expansions. The counties with broad eligibility, including serving the undocumented, did see reductions but had thousands of uninsured residents still needing their assistance. In all cases, counties found savings after health reform, either because the formerly uninsured no longer needed care from safety-net programs or patients continued to see public health providers but now counties received payment from Medi-Cal or Covered California.

The state claimed some of these savings through the legislation that authorized the state's Medi-Cal expansion, AB 85. The formula in AB 85 allowed the state to reclaim a majority of the approximately \$1.4 billion of vehicle license fee dollars that had traditionally flowed to counties to support public health and indigent health care. Counties could choose between two formulas. One option allowed counties to keep around 40% of that state money to support their public health programs and care for the remaining uninsured. The second option was a "cost-based" formula that allowed the county to keep more of the state funding if the county could document the cost of care it provided and offset any additional revenues from newly covered patients. In the latter case, these counties would get reimbursed for care to the uninsured they historically served, but would lose funding if they could not show they are providing such care.

Despite the complexity of the formula, counties found some financial opportunity under the ACA. Sacramento county previously served 10,000 in their safety-net program, but after Medi-Cal's expansion in 2014, the program provides services to virtually no one, due to their low income eligibility and restriction against those who are undocumented. Even under the AB 85 state funding formula, they projected a slight surplus. Similarly, CMSP saw a major reduction in their budget, but the AB 85 funding

formula continues to provide over \$25 million per year to provide safety-net services, despite their enrollment dropping to the low hundreds. Facing this existential question, CMSP went through a strategic planning process which led to several eligibility expansions of its main program, as well as a new primary care benefit that would also extend to some undocumented Californians.

Contra Costa County found additional financial support by getting local hospitals to contribute matching dollars to county funding to provide for a primary and preventive care pilot program for their uninsured population.

Alameda County was able to continue to provide its own funding for safety-net services, including the coverage-like program for the remaining uninsured called HealthPAC. This program continued to be funded through the renewal of a half-cent sales tax through Measure AA, which was renewed in June 2014 with 75% of the vote.¹⁴

Political and community support: A crucial ingredient in all of the efforts to strengthen the county safety-net was political will and leadership, from both policymakers and the public. Recent Field Polls show the majority of voters support providing care to undocumented residents and this support is growing with younger and more diverse voters who are more inclined to back these measures.¹⁵

In many counties, community groups highlighted the need to cover the undocumented and raise public awareness. Faith-based groups like COPA in Monterey, ACT in Sacramento, and CCISCO in Contra Costa led efforts to expand coverage based on immigration status, but other key actors included community groups like Alliance for Californians for Community Empowerment (ACCE), the Monterey Labor Council or the Building Healthy Communities consortiums supported by The California Endowment. Local safety-net providers also played key leadership roles, such as the Contra Costa County Community Clinic Consortium, Community Health Partnership in Santa Clara, the Los Angeles County Community Clinic Consortium, as both advocates and implementers of these safety-net reforms.

To change policy, leadership was also critical at both the county administration and the Board of Supervisors level, where policy change requires at least three of five votes. In Fresno, the county successfully sued to absolve itself of a historic injunction that required the county to serve the undocumented. However, due to community pressure and legislation providing the county more funding flexibility, a relatively conservative Board of Supervisors stopped short of fully repealing the previous program. Instead it voted to create a new program to provide specialty care for the remaining uninsured including undocumented residents. In Sacramento, change became possible when a Supervisor retired and his replacement, Patrick Kennedy, announced that expanding access was a priority for him at a candidate forum sponsored by local community groups. Kennedy worked closely with Supervisor Phil Serna to prioritize the issue, hold a workshop, and ultimately secure the support of the other members of the Board. In Contra Costa, the Health Director William Walker convened a task force of stakeholders to create a proposal and Board Chair John Gioia led the efforts to pass it, resulting in a 4-1 vote to establish and fund the program.

Based on their public deliberations, County Supervisors and other county stakeholders were also cognizant about on-going conversations in other counties and the state level. Some Supervisors

explicitly cited what other counties were doing, either in their advocacy as champions of the change or in explaining why they supported the move. Others had staff review and consider what other counties were doing as a model for action. In some cases, County Supervisors explicitly hoped that their actions in the county would prompt further action at the state and national level. In this way, the advocacy in multiple counties and at the state level has been reinforcing.

Health policy momentum: Finally, many of these changes are a natural outgrowth of the evolution in health policy. The expansions under the Affordable Care Act have not just provided savings, but have brought California closer to providing care to all who need it. With more Californians covered, it is now financially and politically feasible to discuss how to provide care to the remaining uninsured. These county steps extend the premise of the ACA that our health system is stronger and more efficient when everyone is included and our society is healthier when all have access to primary and preventive care.

Many of these counties applied lessons learned from the early expansion of Medicaid through county-based Low-Income Health Programs (LIHPs). Some counties had expanded Medi-Cal under the ACA as much as two years early, providing a coverage-like safety-net program including a medical home. Academic researchers spotlighted the benefits of such an approach.^{16,17} When over 600,000 Californians in county LIHPs were switched to full-scope Medi-Cal at the state level, some counties sought to shift their LIHP infrastructure to cover new populations of the remaining uninsured. Los Angeles relaunched its LIHP program, Healthy Way LA, with new parameters and a new name, My Health LA, in September 2014, but continues to use the same call center and other infrastructure, including restored relationships with partner community clinics.

A Smarter Safety Net, Too.

My Health LA is an example of how the health reform movement is working to provide “Health4All” by shifting the focus away from episodic and emergency care to primary and preventive care. Some counties are enrolling their uninsured residents in coverage-like programs, providing an ongoing relationship with medical professionals and a sense of belonging to a “medical home.” My Health LA provides a card and assigns patients to a primary care home at a community clinic where the patient can develop an ongoing relationship with a health care provider and can be referred to other specialists or hospital care within the county hospital system. Some programs like Healthy San Francisco have existed for years while the Santa Clara Primary Care Program recently started. In the coming years, we expect more counties to create similar programs under this model.

The new opportunity under the Global Payment Program: More progress is expected in counties across California due to a new financing structure for public hospitals systems under the Medi-Cal 2020 federal waiver.¹⁸

The “Global Payment Program” in the new Medi-Cal 2020 waiver provides the financial incentive to have public hospital counties start and/or expand safety-net care programs for the remaining uninsured. Public hospital counties that are impacted by the GPP include: Los Angeles, Riverside, San Bernardino, Ventura, Kern, Monterey, Santa Clara, San Mateo, San Francisco, Alameda, Contra Costa,

and San Joaquin.¹⁹ While some already offer expanded eligibility or benefits, all can use the Medicaid waiver changes to enhance their safety-net programs.

In these counties, public hospital systems will receive new flexibility and new rules to use their Safety Net Care Pool (SNCP) and Disproportionate Share Hospital (DSH) dollars to care for the remaining uninsured, with incentives to provide primary and preventive services outside of the emergency department. Key changes in the rules state that these specific funds could no longer be used for serving the Medi-Cal eligible population and so there is more accountability for counties to directly serve the remaining uninsured. Also, a new points system would shift reimbursements over the course of five years from traditional services like emergency room visits to alternative and preventative care.²⁰

Under this new Global Payment Program, public hospital counties have strong incentives to fully maximize their GPP dollars by:

- **Expanding eligibility:** GPP funds can only be used to care for the remaining uninsured. Income or immigration restrictions effectively leaves money on the table.
- **Emphasizing primary and preventive care:** The new points system will shift reimbursements to incentivize non-hospital, community-based care.
- **Offering an enrollment-based medical home:** The best way to connect the uninsured to “upstream” care is through an enrollment-based system that allows for tracking and giving the patient a sense of membership, continued connection and regular interventions.

California counties should continue the trend to a more inclusive and smarter safety-net, especially those public hospital counties that have new incentives under the Global Payment Program. This includes both public hospital counties that could enhance their initial steps last year, such as Monterey and Contra Costa, as well as counties that would be newly considering the issue, such as San Joaquin, Kern, San Bernardino, and others. The new financing structure could also allow counties to build on their longstanding programs, such as Ventura, Riverside, Los Angeles, San Francisco, Alameda, Santa Clara, and San Mateo.

Conclusion

California is making significant strides to provide care for the remaining uninsured, regardless of immigration status.²¹ In addition to the county expansions, the statewide progress includes:

- **Continuing California’s Coverage of “Deferred Action” Immigrants:** The President’s executive action had the impact of expanding this category of immigrants covered by state-funded Medi-Cal. This was affirmed in the 2015-16 California state budget.
- **Medicaid Coverage for All Children Under 266% FPL, regardless of immigration status:** Starting in May 2016, the state expanded Medi-Cal to an estimated 250,000 undocumented children. The 2016-17 budget includes \$188.2 million to cover potentially 185,000 children.
- **Potential steps to a Statewide Solution for #Health4All:** Currently pending, SB 10 (Lara) would seek a 1332 federal waiver to allow undocumented adults to buy health plans on Covered California using their own money. Covered California produced a report in April clearing the way to advance this 1332 waiver. Other legislative initiatives like SB 1418 (Lara) and budget efforts would expand Medi-Cal to include adults as well.

County efforts to expand coverage and services to the remaining uninsured have been complementary and extensive. The reasons for the boost in county progress have been multi-faceted: political will and climate, better economic news, health reform savings, and the policy logic and momentum from health reform. Health Access expects these reasons will also encourage other counties to experiment and seek new opportunities to cover their uninsured residents. We also expect a new wave of county-based expansions, as those counties that took action last year solidify and take additional steps, and as other counties take advantage of the new opportunities under the Global Payment Program under the Medi-Cal 2020 waiver.

Ultimately, much like the early expansion of county-based Low-Income Health Programs led to a successful Medicaid expansion statewide, these county-based programs can help lead to a statewide solution to ensure true #Health4All, when all Californians have access to the care they need.

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¹ California Welfare & Institutions Code Section 17000

<http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=16001-17000&file=17000-17030.1>

² Health Access, "California's Uneven Safety-Net: A Survey of County Health Care," November 2013.

http://www.health-access.org/images/pdfs/CAunevenSafetyNet_countysurvey_Nov2013.pdf

³ Health Access, "Reorienting the Safety-Net for the Remaining Uninsured: Findings from a Follow-Up Survey of County Indigent Health Programs After the Affordable Care Act." March 2015. http://www.health-access.org/images/pdfs/county_safety_net_survey_reportupdate_march15final.pdf

⁴ Ibid. Health Access' earlier studies also suggested that Kern provided such care to the undocumented, based on reporting by the county to the state Department of Health Care Services. Follow up suggested that this was not the case.

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- ⁵ California Health Care Foundation, Kelch, Deborah. "Locally Sourced: The Crucial Role of Counties in the Health of Californians." October 2015. <http://www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties>. This comprehensive CHCF study has a more strict definition for providing an indigent care program to the undocumented than the Health Access surveys. While both definitions are valid, Health Access does count Ventura's sliding scale reductions for free or reduced cost hospital care, which are available to the undocumented.
- ⁶ [http://stateofreform.com/wp-content/uploads/2016/04/County-Led-Initiatives-for-System-Improvement - Fresno-County-DPH Pomaville.pptx](http://stateofreform.com/wp-content/uploads/2016/04/County-Led-Initiatives-for-System-Improvement-Fresno-County-DPH-Pomaville.pptx)
- ⁷ Monterey County Pilot Programs for the Remaining Uninsured. January 2016. <http://www.mtyhd.org/index.php/monterey-county-pilot-project-for-the-remaining-uninsured/>
- ⁸ Contra Costa CARES factsheet: <http://cchealth.org/insurance/pdf/2015-Contra-Costa-CARES-faq.pdf>
- ⁹ Sacramento County Healthy Partners Program: <http://www.dhhs.saccounty.net/PRI/Pages/Healthy%20Partners/GI-PRI-Healthy-Partners.aspx>
- ¹⁰ CMSP All-County Letter on eligibility expansions: http://www.cmspcounties.org/pdf_files/acls/acls2016/ACL_16_02_WITH_MANUAL.pdf
- ¹¹ CMSP All-County Letter on the new Primary Care Benefit: http://www.cmspcounties.org/pdf_files/acls/acls2016/ACL_16_03.pdf
- ¹² Information from My Health LA: <https://dhs.lacounty.gov/wps/portal/dhs/coverageoptions/myhealthla>
- ¹³ My Health LA Annual Report, 2016. http://file.lacounty.gov/dhs/cms1_238009.pdf
- ¹⁴ Health Access, Cleveland, Bradley. "Winning Revenues for the Remaining Uninsured: Lessons from Alameda County's Successful Measure AA Campaign" http://www.health-access.org/images/pdfs/alameda_county-measure_aa_report_april9_2015.pdf
- ¹⁵ Field Poll, DiCamillo, Mark. August 26, 2015. <http://www.field.com/fieldpollonline/subscribers/RIs2510.pdf>
- ¹⁶ Health Affairs, Long, Peter and Richard Thomason. "California's Low Income Health Program: A Public-Private Partnership That Worked." <http://healthaffairs.org/blog/2014/02/14/californias-low-income-health-program-a-public-private-partnership-that-worked/>
- ¹⁷ UCLA Center for Health Policy Research, Low-Income Health Program Evaluation. <http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/low-income-health-program/Pages/default.aspx>
- ¹⁸ Information about the Medi-Cal 2020 waiver: <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>
- ¹⁹ Information about the Global Payment Program (GPP): <http://www.dhcs.ca.gov/provgovpart/Pages/GlobalPaymentProgram.aspx>
- ²⁰ Harbage Consulting. Pagel, Lucy and Jennifer Ryan. "The Medi-Cal 2020 Global Payment Program (GPP): A New Approach to Safety Net Funding for Public Hospital Counties." March 2016. <http://www.health-access.org/images/pdfs/HC%20Global%20Payment%20Program%20Fact%20Sheet%203-22-16.pdf>
- ²¹ Public Policy Institute of California. McConville, Shannon, Laura Hill, Iwunze Ugo and Joseph Hayes. "Health Coverage and Care for Undocumented Immigrants." November 2015. http://www.ppic.org/main/publication_quick.asp?i=1167

Contra Costa County

Contra Costa CARES

Contra Costa CARES is a pilot program designed to provide access to primary care services and a medical home to low income, uninsured adults living in Contra Costa County who do not qualify for full-scope Medi-Cal or Covered California. Through this pilot program, Contra Costa CARES will provide primary care medical homes to an estimated 3,000 uninsured residents. While current estimates vary in terms of the number of individuals who potentially qualify for the program, a total of 19,000 uninsured individuals are estimated to be eligible for the pilot program.

SNAPSHOT

Base Program:	Basic Health Care
Eligibility Requirements:	Under 300% FPL, no age requirements
Undocumented Residents Included:	No, except for children under 19
Covered Services:	Physician, hospital, drugs, lab and specialists
Share of Cost:	Yes
<i>Pilot Program:</i>	<i>Contra Costa CARES</i>
<i>Eligibility Requirements:</i>	<i>Under 138% FPL, over 19 years old</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Primary care services and some ancillary services, including lab and radiology; limited specialty care</i>
<i>Share of Cost:</i>	<i>Pharmacy only</i>

Political Context

Contra Costa was one of three counties that eliminated access to its county safety net program for undocumented adults in 2009, eliminating care to thousands of residents for a projected \$6 million in savings. The county continued to serve undocumented children through its Basic Health Care program and provided some direct grants to community clinics to help them provide health care services for individuals impacted by that policy shift.

This context provided the impetus for stakeholders to form a campaign to restore services for the undocumented adult population in Contra Costa County. Local providers who were the most impacted by the 2009 decision, including community clinics that needed greater capacity to serve this population and local hospitals that were seeing the uninsured in their emergency rooms, were motivated to address the health care needs of this population. There was also strong interest from community groups like Healthy Richmond, ACCE, and others to address this issue.

Contra Costa CARES pilot program was developed following an extensive planning process with many local and state stakeholders, including Contra Costa Health Services, the Hospital Council of Northern & Central California, and the Community Clinic Consortium of Contra Costa and Solano.

Other groups engaged in the planning process as well including Kaiser Permanente Community Benefits, Sutter-Delta Medical Center Community Benefits, John Muir Health Community Benefits, La Clinica de la Raza, LifeLong Medical Care, and Planned Parenthood of Northern California. The planning process was funded by the Blue Shield of California Foundation and John Muir/Mt. Diablo Community Health Fund.

Organized under a #OneContraCosta campaign, community organizations secured endorsements from over thirty local and statewide organizations, generating postcards, calls and letters in support of the Contra Costa CARES program. Championed by Supervisor John Gioia, the board voted 4-1 to establish and fund the program in conjunction with funding from the three local hospitals (Kaiser, John Muir, and Sutter).

Program Details

To be eligible for Contra Costa CARES, residents of Contra Costa County must be uninsured, 19 years of age or older, not eligible for full-scope Medi-Cal or Covered California, and have a household gross income that does not exceed 138% FPL.

The program offers primary care services and some ancillary services, including lab and radiology. While specialty care is not a covered benefit under CARES, residents can access limited specialty care services through the local hospital systems under existing charity care programs and services offered through Operation Access. Dental and vision are also not covered benefits. Services offered by state coverage programs such as FamilyPACT, Every Woman Counts, and Breast Cancer Early Detection Program are also not covered by the CARES program.

Patients requiring emergency care and/or hospitalization may go to any hospital for these services, at which point they are screened for Medi-Cal, CARES, charity care, and other health insurance and coverage programs. Patients who are eligible for the CARES program are referred to a participating community clinic.

Residents can access care at any of the following participating community health centers: La Clinica de La Raza with sites in Pittsburg, Oakley and the Monument Corridor; LifeLong Medical Care with sites in Richmond and San Pablo; Axis Health with sites in Pleasanton and Livermore serving south county residents; and Brighter Beginnings with sites in Antioch and Richmond. Planned Parenthood of Northern California also provides limited primary care services for selected primary care conditions. Patients with more complicated conditions are referred to providers in the CARES network. Enrollment and eligibility are completed at participating community health centers.

The Contra Costa Health Plan (CCHP) serves as the fiscal agent and helps manage the program at no cost. CCHP monitors patient enrollment and eligibility, issues membership cards to patients, and provides nurse advice services.

Primary care providers participating in the CARES program are paid a capitated rate of \$28.00/per participant/per month for a total annual cost of \$336.00/per year per participant. This rate covers primary care services and basic laboratory and radiology services. Planned Parenthood is provided with a small grant to provide limited primary care services for individuals in the CARES program. There are no co-payments for services covered under the CARES program, however patients

experience small co-payments for pharmacy services and other out-of-pocket expenses for services not covered by the program

It is expected that an estimated 3,000 individuals will enroll in the program by the end of May 2016, at an annual cost in the first year of \$1 million, with \$500,000 contributed by the county and another \$500,000 in matching funds from local hospitals.

Next Steps

Enrollment for the Contra Costa CARES program began in November 2015 and enrollment is expected to reach its capacity by the end of May 2016. Over the next two years, the Community Clinic Consortium will work with CCHP and program providers to measure the impact of the program across a variety of indicators: number of individuals enrolled in primary care and with a designated medical home; impact on emergency room utilization for enrollees; effective hospital referral to a primary care medical home; and other qualitative measures.

Advocates are continuing their work with Contra Costa County leaders to secure an additional \$250,000 in funding for the program, which would in turn lead to another \$250,000 in matching grants from local hospitals. This funding would extend the pilot through June 2017, allowing for time to conduct a more thorough analysis of the program's impact, which will help inform long-term funding options. Advocates are also looking at how the Global Payment Program under the Medicaid waiver might help, given that its incentives align with the structure of Contra Costa CARES.

Rural California

CMSP with Expanded Eligibility and a Primary Care Benefit

The County Medical Services Program (CMSP) Governing Board provides indigent care services for 35 of California's small and rural counties, mostly north of the Bay Area but also in the Central Valley and along the eastern part of the state including in the Sierra Nevada mountains. Following a strategic planning process and board decision made in June 2015, CMSP is expanding its eligibility in May 2016 and adding a new primary care benefit for eligible members.

SNAPSHOT

Base Program:	CMSP Standard Benefit
Eligibility Requirements (expanded):	Under 300% FPL, ages 21-64
Undocumented Residents Included:	No
Covered Services:	Doctor, clinic, outpatient, and hospital care
Share of Cost:	Yes
<i>Pilot Program:</i>	<i>CMSP Primary Care Benefit</i>
<i>Eligibility Requirements:</i>	<i>138-300% FPL, ages 21-64</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Three doctor visits and up to \$1500 pharmacy</i>
<i>Share of Cost:</i>	<i>No</i>

Political Context

The 35 least-populated counties in California, each representing mainly rural areas with less than 500,000 residents, have long been part of the CMSP. While they separately operate public health programs, they pool together their indigent care funding as a more efficient way for them to fulfill their health care safety net obligations rather than each administering their own smaller program. CMSP leveraged the Medi-Cal computer systems and contracted with third party administrators to provide health care and pharmaceutical services to uninsured residents who are eligible for services, which included legal and undocumented residents not eligible for Medi-Cal up to 200% FPL.

The county's responsibility to provide coverage grew substantially in the implementation of the Affordable Care Act with the early expansion of Medicaid, which California implemented using the county-based Low-Income Health Programs (LIHP). CMSP ran the second-largest LIHP in the state, called Path2Health, with over 80,000 Californians enrolled at its peak and with a budget of over \$400 million, including state and federal matching funds. In 2014, the majority of CMSP members were eligible for full-scope Medi-Cal or Covered California.

At the same time, under AB 85, the state of California reclaimed most of the indigent care funding going to counties under the argument that many of these members were now being covered under state and federal programs. The result is that CMSP ended up being a significantly smaller program. The rural counties preserved their funding for public health programs, but the annual allocation to CMSP for indigent care is roughly \$30 million a year.

At the same time, since ACA expansion, the number of people served by CMSP has dwindled to 700 members per year. CMSP has now grown a reserve of over \$230 million and has a steady stream of funding going forward, but a very small population to serve since the vast majority of those previously served are now covered by the Medi-Cal expansion. Under the old eligibility rules, only patients with incomes in 138%-200% FPL who missed the open enrollment periods in Covered California are eligible for CMSP assistance, a narrow slice of the uninsured.

Recognizing the need to adapt to a world post-implementation of the ACA and AB 85, the CMSP Governing Board undertook a strategic planning process through its two standing committees, one on eligibility and the other on planning and benefits, culminating in a major meeting in June 2015. At that meeting the CMSP Governing Board, made up of a mix of County Administrators, Supervisors and Health Directors and Welfare Directors from a range of CMSP counties, unanimously adopted recommendations that were crafted by staff and vetted by the CMSP committees. The recommendations included expanding eligibility, offering an initial grant program to increase capacity in rural areas, and providing a new Primary Care Benefit for those eligible for emergency services only due to immigration status.

Program Details

Starting in May 2016, CMSP will adopt several eligibility expansions. Most notably, the expansions include expanding eligibility from 200% to 300% of the FPL, lifting the “asset test” of what recipients can own in assets (from \$2,000 to \$20,000), increasing the eligibility term from three months up to six months, and reducing cost-sharing for recipients.

Health Access and other advocates believed that CMSP’s funding stream could have allowed for broader expansions in each of these areas, such as even further reduced share of cost, up to 400% FPL, and eliminating the asset test similar to the Medi-Cal program. However, CMSP stated this initial program is a pilot effort that will be reevaluated after two years and could be adjusted if found to be too cautious or ambitious.

While eligibility for the Standard Benefit program continues to be restricted to legal residents and excludes undocumented immigrants from comprehensive services, CMSP is launching a new primary care benefit starting in May 1, 2016. This new primary care benefit covers three doctors’ visits and up to \$1,500 in pharmacy during the member’s enrollment term.

The doctor visits could include primary care physicians or specialists, in-office minor medical procedures, physical therapy, X-rays, ultrasounds, and other scans, lab tests, immunizations and screenings. This new benefit is intended to help members receive primary care that may prevent an emergency room visit as well as follow-up care after an emergency room visit. The benefit is available to those excluded from Medi-Cal, adults between 138%-300% FPL regardless of

immigration status. This will aid undocumented immigrants in this income range, as well as allow members in the standard CMSP program to receive care before they have to pay their share-of-cost.

What's Next

While these eligibility expansions and the new primary care benefit pilot program is limited in scope and impact, it is a notable step in the 35 rural counties where providing care to immigrant communities is practically and politically difficult. The CMSP Governing Board is also developing a short-term grant program to help enhance health care provider capacity and improve integration with health services.

The most obvious gap is that the current expansions do not serve the most vulnerable—undocumented immigrants below 138% FPL. The Governing Board has committed in public discussion to explore extending the primary care benefit, as well as further improvements, in the future after implementing and evaluating this initial expansion and determining what funding is available.

Fresno County

Fresno County Non-Resident Specialty Fund

In 2014, Fresno County voted to provide specialty medical services to undocumented immigrants as a result of an agreement reached with the state involving the county’s realignment funding formula. As a result, undocumented immigrants can access primary care, basic lab, radiology and hospital services at participating federally qualified health centers (FQHCs).

SNAPSHOT

Base Program:	Medically Indigent Services Program (MISP)
Eligibility Requirements:	Under 138% FPL, ages 21-65
Undocumented Residents Included:	No
Covered Services:	Primary care, specialty care, hospitalization, outpatient clinics, labs, and pharmacy services
Share of Cost:	No, under 138% FPL; Yes, 138-224% FPL
<i>Pilot Program:</i>	<i>Non-Resident Specialty Fund</i>
<i>Eligibility Requirements:</i>	<i>Up to 138% FPL, ages 21-65</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Gap coverage, specialty services and limited hospital services</i>
<i>Share of Cost:</i>	<i>Yes</i>

Political Context

Fresno County had a unique arrangement where it paid a set amount of money to the county hospital to provide care to the indigent population. Following the implementation of AB 85 and the reallocation of realignment dollars, the county determined that the existing contract with the county hospital would need to be renegotiated. Because Fresno County was receiving less money from the state, and the demand for care was reduced by the implementation of the ACA, the county felt the need to renegotiate their existing arrangements. What was not apparent or expected from community advocates and other stakeholders was Fresno County leaders would move to terminate its indigent health care program for undocumented immigrants. In a quick Christmastime action, the county sued the state to absolve itself from a longstanding court injunction requiring Fresno County to provide indigent services to the undocumented. While legal services groups like Western Center on Law and Poverty (WCLP) and California Rural Legal Assistance Foundation (CRLAF) fought the effort, the county prevailed. That set the stage for Fresno disbanding its longstanding arrangement with Community Hospital and in effect its longtime indigent care program and setting the stage for negotiations for what would replace it.

After several months of pressure from constituents, advocate groups and other stakeholders, Fresno County ultimately voted, in a close 3-2 vote with much contention, to provide undocumented immigrants with specialty services only. This came about through an agreement reached between the state and the county which enabled Fresno County to provide specialty medical services to undocumented immigrants at no net cost to the county.

One area of concern was that the new formula under AB 85 (through which realignment dollars would flow to the county) and how much would be reclaimed by the state. Under AB 85, the state reclaimed some of the money that came to them for indigent care and public health, but allowed counties to still to be reimbursed for an amount equal to what the county spent on caring for the remaining uninsured, within certain limits based on historical data. The state accepted this agreement, in part because Fresno County covered undocumented immigrants on July 1, 2013, the base period for the calculation on county contributions.

Advocate groups involved in the effort to secure comprehensive health care for undocumented immigrants included Centro La Familia Advocacy Services, Fresno Center for New Americans, Faith in Community PICO, Fresno Barrios Unidos and Leadership Counsel for Justice Accountability. Many worked together as part of the Building Health Communities (BHC) group in Fresno.

Program Details

The county Medically Indigent Services Program (MISP) program now excludes undocumented residents and has experienced limited enrollment as a result. A new Non-Resident Specialty Fund offers gap coverage, specialty services and limited hospital services to adults up to 138% FPL. County officials argued that primary care was already provided by existing community clinics, such as Clinica Sierra Vista, and that emergency room services would be provided by hospitals under their existing obligations, including charity care, but specialty care is not covered by any program.

Patients are referred to specialty care by participating community clinics. Patients must meet eligibility requirements, demonstrate medical necessity and exhaust all possible health care options, such as Medi-Cal, before receiving specialty care services. Fresno County contracts for specialty services and inpatient services at Medi-Cal rates for services not reimbursable under Medi-Cal.

Since the AB 85 formula reimburses the county for care it provides, Fresno County argued it needed additional flexibility to have the cash flow and initial funds for the first year of the program. AB 2731 (Perea), supported by advocates like Health Access, WCLP and CRLAF, provided Fresno County a five-year delay in having to pay a maintenance-of-effort fee to a transportation fund. That provided Fresno County \$5.5 million to start the safety-net program. The county can run the program at essentially no new cost going forward, with reimbursements provided by the state under AB 85. Under AB 85, Fresno County is no longer guaranteed a set amount of indigent care dollars, but is reimbursed for the cost of care it provides (up to a certain level). If Fresno County does not provide care, it does not draw down the funding that is available.

As of March 2016, only 69 patients have been referred to the program and only half (about 30 patients) have accessed services. Of the \$5.5 million available, only \$260,000 has been spent.

What's Next

It is a victory that Fresno County continues to serve the remaining uninsured residents in their county, including undocumented immigrants. However, the program that is in place is limited and underutilized. While program administrators have identified more people who are eligible for full-scope Medi-Cal, there is certainly a larger population of uninsured residents who are in need of health care coverage and services. Advocates are trying to determine if the issue is reimbursement levels (which the county says is restrained by the current funding formula) or how the program is structured, in terms of outreach, referral, or benefits provided.

Los Angeles County

My Health LA

My Health LA, which launched October 1, 2014, may be the largest source of coordinated care to undocumented immigrants in the nation, providing primary and specialty care services to over 145,000 residually uninsured low-income residents of Los Angeles County, including undocumented immigrants.

SNAPSHOT

Base Program Name:	Ability to Pay
Eligibility Requirements:	No FPL Cap
Undocumented Residents Included:	Yes
Covered Services:	Hospital care and related clinics
Share of Cost:	Yes
<i>Pilot Program:</i>	<i>My Health LA</i>
<i>Eligibility Requirements:</i>	<i>Under 138% FPL, over age 6</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Primary care, emergency, prescription, outpatient/specialty, and inpatient</i>
<i>Share of Cost:</i>	<i>No, under 138% FPL; Yes, over 138% FPL</i>

Political Context

With an estimated 400,000 residents in Los Angeles County unable to qualify for health coverage under the Affordable Care Act, there is a significant need to expand health coverage to the uninsured and to ensure the most vulnerable has access to care. While Los Angeles County already served undocumented residents, including through its partnership with local community clinics and health centers, this new effort provided a medical home to over 140,000 uninsured residents with primary and specialty health care.

Community organizations, like Community Health Councils, Health Access, California Partnership, LA Voice, One LA, and others participating in the LAHealth4All Coalition, strengthened the county's health safety-net infrastructure in order to increase the quality and access to health care for the residents that remained uninsured. The coalition played a critical role in the development of My Health LA and continues to play a vital role in the ongoing development of the program. These partners provided support in their respective areas of expertise, including community-based research, community engagement, and consumer education.

My Health LA builds upon two previous efforts in Los Angeles to provide health care covered to those who are uninsured. The first effort is the two decades' long partnership of the county hospital

system with community clinics. This program was seen as a more effective way to structure the previous funding for community clinics. My Health LA also capitalized on the success of Los Angeles' early expansion of Medicaid through a Low-Income Health Program called Healthy Way LA. When 280,000 Angelenos in that program were shifted into full-scope Medi-Cal, it left behind an infrastructure (staff for an enrollment based program, a call center helpline, etc.) that could be repurposed to serve a new population. In fact, while Healthy Way LA mostly served those who would be eligible for the ACA Medi-Cal expansion, patients who were not eligible were placed in "Healthy Way LA Unmatched" to be reimbursed through other funds. This was the early version for what became My Health LA.

Program Details

Uninsured residents of Los Angeles County can access primary care services at one of 200 participating community clinics across Los Angeles County. The selected community clinic serves as the patient's medical home. Specialty, hospital and emergency care are available at the Department of Health Services' (DHS) clinics and hospitals. Residents of Los Angeles County, age 6 and older, who meet income requirements and are ineligible for other coverage options are eligible for the My Health LA program.

Next Steps

Los Angeles County is in the final stages of preparing My Health LA's first annual report. The county has solicited feedback from community partners about the type of data that should be included in the report.

While over 140,000 residents are now enrolled in My Health LA, there is still a significant number of residents who remain uninsured, especially within certain ethnic groups, such as the Asian/Pacific Islander (API) community. Community stakeholders are working with DHS to improve education and outreach, recognizing that DHS is limited in its ability to engage in a full outreach campaign. Organizations have provided DHS recommendations of data to include in the My Health LA annual report in order to ensure the collection of robust data that can inform the ongoing program development.

Further, with the expansion of Medi-Cal to undocumented children and pending executive actions, Los Angeles County has the opportunity to provide comprehensive coverage to more, if not all, undocumented residents who remain excluded from full-scope Medi-Cal.

Monterey County

Monterey County Pilot Program for the Remaining Uninsured

In September 2015, the Monterey County Board of Supervisors approved a \$500,000 pilot program to cover pharmacy, laboratory and radiology services for the county's remaining uninsured residents who are ineligible for health coverage under the federal Affordable Care Act. This pilot program began November 1, 2015.

SNAPSHOT

Base Program:	Monterey County Medical Services Program
Eligibility Requirements:	Under 250% FPL, ages 21-64
Undocumented Residents Included:	No
Covered Services:	Primary care and hospital care
Share of Cost:	Yes
<i>Pilot Program:</i>	<i>Pilot Program</i>
<i>Eligibility Requirements:</i>	<i>Medi-Cal eligibility, no age cap</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Pharmacy, laboratory and radiology services</i>
<i>Share of Cost:</i>	<i>No</i>

The Need

The pilot program is a collaboration between the county health department, Natividad Medical Center and the social justice organization Communities Organized for Relational Power in Action (COPA), which has advocated for health coverage for undocumented and uninsured residents for years.

Approximately 55,000 undocumented immigrants currently live in Monterey County, many of whom are excluded from health care coverage through Covered California and full-scope Medi-Cal. Currently in Monterey County, undocumented immigrants access health care services at Natividad Medical Center, Monterey County health clinics, or at a number of other FQHCs and see doctors on a sliding pay scale. However, if a doctor writes a prescription or refers an undocumented immigrant to a lab or radiology service, patients must pay for these services themselves.

Through the pilot project that started in November, Monterey County will pay for lab tests, radiology and pharmacy services. Uninsured residents, including undocumented immigrants, now have access to needed follow-up care which will help ensure these patients avoid developing more serious illnesses. The county also benefits, as acknowledged by former County Health Department

Director Ray Bullick, because limiting access to follow-up care and preventable care ultimately ends up costing the county health care system much more in the long run.

Political Context

The Monterey Board of Supervisors approved this measure unanimously, with many community groups in support representing faith, labor, immigrant, and health organizations.

Program Details

The pilot program provides uninsured residents coverage for lab and radiology services through Natividad Medical Center and the county safety-net hospital. The program also provides over 2,000 free medications through local Walgreens stores; Walgreens fills the prescriptions and invoices the county health department. Certain specialty medications are not covered, like expensive medications treating Hepatitis C.

Next Steps

As of April 2016, the program served almost 700 Monterey residents, but much of the allocated funding has gone unspent. Advocates are looking at broader outreach and an expansion of included services to improve upon the program.

The pilot program will continue to provide pharmaceutical, lab and radiology services to uninsured residents until the county exhausts the initial \$500,000 in funding. County officials are hopeful that local employers support the program with additional funding and that other funding sources will become available. Local advocates are looking for another \$500,000 county allocation to continue the program.

Sacramento County

Sacramento Healthy Partners

In June 2015, the Sacramento County Board of Supervisors voted to extend primary care and specialty care coverage to undocumented immigrants. As of May 2016, 2,003 Sacramentans are enrolled in Sacramento Healthy Partners, which started at the beginning of 2016. The program is capped at 3,000 individuals.

SNAPSHOT

Base Program:	Medically Indigent Services Program (CMISP)
Eligibility Requirements:	Under 138% FPL, ages 19-64
Undocumented Residents Included:	No
Covered Services:	Primary care, pharmacy, labs, specialty care, emergency care
Share of Cost:	Yes

<i>Pilot Program:</i>	<i>Healthy Partners</i>
<i>Eligibility Requirements:</i>	<i>Under 138% FPL, ages 19-64</i>
<i>Undocumented Residents Included:</i>	<i>Yes, for limited benefits</i>
<i>Covered Services:</i>	<i>Primary care, pharmacy, labs, and donated specialty care, medications</i>
<i>Share of Cost:</i>	<i>Co-pays for pharmacy</i>

Political Context

Sacramento was one of three counties that eliminated services to undocumented individuals in 2009 during the financial crisis (along with Yolo County and Contra Costa County). Following the implementation of the Affordable Care Act and the resulting decrease in enrollment in the County Medically Indigent Services Program (CMISP), there was increased interest from community groups, elected officials and other stakeholders to urge the CMISP to cover undocumented immigrants.

Providing coverage options for undocumented immigrants was a top priority for the Sacramento Building Healthy Communities Health Access Action Team, with leadership from Sacramento Area Congregations Together (ACT), Legal Services of Northern California (LSNC), Sacramento Covered, Health Education Council and Iu-Mien Community Services. They also worked with provider groups, including the Sacramento Latino Medical Association and the Capitol Health Network (CHN)/Federally Qualified Health Centers (FQHC) and community residents to promote health care coverage for undocumented residents in Sacramento County.

Community and provider groups worked together to form a broad coalition of support to get the county to rescind the 2009 decision to cut services to undocumented individuals. This grassroots advocacy created momentum for change.

Due in large part to Supervisor Phil Serna's leadership on the issue, the county agreed to hold a workshop on the issue of coverage for undocumented individuals (including a simulcast in Spanish). Over 400 people attended to show their support for extending coverage to the undocumented population. Community groups, faith based groups and local elected officials from surrounding counties also advocated for this change in policy, as well as elected leaders such as Mayor Kevin Johnson, California State Senator Dr. Richard Pan and others.

During this time, Supervisor Serna had a new ally on the board, Supervisor Patrick Kennedy, who replaced retired Supervisor Jimmie Yee. During Kennedy's election, community groups made immigrant health care a priority issue. Sacramento ACT held a candidate forum focused on this issue during which then-candidate Kennedy declared that a priority during his term would be extending coverage to undocumented immigrants. With Serna and Kennedy actively supporting this expansion, community groups shared many moving stories about health care gaps and needs among undocumented residents with Supervisor Don Nottoli. His support created a majority on the board in supporting not just a primary care program but one with specialty services.

At the workshop convened by the County Board of Supervisors, stakeholders explored various options for coverage, including: cover only non-emergency services not covered by the state; provide both emergency and non-emergency services and have Medi-Cal and other state programs be the primary payer; and provide both emergency and non-emergency services and have the county be the primary payer. The Sacramento Health Department presented information and cost estimates about the various options of coverage. This workshop was an opportunity for stakeholder groups and individuals to weigh-in on the need for health services for undocumented immigrants.

Following the workshop, several stakeholder meetings were held with advocates from Building Healthy Communities (BHC), including Sacramento Covered, Sacramento Area Congregations Together (Sac ACT), Legal Services of Northern California (LSNC), Iu-Mien Community Services and Health Education Council. Other stakeholders from community-based organizations like La Familia Counseling Center and Asian Resources, provider groups like Sacramento Latino Medical Association (SaLMA), the Capitol Health Network (CHN)/Federally Qualified Health Centers (FQHC), hospital systems, and faculty, residents and students from UC Davis TEACH (Transforming Education and Community Health) also participated. The medical students showed their strong support by sharing their own stories as immigrant families, serving immigrants, and being undocumented themselves. Another influential moment was Bishop Jaime Soto decrying categories of "unpeople" and urging full inclusion of undocumented immigrants in health care. The county continued to solicit feedback from stakeholders on the various potential options for coverage and explored other counties' programs including Fresno County's program. However, as various options were explored, advocates and the county agreed that there was a need for covering both primary and specialty care.

Sacramento County also explored various delivery system methods, including: paying providers on a fee-for-service basis for each service that they provide (the model the CMISP uses); contracting with a managed care plan on a per member per month basis and requiring the plan to manage the

care (this was the model used for the LIHP program); and contracting directly with providers for services but paying those providers on a per member per month basis for the services they provide.

The county approved the delivery of primary and preventative care to uninsured adults, including undocumented immigrants. The program is called “Healthy Partners,” reflecting the partnerships between the patients and the primary care provider team. It also includes county partners, such as Employee Health Systems Medical Group (contracted to provide specialty care), the efforts of Sierra Sacramento Valley Medical Society (SSVMS), SPIRIT program, UC Davis’ TEACH program, the local hospital systems, Sacramento Covered, and advocates.

Program Details

The County Health Center, also a teaching program, provides primary care services for the Healthy Partners program. The program covers integrated primary care and does not include specialty care services. The only cost to the patient is for low-cost retail pharmaceuticals.

Specialty care is provided through a program called “Healthy Partners Plus” and is only available for patients who are enrolled in Healthy Partners and who meet medical-necessity criteria and if the particular specialty service needed is available. Patients must enroll at the Sacramento County Health Center and enrollment is limited. Due to limited funding, not all specialties are covered.

Staff and navigators refer patients for any available specialty services that are not covered. Services covered by other programs and any emergency or inpatient hospitalization are excluded and not covered by the program. However, emergency services are covered through restricted scope Medi-Cal. Specialty services are provided through three means: County Health Center, Sacramento Physicians’ Initiative to Reach Out, Innovate and Teach (SPIRIT) Volunteer Program and EHS, which is the contracted vendor that provides identified advanced diagnostic testing (such as a MRI) and identified specialty care.

Next Steps

Advocates are exploring expanding the program by age and benefits provided. Geographic access is also an issue the advocates would like to address, since Sacramento County currently operates only one clinic.

Partly due to the program starting later than expected, enrollment and utilization have been slower than expected. Despite some Supervisors’ concerns, the system was not overwhelmed and the enrollment age skewed younger than expected. Advocates plan to push to lift the age cap and enrollment cap in the next year.

Through the relationships built in this effort, the coalition has stayed together focusing on other issues such as getting access for Medi-Cal patients at UC Davis.

Santa Clara County

Primary Care Access Program

On November 3, 2015, the Santa Clara County Board of Supervisors voted unanimously to approve the Primary Care Access Program (PCAP). This health coverage initiative provides primary care services to residually uninsured, low-income residents of Santa Clara County, including undocumented residents. The approved proposal is a 12-month pilot program with \$1.68 million in funding. Enrollment is capped at 5,000 patients to the following Community Health Partnership (CHP) participating community health centers/clinics: Asian Americans for Community Involvement, Gardner Family Health Network, Indian Health Center of Santa Clara Valley, MayView Community Health Center, North East Medical Services, Planned Parenthood Mar Monte, Mar Monte Community Health Center, and School Health Clinics of Santa Clara County. Since the program started on March 1, 2016, the health centers have enrolled 630 individuals.

Once a PCAP beneficiary is enrolled, they are simultaneously qualified for the Ability to Pay Determination program. The APD program provides access to specialty care, emergency and hospital services by Santa Clara Valley Medical Center and their affiliate clinics.

SNAPSHOT

Base Program:	Ability-to-Pay Determination (APD)
Eligibility Requirements:	Under 350% FPL, over 19 years old
Undocumented Residents Included:	Yes
Covered Services:	Specialty care, emergency, and hospital services
Share of Cost:	Co-payments based on income
<i>Pilot Program:</i>	<i>Primary Care Access Program (PCAP)</i>
<i>Eligibility Requirements:</i>	<i>Under 200% FPL, over 19 years old, patients at participating community health centers</i>
<i>Undocumented Residents Included:</i>	<i>Yes</i>
<i>Covered Services:</i>	<i>Primary care</i>
<i>Share of Cost:</i>	<i>Nominal Fees</i>

Political Context

The Affordable Care Act increased access to health care services for a significant number of Santa Clara County residents; currently about 59,000 individuals in Santa Clara County are enrolled in Covered California and enrollment in Medi-Cal has increased 30%. Despite existing coverage options for health care services, 54,000 residents remain uninsured for various reasons, including affordability, program eligibility and program awareness. While Santa Clara County has historically provided health care coverage to undocumented children and services to undocumented adults, the

need to improve health care access and outcomes for low-income uninsured adults in Santa Clara County is ever-present.

Working Partnerships USA (WPUSA), Community Health Partnership (CHP) and Santa Clara Valley Health and Hospital Systems (SCVHHS) received a \$200,000 planning grant from the Blue Shield of California Foundation to develop a coverage program for the residually uninsured in Santa Clara County. The goal of the planning grant was to improve health care access and outcomes for low-income uninsured residents in Santa Clara County by developing a viable coverage initiative program design and proposal that would provide uninsured residents a more comprehensive system of coverage, so that individuals can benefit from preventative care.

WPUSA, CHP and SCVHHS worked together to define the characteristics and health care preferences and challenges of the remaining uninsured, researched coverage models across California, and developed policy options informed by community input and actuarial analysis. WPUSA coordinated collaborative efforts among the partner organizations and conducted outreach to immigrant communities, while CHP conducted community outreach through intensive focus groups and engaged community clinic leadership and patients. SCVHHS oversaw the actuarial analysis and worked with partners to develop the program design details.

Program Details

PCAP will operate as a 12-month pilot program, funded through March 31, 2017, for uninsured residents in Santa Clara County aged 19 and older who do not qualify for Medi-Cal, Covered California nor have private insurance through an employer, and whose income is at or below 200% FPL.

Enrollees are pre-screened for Medi-Cal and Covered California eligibility before applying for the coverage initiative. Once eligibility is determined, enrollees choose a clinic or primary care provider which serves as their medical home for all primary care services. Enrollees can access specialty care, emergency and hospital services at the Santa Clara Valley Medical Center (SCVMC) through the Ability-to-Pay-Determination (APD) program. Patients who would otherwise qualify for health care services through program-specific coverage (e.g., Breast Cancer Early Detection Program, End Stage Renal Disease, Emergency Medi-Cal) are assisted by staff to enroll into the program for which they qualify. Pharmaceuticals are provided through the clinics' 340B Public Health Pricing programs and/or the Medication Assistance Program through SCVMC. The cost for these services are covered through existing programs and, as a result, ensures the maximum utilization of funds designated for the uninsured population.

The coalition opted against a monthly premium, following a determination that even a \$25 monthly premium would be too expensive for county residents earning under 200% FPL. Enrollees may be subject to a nominal fee per visit, depending on a sliding fee scale as currently required at the CHP clinics.

The participating CHP clinics receive a capitated payment of \$28 per enrollee, per month. This monthly grant amount was modeled after the My Health LA program which has 130,000 people enrolled and operates in a similar fashion to Santa Clara County's program.

Next Steps

The coalition will monitor enrollment trends, cost and budget impacts during the 12-month pilot program. The coalition will also develop and present a plan to the Board of Supervisors which will include assumptions regarding phased growth and enrollment targets, as well as any necessary modifications to the grant structure and funding for the program in subsequent years.