

Interim Evaluation Report on California's Health Care Coverage Initiative

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I. INTRODUCTION

In August 2005, the Centers for Medicare and Medicaid Services (CMS) approved California's five-year Section 1115 demonstration waiver (No. 11-W-00193/9). This waiver provided \$180 million in years 3, 4, and 5 for the development and implementation of Health Care Coverage Initiative (HCCI) programs that expanded coverage options for eligible, low-income individuals who were currently uninsured in selected counties. State legislation required to implement HCCI, Chapter 76, Statutes of 2006 (SB 1448, Kuehl), became law on July 18, 2006, and was codified at Part 3.5 (commencing with Section 15900) of Division 9 of the W&I Code. HCCI is currently being implemented in ten counties in California, beginning September 1, 2007 and ending on August 31, 2010. The goals of the HCCI program in each county are to:

- Expand the number of Californians who have health care coverage;
- Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics, and community clinics;
- Improve access to high quality health care and health outcomes for individuals;
- Create efficiencies in the delivery of health services that could lead to savings in health care costs;
- Provide grounds for long-term sustainability of the programs funded under the initiative; and
- Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

In addition to providing the statutory framework for the development and implementation of the HCCI programs, Senate Bill (SB) 1448 requires the State to assess specific impacts of the HCCI programs. In response, the State contracted with the University of California, Los Angeles (UCLA) Center for Health Policy Research (CHPR) to provide an independent evaluation of the HCCI demonstration project. This report presents interim findings on the HCCI program, with particular emphasis on findings within each individual demonstration county. In accordance with UCLA's contract with the State, this report addresses each of the 6 goals of the HCCI program described above. In addition, this report examines program revenues and expenditures, including per capita costs, in compliance with the evaluation requirements specified in SB 1448. This report presents interim findings on each of the seven evaluation criteria required by CMS and the State, organized according to the following sections:

- Expansions in Health Care Coverage,
- Expenditures,
- Expansions to Safety Net Infrastructure,
- Access and Quality of Care,
- Efficiencies,
- Sustainability, and
- Implementation.

In addition, this report includes preliminary Conclusions in the final section. This final section essentially serves as an Executive Summary, so those interested in an overview of our findings should read the final section first.

A. Evaluation Data

In accordance with our evaluation design, the findings presented in this interim report utilize data from a range of sources as received by UCLA as of April 30, 2010. The two primary data sources are individual-level enrollee data provided to UCLA by the HCCI counties and county-level progress report data submitted by the counties to the California Department of Health Care Services (DHCS). Detailed information regarding the methods used in preparation of the analyses presented in this interim report can be found in Appendix A.

Our ability to analyze individual-level data has been limited by delays in receiving these data from HCCI counties. Nevertheless, we have been able to obtain and verify data for the baseline period (September 1, 2006 to August 31, 2007), program Year 1 (September 1, 2007 to August 31, 2008) and program Year 2 (September 1, 2008 to August 31, 2009) for most HCCI counties (Exhibit 1). Data from the baseline year include individuals who were enrolled in HCCI at some time during the program period, and who had previously received care through the county indigent care program. Therefore, the baseline measures are based on a subset of the same individuals included in Year 1 and Year 2 analyses. As of April 30, 2010, all counties have provided claims data across both program years, and 9 have provided a full baseline year of claims data. Only a partial baseline year of data was available at the time of this report from Santa Clara County (Exhibit 1). Six of the 10 counties have provided a comprehensive data set including the full scope of data types as requested by UCLA, and at least a subset of enrollment data has been provided by each of the 10 counties (Appendix B).

Exhibit 1: Number of Months of HCCI Patient-Level Claims Data Available to UCLA, by County, Baseline Year and Years 1 and 2.

County	Baseline Year	Program Year 1	Program Year 2
	9/1/2006 - 8/31/2007	9/1/2007 - 8/31/2008	9/1/2008 - 8/31/2009
Alameda	12	12	12
Contra Costa	12	12	12
Kern	12	12	12
Los Angeles	12	12	12
Orange	12	12	12
San Diego	12	12	12
San Francisco	12	12	12
San Mateo	12	12	12
Santa Clara	8	12	12
Ventura	12	12	12

Notes: As of April 30, 2010. Appendix B displays the detailed information regarding the availability of requested data fields to UCLA.

Due to variations in the extent and quality of data received by UCLA, our analyses based on individual-level data cover different time periods in different counties. Because of delays in receiving data from most counties, the measures that could be analyzed and verified in time for submission of this interim report were limited to:

- total unduplicated number of enrollees;
- demographic characteristics of enrollees;
- prevalence of chronic disease diagnoses among enrollees actively using services;
- proportion of enrollees utilizing ER and inpatient care services;
- average number of inpatient days, hospital admissions, and ER visits per 1,000 enrollees per year by county; and
- selected clinical measures among enrollees with a diagnosis of diabetes, including average cholesterol and HgA1c levels, and the provision of services in accordance with clinical care guidelines.

In cases where sufficient individual-level data are not available or could not be analyzed, aggregated data provided by HCCI counties in quarterly and annual program progress reports are used. These reports include summary statistics and trend data by quarter for each county participating in the HCCI program, including data for the majority of counties on inpatient days, ER utilization, outpatient visits, enrollment and disenrollment, total expenditures, medical home assignment, outreach, and other information used by DHCS to monitor current progress in implementing the respective HCCI programs. The progress reports also include limited descriptions of the successes and challenges faced by each participating county.

Aggregated county-level data presented in this report are drawn from the revised Year 1 and Year 2 progress reports submitted by the counties to DHCS. For the first program year, San Francisco County did not report quarterly data, but did report annual data. Therefore, all quarterly trends for the first four quarters exclude data from San Francisco County, unless otherwise noted. Revised Year 2 progress reports have not been submitted by 4 counties (Kern, San Mateo, Santa Clara and Ventura). Therefore the Year 2 data for these counties are likely to be incomplete.

Additional qualitative information provided in this interim report was gathered by UCLA through interviews, site visits, and meetings. These data include information on scope of service delivery, outreach and in-reach strategies, enrollment and eligibility information, program implementation and design strategies, and challenges and successes experienced by the programs to date. Many of these findings are discussed in Policy Briefs prepared by UCLA and included in Appendices C and D. Finally, supplemental quantitative and qualitative data provided by counties are presented. These data were requested by UCLA, and include information on delivery of clinical guideline concordant services and changes in patient health status during program implementation. These further data submissions from specific counties are included in Appendices E – H and referenced in the applicable exhibits.

Several important caveats exist with respect to the data presented and discussed in this report. While the majority of measures are standardized to control for population size, these measures do not control for population characteristics or program implementation strategies. Counties vary

significantly in population, program design, and other important factors. Moreover, individual-level data provided by counties in most cases are limited to a subset of the population, and should not be considered comprehensive. In particular, it is unknown whether the subset of HCCI enrollees included in the baseline year data is a representative sample. Due to differences in data processing and categorization, UCLA analysis of claims data and progress report data may not match exactly, and are not comparable. We have presented both UCLA analyzed progress report data and UCLA analyzed individual-level data when available. Finally, data from different counties are not often comparable and direct comparisons among the counties are not meaningful. We have included county-level data in most exhibits to facilitate data presentation.

B. Description of HCCI County Programs

HCCI is currently implemented in 10 California counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Each of the demonstration counties has implemented HCCI in a unique model designed to meet local needs and resources. These counties are geographically diverse and vary in their targeted populations and program designs. In addition, each county has implemented innovative strategies to address their unique setting and challenges. Because Alameda and San Diego counties targeted their HCCI programs towards specific chronic illnesses, rather than the general indigent population, their data are presented in adjacent rows in all tables and charts within this report. The remaining counties are presented in alphabetical order.

Alameda County: Alameda County Excellence (ACE) Program

The HCCI program in Alameda County is called the Alameda County Excellence (ACE) program and is administered by the Alameda Health Care Services Agency (HCSA). ACE focuses on improving the quality of care for low-income uninsured adults with diabetes, hypertension, asthma, and congestive heart failure. The program uses the chronic care model in conjunction with panel management, a population-based, data-driven multidisciplinary approach to provide team-based primary care. The ACE program began enrollment on September 1, 2007. Enrollees are primarily recruited through point-of-care contacts, with an emphasis on enrolling individuals with high utilization of services. The ACE program has met its enrollment target since the fourth quarter of Year 1, but the county currently continues to enroll new individuals.

San Diego County: Coverage Initiative (CI) Program

The HCCI program in San Diego, known as the Coverage Initiative (CI) program, focuses on individuals with hypertension and diabetes, and contracts with a previously developed chronic care model with disease management (Scripps Whittier Institute's Project Dulce) to achieve the goals outlined for their CI program. Enrollees were recruited through a range of strategies, and are required to have a qualifying chronic illness in order to be eligible to enroll. The CI program began enrollment on November 26, 2007. Therefore, enrollment in Year 1 was delayed, and the CI program met its enrollment target in the second quarter of year two. In January of 2009 the county capped new enrollment to control program expenditures and focused on providing comprehensive care to existing enrollees. However, the program continues to renew coverage for eligible existing enrollees.

Contra Costa County: Health Coverage Initiative (HCI) Program

The Contra Costa Health Plan (CCHP), a Knox-Keene licensed Health Maintenance Organization owned and operated by the county, administers the HCCI program in the county. The program has focused on improving access to services for individuals enrolled in their safety-net program, and increasing the number of individuals enrolled. The HCI program began enrollment on September 1, 2007. The county has targeted enrollment to uninsured college students, homeless individuals, and high utilizers of health care services, although the focus on students was abandoned after August 2009. The HCI program met its enrollment target in the fourth quarter of Year 1, but the county currently continues to enroll new individuals.

Kern County: Kern Medical Center Health Plan (KMCHP)

The HCCI program is known as the Kern Medical Center Health Plan (KMCHP) and is administered by COPE Health Solutions. KMCHP utilizes an integrated delivery network (IDN) approach to build strategic alliances with public and private providers, and to create a system of care that can improve access to the low-income uninsured population in the county. The KMCHP program began enrollment on February 1, 2008. Enrollment focuses on individuals with high utilization of services. The KMCHP program met its enrollment target in the fourth quarter of Year 1, but the county currently continues to enroll new individuals.

Los Angeles County: Healthy Way LA (HWLA) Program

The Los Angeles County Department of Health Services (LACDHS) administers the HCCI program known as Healthy Way LA (HWLA), which requires individuals to meet one of three program-specific eligibility criteria. Enrollees must have either a specific chronic illness; be pre-Medicare ages 63-64; or be a previous user of LACDHS or public-private partnership (PPP) clinics who does not have a medical home. CMS recently approved amended Special Terms and Conditions (STCs) effective February 1, 2010, which allow for expansion of HWLA to include individuals up to 200% of the federal poverty level. Prior to this approval, HWLA enrollment was limited to individuals below 133.33% of the federal poverty level. The HWLA program began enrollment on September 1, 2007. Recruitment for the program occurs primarily at point-of-care locations. The HWLA program has not yet met its proposed enrollment target of 94,000 individuals.

Orange County: Health Care Coverage Initiative (HCCI) Program

The HCCI program in Orange County is designed to improve access to primary and preventive care services for eligible individuals throughout the county. The county enrolled all eligible individuals who had previously utilized the county Medical Services Initiative (MSI) program into its HCCI program and recruited additional eligible low-income uninsured adults who had not previously used the MSI program. The HCCI program began enrollment on September 1, 2007 and met its enrollment target in the fourth quarter of Year 1. In September 2009, Orange County halted new enrollment into the HCCI program, although the program continues to renew coverage for eligible existing enrollees as well as enroll new individuals with urgent or emergent conditions.

San Francisco County: Healthy San Francisco (HSF) Program

The Department of Public Health (DPH) operates the HCCI program in San Francisco County as part of a larger effort known as Healthy San Francisco (HSF). HCCI program eligibility was incorporated into the larger eligibility and enrollment department used by the county for HSF. Applicants for HSF are automatically screened for HCCI eligibility and enrolled if eligible. HSF began operation in July 2007, shortly before HCCI began enrollment on September 1, 2007. The HCCI component of HSF met its enrollment target in the second quarter of Year 2, but the county currently continues to enroll new individuals.

San Mateo County: Access and Care for Everyone (ACE) Program

The San Mateo County HCCI program is called Access and Care for Everyone (ACE). It is operated by the San Mateo County Health System (SMCHS) and includes the San Mateo Medical Center (SMMC), the San Mateo Health Department, and the Health Plan of San Mateo (HPSM), which acts as the third-party administrator for the program. The ACE program emphasizes primary and preventive care, as well as management of chronic conditions, and enrolls individuals primarily at point-of-care locations. The ACE program began enrollment on September 1, 2007 and met its enrollment target in the third quarter of Year 1. The program halted new enrollment in January 2010 but the county continues to renew coverage for eligible existing enrollees.

Santa Clara County: Valley Care Program

The HCCI program in Santa Clara, known as Valley Care, provides care to uninsured low-income adults through a coordinated network called Santa Clara County Health and Hospital System (SCVHHS). This system includes the Valley Medical Center and clinics, the Valley Health Plan (VHP), private community clinics and an Independent Practice Association (IPA) called Physicians Medical Group. The Valley Care Program does not have a specific target population, and primarily conducted enrollment activities through community outreach. Valley Care began enrollment on September 1, 2007 and met its enrollment target in the first quarter of Year 2. The county halted new enrollment in September 2009, but continues to renew coverage for eligible existing enrollees.

Ventura County: Access, Coverage, Enrollment (ACE) Program

The Ventura County Health Care Agency (HCA) administers the HCCI program in Ventura, which is known as Access, Coverage, Enrollment (ACE). The ACE program targets its enrollment to individuals who are homeless, those with chronic illnesses, and high utilizers of services, and conducts enrollment primarily through community outreach. The ACE program began enrollment on September 1, 2007 and met its enrollment target in the third quarter of Year 2. The county has ceased new enrollment as of April, 2009, but continues to renew coverage for eligible existing enrollees.

C. Eligibility Requirements

Basic eligibility requirements for the HCCI program are defined in county contracts with DHCS, which stipulates that the counties must screen all potential enrollees to determine eligibility for enrollment. Enrollment is effective on either the date of application or the first day of the month in which the application was submitted, although coverage could not begin earlier than September 1, 2007. Eligibility criteria must include, but are not limited to, the following:

- Citizen or legal resident with at least five years of residence in the United States;
- Annual income verification below 200% of federal poverty level;
- Currently uninsured:
 - Individuals between 101 and 200% of federal poverty level must not have had insurance in the 3 months prior to enrollment except in specific circumstances;
- Adult, ages 19 – 64; and
- Not eligible for any other public program.

HCCI counties must verify citizenship or legal residency status in compliance with section 6036 of the Deficit Reduction Act (DRA) of 2005, entitled, "Improved Enforcement of Documentation Requirements," to enroll eligible low-income, uninsured individuals into HCCI programs. HCCI counties are required to obtain "satisfactory documentary evidence" of U.S. citizenship and/or identity from eligible individuals prior to enrollment in HCCI. Documents that provide proof of citizenship and identity include U.S. passports issued without limitation; certificates of naturalization; or certificates of U.S. citizenship. Without one of these documents, individuals must show both a citizenship document, such as a birth certificate, and an identity document, such as driver's license.

As described in the amended Special Terms and Conditions (STCs) approved by CMS on January 27, 2010 and effective February 1, 2010, the State may apply flexibilities defined by the Children's Health Insurance Program Reauthorization Act (CHIPRA) in meeting DRA requirements for new enrollees. Under CHIPRA, the counties may provide coverage to an individual if he or she is making a good faith effort to obtain or provide documentation of citizenship/identity but requires additional time. An applicant or beneficiary is making a good faith effort if he or she demonstrates an ongoing effort to obtain and present satisfactory documents. This may include acceptance of verbal or written statements, copies of original documents, electronic social security number match, or other documentation of an effort to meet DRA requirements. At this time the State is reviewing these flexibilities, and has not yet issued direction to the HCCI counties with regard to how to implement this change.

In addition to the standard program eligibility requirements, counties were permitted to define further eligibility and enrollment criteria for their programs to fit local needs and to target the program to a specific population as desired, as indicated in the county program descriptions presented above. In addition, counties were allowed to require enrollees to pay moderate enrollment fees or monthly premiums, as well as some co-payments.

Exhibit 2 displays the program eligibility criteria and enrollment requirements currently in place in each HCCI county. The program-wide deadline to halt new enrollment was lifted in February

2010 in anticipation of renewal of the 1115 Waiver. Five counties halted new enrollment prior to the original program-wide deadline of March 1, 2010 for a variety of reasons, including: enrollment that has exceeded projected levels; lack of local funds to support continued enrollment; and, receipt of full annual allocation of reimbursement funds. Some of these counties have experienced attrition of the enrollee population due to inability to re-certify eligibility for all existing enrollees whose enrollment terms have come to an end. As a result, some are maintaining waiting lists of eligible individuals, and are considering re-opening the program to new enrollment if the population drops below the target level or the county becomes unable to expend the necessary funds at the local level to claim the allocated reimbursement funds.

Exhibit 2: Eligibility Criteria and Enrollment Requirements, by County, as of April 2010.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura
Standard Eligibility Requirements										
Age range	19-64	21-64	19-64	19-64	19-64	21-64	19-64	19-64	19-64	19-64
Legal Resident or US Citizen with >5 years residence in US	X	X	X	X	X	X	X	X	X	X
Uninsured for >3 months	X	X	X	X	X	X	X	X	X	X
Ineligible for other public programs	X	X	X	X	X	X	X	X	X	X
Federal Poverty Level (FPL)	200%	200%	200%	200%	200% ¹	200%	200%	200%	200%	200%
Additional Eligibility Criteria Adopted by Counties										
Chronic condition diagnosis:	X	X			X					
Hypertension	X	X			X					
Diabetes	X	X			X					
Dyslipidemia		X			X					
CHF	X				X					
Asthma and/or COPD	X				X					
Urgent or emergent condition						X				
Other					X ²					
Date New Enrollment Halted	-	Jan-09	-	-	-	Sep-09 ³	-	Jan-10	Sep-09	Apr-09
Coverage Premium	No	No	Yes ⁴	No	No	No	Yes ⁴	No	No	Yes
Co-Pays	Yes	No	No	Yes ⁴	No	Yes	Yes ⁴	Yes	Yes ⁴	Yes

Source: Original and amended county contracts with DHCS; county personnel.

Notes:

- (1) Effective February 1, 2010. Prior to this date, Los Angeles County only enrolled individuals up to 133.33% FPL.
- (2) Individuals pre-Medicare age (63-64 years) and current DHS users with uncoordinated care are also eligible.
- (3) New enrollees with urgent or emergent conditions continue to be accepted.
- (4) For select enrollees, based on percent federal poverty level (FPL).

II. FINDINGS

A. Expansions in Health Care Coverage

HCCI is designed to expand health care coverage for eligible individuals. Expansion can include increasing the number of eligible individuals who are provided health care coverage, or providing newly covered services to eligible individuals, or both. As discussed in this section, all counties expanded the benefits provided to HCCI enrollees relative to the scope of services previously provided under their indigent care programs, and all counties expanded their enrollment of eligible individuals through outreach efforts.

1. *Outreach and Recruitment*

HCCI counties conducted intensive outreach campaigns to eligible targeted populations in their respective counties. The recruitment strategies utilized by each county may impact the characteristics of the enrolled population, and are displayed in Exhibit 3. Four counties conducted outreach and enrollment at emergency departments (Contra Costa, Kern, Orange and San Diego), while 8 recruited enrollees at other service locations such as clinics, and 6 focused enrollment on community-based outreach.

In Alameda and San Diego counties, enrollees are required to have a chronic illness to be eligible, while both Los Angeles and Ventura counties focus enrollment on chronically ill populations but also accept individuals who do not have a qualifying disease (Exhibit 2). Other targeted populations include homeless individuals (2 counties), college students (targeted by Contra Costa County during program Years 1 and 2) and people who have frequent use of the emergency department or other services (4 counties) (Exhibit 3).

Specific outreach activities employed by each county are shown in Exhibit 3. As part of the outreach and enrollment process, HCCI counties developed and distributed a broad array of informational materials, including brochures, posters, flyers, letters, banners, newsletters, and handbooks. Some of the materials are produced in multiple languages to reach the diverse populations eligible for the program.

Nine counties have organized community events to promote the HCCI programs, reaching more than 274,000 individuals across the state. All counties have additionally conducted outreach trainings or service delivery coordination meetings. In addition to traditional outreach strategies, some counties used innovative methods to reach eligible populations, including:

- Contra Costa, Los Angeles, and San Francisco counties developed program websites targeted to the eligible or enrolled population.
- San Francisco County incorporated HCCI eligibility processes into their larger indigent care program and screened all applicants for HCCI eligibility.
- Los Angeles, Orange and San Francisco counties queried existing databases to identify potential clients who may be targeted for outreach.

- Contra Costa, Orange and Ventura counties conducted outreach activities targeting homeless individuals, including events at homeless shelters.
- Ventura County advertised in local media including newspaper, radio, and television.
- Contra Costa County promoted HCCI to parents when they brought their children to county clinics for care, as well as to community college students who sought primary care or mental health services on campus.
- Contra Costa, San Diego, and San Mateo counties employed certified application assistants stationed at sites within the county-wide health care delivery system, such as the emergency department at the Regional Medical Center.
- Los Angeles, Orange and San Francisco counties implemented a program newsletter.

Counties have further developed partnerships with other organizations, such as faith-based and other community-based organizations, to provide outreach to HCCI targeted populations. Los Angeles County worked with other departments as well as the local Public Private Partnership Clinics (PPPs) to establish regional/community collaboration. San Francisco County developed a partnership with the city and the county's 3-1-1 system to provide public information on the program, and also collaborated with the local Social Services Department.

Exhibit 3: Targeted Populations and Outreach Activities, by County, Years 1 and 2.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura
Primary Recruitment Strategies										
Community outreach		X	X	X		X			X	X
Emergency room		X	X	X		X				
Other point-of-care locations	X	X	X	X	X	X	X	X		
Specific Target Populations										
	Yes	Yes	Yes ¹	Yes	Yes	No	No	No	No	Yes
Chronically ill individuals	X	X			X					X
Homeless individuals			X			X				X
High utilizers / Multiple ER visits	X		X	X						X
Outreach Events Conducted:										
Health-Promotion Events	-	26	46	3	1,776	65	-	36	-	78
Non Health-Promotion Events	-	25	23	5	2,724	22	45	51	20	83
Total Attendees	-	355	4,117	≥172	217,104	14,270	≥1,100	5,313	16,227	15,751
Outreach Training Meetings:										
Meetings	18	38	18	40	1,982	172	26	36	107	3
Total Attendees	225	326	431	300	22,646	492	1,030	3,240	1,740	444
Materials Languages:										
English	X	X	X	X	X	X	X	X	X	X
Spanish	X	X			X	X	X			
Korean					X					
Vietnamese					X	X				

Source: Years 1 and 2 revised county progress reports to DHCS; county personnel.

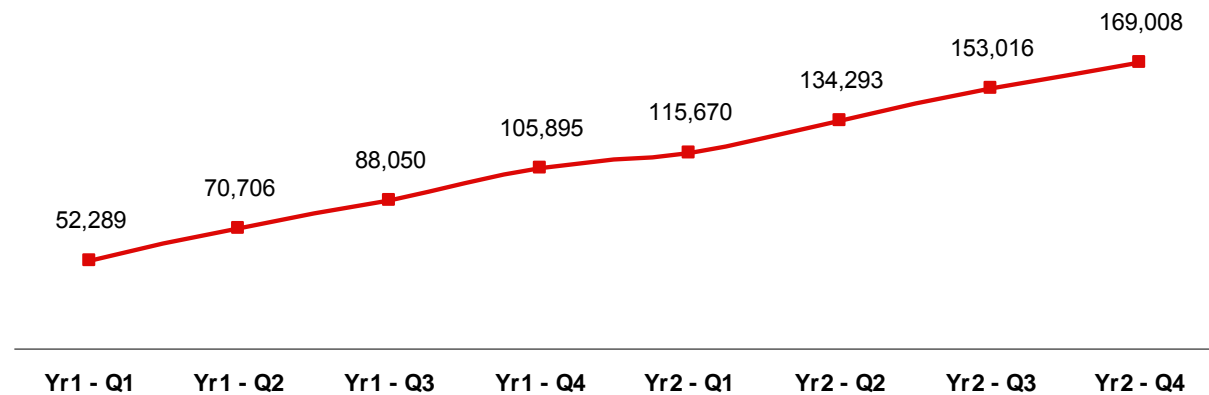
Note: (1) Contra Costa County also previously targeted uninsured college students. The last outreach to this population was in August 2009.

2. Enrollment

a) Covered Population

HCCI counties projected a total target enrollment of 167,960 in the first program year, and 168,760 in the second program year. These projections were based on county estimates of the number of eligible low-income uninsured adults in their counties who could be enrolled given the availability of local funds and their allocation of federal reimbursement funds. Overall HCCI enrollment has steadily increased and has more than tripled since the start of the program in September 2007 (Exhibit 4).

Exhibit 4: Total Enrollment, by Quarter, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

Note: San Francisco County quarterly year one enrollment is estimated based on annual reported enrollment

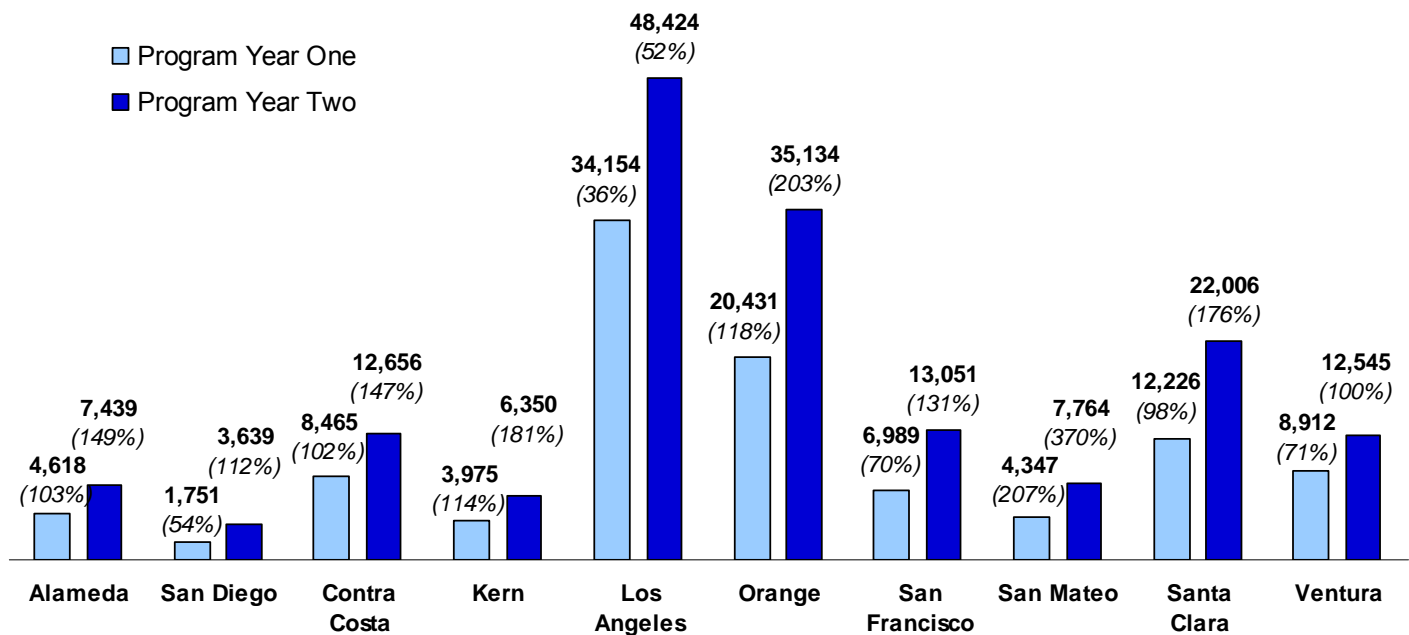
As displayed in Exhibit 4, HCCI counties reported a total of 105,895 individuals enrolled during program Year 1 (63% of projected enrollment) and 169,008 individuals enrolled during Year 2 (100% of projected enrollment). Counties report total unduplicated enrollment on an annual basis. Therefore, the actual total number of individuals enrolled by the program throughout the implementation period is likely to be higher than the number of individuals enrolled at the end of Year 2 alone. Preliminary individual-level enrollment data received by UCLA indicate a total of 192,715 unduplicated individuals served throughout the implementation period to date. A final total unduplicated enrollment figure will be provided by UCLA after August 31, 2010.

Unduplicated annual enrollment figures by county for each year are displayed in Exhibit 5. Five counties did not meet their enrollment targets during Year 1 primarily due to unavoidable delays in program implementation. By the end of Year 2, 9 counties met or exceeded their two-year enrollment target, and 4 counties exceeded 150% of their target enrollment level. Los Angeles County has not met their original enrollment target to date. As of March 2010, 5 counties have halted new enrollment (Exhibit 2).

HCCI counties had estimated the eligible populations in their counties to establish the enrollment targets in their contracts. These targets are non-binding. However, they were subject to a degree of error due to lack of sufficient information in publicly available sources of data. Most counties

either under- or overestimated the size of the eligible population, and in addition they were impacted by their ability to verify eligibility, the availability of local funds, allocation of reimbursement funds, and changes in the local uninsured rate. As a result, counties' ability to reach their estimated targets in a timely manner was impacted. Other factors that may have precluded counties from meeting their annual enrollment targets include late implementation of enrollment, delayed approval of the STCs by CMS (approved in October 2007), and other local programmatic issues such as staffing delays. These factors may partially explain differences between target and actual enrollment numbers found in some counties.

Exhibit 5: Annual Enrollment and Percent of Target Enrollment, by County Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

The rate at which each county enrolled individuals may impact the utilization and expenditure patterns seen for that county, as the amount of time for which an individual has been enrolled, or their “intervention period” will impact his or her health and utilization behavior. In particular, newly enrolled individuals are likely to have higher utilization due to pent up demand, uncontrolled chronic conditions, and other factors. Therefore, if a significant proportion of enrollees during a time period of study are new enrollees, utilization and expenditure measures for the same time period are likely to be higher. Conversely, if most of the enrollees during a time period of study are continuing enrollees, the effects of previous uninsurance are likely to have been mitigated by continued access during their previous enrollment, and their utilization and expenditures may be lower.

Some counties were able to begin enrollment of eligible individuals quickly while others needed more time to build provider networks and other necessary infrastructure leading to delays in enrollment. Notably, San Diego County experienced a delay in enrollment during the first year, with only 15% of their 1,751 first year enrollees joining in the first three quarters of Year 1, and

the remaining 85% enrolling in the final quarter of Year 1. Therefore, first year evaluation measures reported for San Diego County are not necessarily comparable with those for other counties. Similarly, some counties continued to experience significant new enrollment throughout the first two program years. San Mateo, Santa Clara, Orange, San Francisco and San Diego counties nearly doubled their enrollee population between the first and second years, with new enrollees accounting for approximately half of Year 2 population. In these cases, Year 2 utilization and expenditure trends may differ from those seen in counties with a higher proportion of continuing enrollees in Year 2, such as Alameda, Contra Costa, or Ventura (Exhibit 5).

Exhibit 6 presents the demographic characteristics of HCCI enrollees in each county at the time of their initial enrollment, including age, gender, marital status, race, language, federal poverty level, and immigration status. Exhibit 6 also presents the prevalence of chronic illness among users of health care services in each county program, while Exhibit 7 presents the prevalence of specific chronic diseases investigated by UCLA.

As displayed in Exhibit 6, Alameda and San Diego counties have enrolled a generally older population, likely due to their addition of chronic illness to the standard eligibility requirements. Los Angeles County has a substantially lower proportion of English speakers (46%) relative to other counties, although all counties have enrolled a large number of non-English speaking individuals, indicating the high level of cultural competency required of the programs. A higher proportion of the HCCI enrollees in Alameda, Contra Costa, Kern and San Francisco counties are low-income, with more than 70% of the population in these counties under 100% of the federal poverty level. Los Angeles County is the only program where eligibility was limited to below 133.33% of the federal poverty level, although the county recently received approval effective February 1, 2010 to expand enrollment up to 200% of federal poverty level. In all counties, more than 40% of users of health care services have been diagnosed with at least 1 of the chronic conditions studied (Exhibit 6), and across all counties, diabetes, hypertension and dyslipidemia are the most prevalent conditions (Exhibit 7).

The demographic profile of enrollees in each HCCI program provides a context for interpreting utilization and expenditure findings, and may partially explain differences seen in these patterns between counties. The findings in this interim report do not adjust for population differences, because the patient-level data needed to make these adjustments were only delivered recently to UCLA. However, we intend to stratify future utilization analyses by some of the major demographic characteristics shown in Exhibits 6 and 7 as part of our final evaluation report. These stratified analyses will provide more useful information on how HCCI programs are affecting important subgroups within the HCCI eligible population.

Exhibit 6: Demographic Characteristics of HCCI Enrollees, Years 1 and 2 Combined, as of April 2010.

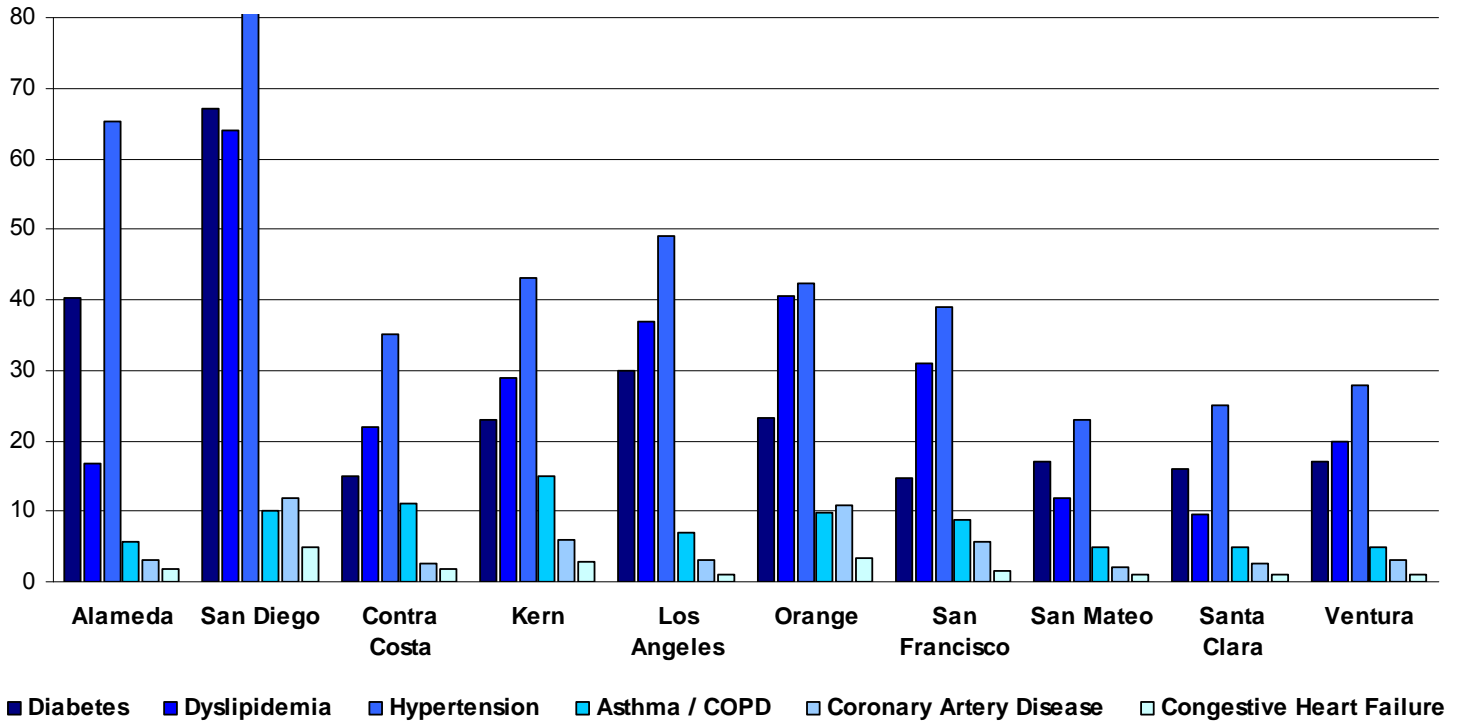
	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura
Age (%):										
Under 40	14	9	39	34	16	32	36	33	32	36
41-50	22	19	26	28	25	20	21	22	21	24
51-60	43	47	26	29	46	32	29	31	32	26
61+	21	26	9	9	13	15	14	14	15	8
Gender (%):										
Female	54	60	48	46	62	51	47	50	53	52
Male	46	40	52	54	38	49	53	50	47	48
Marital Status (%):										
Married	32	-	15	16	8	-	25	28	28	-
Divorced/Widowed	23	-	21	30	4	-	14	19	20	-
Single/Never Married	45	-	64	53	15	-	60	53	51	-
Data not available	-	100	-	-	73	100	-	-	1	100
Race (%):										
Asian/Pacific Islander	28	6	7	1	9	24	29	16	31	-
Black	31	7	20	10	12	2	1	7	5	-
Hispanic	20	33	19	41	56	23	10	30	30	-
White	16	15	44	46	13	23	3	22	24	-
Other	5	2	10	2	4	3	2	5	5	-
Data not available	-	36	-	-	6	24	56	20	5	100
Language (%):										
Asian Languages	20	-	1	0	4	17	24	3	18	0
English	68	-	89	82	46	68	68	77	73	70
Spanish	11	-	9	12	45	14	8	19	8	30
Other	1	-	1	0	5	1	1	1	1	0
Data not available	-	100	-	6	-	-	-	-	-	-
%FPL (%):										
0-100%	74	58	72	80	-	64	71	62	68	57
101-133%	11	14	-	9	-	13	-	13	-	16
134-150%	5	6	-	3	-	6	-	7	-	8
151-200%	10	14	-	8	-	15	-	18	-	18
101-200%	26	34	28	20	-	35	29	38	32	42
Data not available	-	8	-	-	100	1	-	-	-	-
Immigration Status (%):										
Legal Resident	12	-	10	11	-	19	-	21	0	-
US Citizen	81	-	90	87	-	81	-	79	100	-
Data not available	7	100	0	2	100	0	100	0	0	100
Chronic Disease Conditions Among Users of Health Care Services (%):										
Any Chronic Disease ¹	91	98	48	57	69	62	54	42	42	46

Source: UCLA analysis of HCCI enrollee demographic and claims data provided by April 30, 2010.

Note: "Data not available" may denote data not collected, or data collected but not available to UCLA.

Note: (1) By UCLA diagnosis methodology, among 7 chronic conditions investigated (Appendix A). Methodology does not have 100% sensitivity. Sensitivity is higher in counties with more detailed data

Exhibit 7: Prevalence of Specific Chronic Diseases among Users of Health Care Services, by County; as of May 2010.



Source: UCLA analysis of HCCI enrollee demographic and claims data provided by April 30, 2010.
 Note: By UCLA diagnosis methodology, among 7 chronic conditions investigated (Appendix A).

b) Retention

HCCI program disenrollment data are reported by HCCI counties in progress reports to DHCS. Counties are required by contract to conduct annual recertification of eligibility for enrollees. Nine counties reassess eligibility on an annual basis, while Contra Costa County re-determines basic eligibility factors such as age every six months (income verification is conducted annually). Disenrollment from the program occurs primarily due to loss of eligibility or failure to complete eligibility re-determination at the time of recertification. In addition, disenrollment can be due to a range of other reasons, including:

- change in county of residence;
- income in excess of eligibility guidelines;
- eligible for another public program (due to age, pregnancy, etc.);
- new health insurance coverage, such as employer-based insurance; or
- enrollee request for disenrollment.

The reasons for disenrollment reported in program Years 1 and 2 are presented in Exhibit 8. Counties reported failed or incomplete redetermination as the cause of 70% of all disenrollments that have occurred to date.

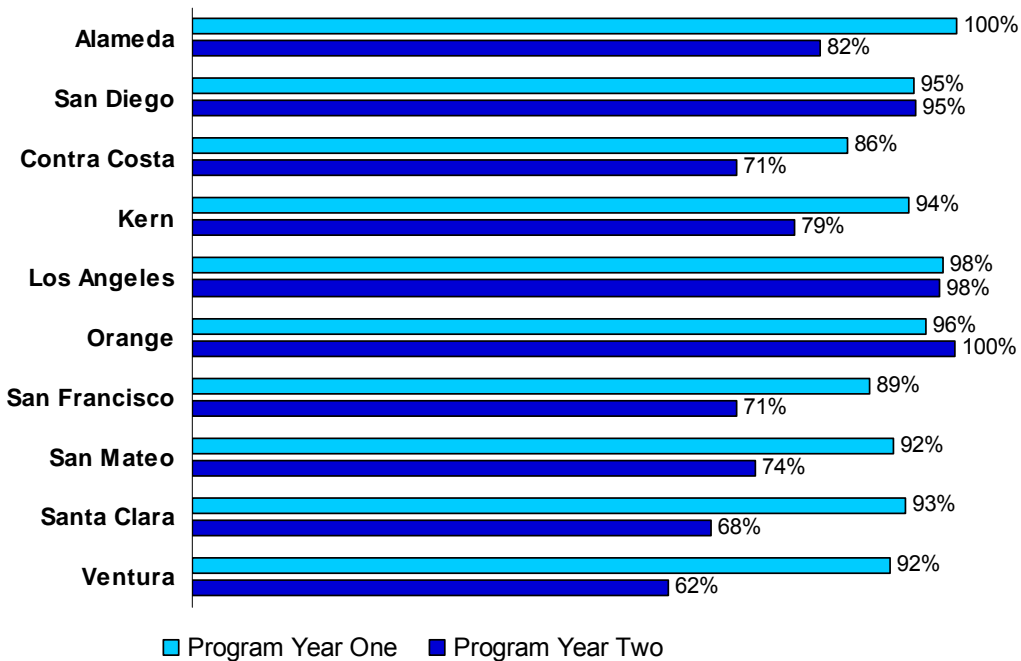
Exhibit 8: Total Disenrollments According to Reason, by County; Years 1 and 2.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura	HCCI Total
Failed/Incomplete Redetermination	1,329	0	3,422	1,188	0	420	2,699	1,711	5,684	5,017	21,470
Relocated	0	0	85	4	48	1	64	45	37	0	284
Deceased	0	0	16	4	0	0	5	4	6	0	35
Increased Income	0	0	245	5	45	0	0	3	133	0	431
New Health Insurance Coverage	0	0	15	16	42	18	180	74	279	0	624
Eligible for Another Public Program	0	0	1,041	326	857	343	771	411	951	40	4,740
Enrollee Request	0	0	6	33	16	2	25	8	6	0	96
Other	0	285	3	14	545	60	788	139	582	429	2,845
Total	1,329	285	4,833	1,590	1,553	844	4,532	2,395	7,678	5,486	30,525

Source: Years 1 and 2 revised county progress reports to DHCS.

Exhibit 9 displays the enrollee retention rate in each county for program Years 1 and 2 (total unduplicated enrollees minus total unduplicated disenrollees and divided by total enrollees). The majority of counties experienced a retention rate above 90% during Year 1. However, many counties lost a significant number of enrollees in Year 2, likely due to the need to recertify eligibility as the coverage term for individuals enrolled in the first year came to term (Exhibit 8).

Exhibit 9: Enrollee Retention Rates, by County; Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

Individual-level data indicate that temporary breaks or lapses in coverage are common, and may partially account for the high number of disenrollments that have been reported by HCCI counties. Further analysis of enrollment and disenrollment patterns based on individual-level data will be presented in the final evaluation report.

c) Referral to Other Public Programs

HCCI program enrollment and eligibility processes are effective in promoting participation in other public programs. Individuals who are eligible for another public program may be referred to that program at the time of application to the HCCI program, or through the disenrollment process. In total, counties report that 4,740 individuals (16% of all disenrollees) were disenrolled from the HCCI program due to eligibility for Medi-Cal, Healthy Families, or the Access for Infants and Mothers (AIM) program (Exhibit 8). An additional 10,254 HCCI applicants (19% of coverage denials) were denied HCCI coverage due to eligibility for one of these programs (Exhibit 10).

Exhibit 10: Total Application Denials According to Reason, by County, Years 1 and 2.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura	HCCI Total
Income Above FPL Limit	1	247	4,093	116	27	1,892	3,745	70	435	390	11,016
Age	28	0	73	29	19	37	0	0	66	93	345
DRA Requirements	256	0	2,236	231	36	1,565	0	38	75	65	4,502
Other Health Insurance Coverage	0	6	28	29	0	112	0	1	109	60	345
Eligible for Another Public Program	40	119	2,645	384	14	755	5,170	31	571	525	10,254
Non-Responsive Applicant	101	41	11,992	1,377	1	3,816	0	0	3,303	3,057	23,688
Other	119	370	14	27	12	306	0	82	2,217	1,271	4,418
Total	545	783	21,081	2,193	109	8,483	8,915	222	6,776	5,461	54,568

Source: Years 1 and 2 revised county progress reports to DHCS.

3. Scope of Service Expansions

All participating counties cover basic services for enrollees under their HCCI programs, including outpatient visits, emergency visits, and inpatient care. These basic services were generally provided under their previous indigent care programs. In addition, all HCCI counties have expanded the types of services available in their programs. In some counties, these expansions have been extensive, providing a broad array of services along the continuum of care. Key service expansions include:

- specialty services including audiology, vision and podiatry services;
- outpatient physical, occupational, and speech therapy;
- mental health services;

- home health care;
- dental care;
- prescription medications;
- durable medical equipment (DME);
- telemedicine; and
- smoking cessation.

Because most HCCI programs have exceeded their original enrollment targets, counties have implemented several cost containment measures. Five counties have halted new enrollment, although they continue to re-certify continuing enrollees (see Exhibit 2 and program descriptions in Section I.B above). Some counties have changed the scope of services covered in their initial contract or have added new co-pays to control program costs. Kern, Orange, San Diego and Ventura counties have executed contract amendments with DHCS to change the scope of services. Alameda County has limited HCCI covered benefits to mirror changes to the Medi-Cal scope of services. The specific limits to covered services implemented by counties since their initial contract negotiations are:

- Orange and Kern counties added new co-pays in September and November of 2009, respectively;
- Orange County restricted covered services by requiring prior-authorizations or through other methods in a contract amendment executed in September 2009, including:
 - dental services, and
 - physical and occupational therapy; and
- Alameda County limited optometry, podiatry, and dental benefits in accordance with changes to the Medi-Cal scope of services that went into effect July 1, 2009.

There is only one example of an expansion of benefits since the original implementation of the HCCI programs. Ventura County began covering dental services in program Year 2, through a contract with an organization called *Clinicas de la Camino Real*.

A comprehensive list of covered services as of March 2010 is presented in Exhibit 11. It is important to note that this table does not incorporate information on service limitations.

Exhibit 11: HCCI Covered Services by County, March 2010

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura	% with Service
Key: X = Covered Service											
Acupuncture	X							X	X		30%
Acute rehabilitation	X	X	X	X	X	X	X		X		80%
Ambulatory surgical center services	X	X		X	X	X	X	X	X	X	90%
Audiology (includes hearing aids)	X	X	X	X	X	X	X	X	X		90%
Blood bank services	X	X	X	X	X	X	X	X	X	X	100%
Dental Services (includes dentures)	X	X	X	X	X	X		X	X	X	90%
Dental services provided by a physician	X		X	X		X	X	X	X	X	80%
Durable medical equipment	X	X	X	X	X	X	X	X	X	X	100%
Emergency room	X	X	X	X	X	X	X	X	X	X	100%
General acute hospital	X	X	X	X	X	X	X	X	X	X	100%
Hemodialysis	X	X	X	X	X	X	X		X		80%
Home health aide	X			X				X			30%
Indian health services		X							X		0%
Infusion services	X	X		X	X	X					50%
Inpatient drug and alcohol treatment				X			X				0%
Laboratory	X	X	X	X	X	X	X	X	X	X	100%
Licensed vocational nurse	X			X	X	X	X	X			60%
Medical supplies	X	X	X	X	X	X	X	X	X	X	100%
Non-emergency medical transportation		X	X	X	X	X					0%
Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)	X	X	X	X	X	X	X	X		X	90%
Mental health services	X			X	X		X	X	X	X	70%
Nursing home care: skilled nursing, intermediate care	X			X		X	X				40%
Occupational therapy	X	X	X	X	X	X	X	X	X	X	100%
Ophthalmology and optometry services,	X	X	X	X	X	X	X	X	X	X	100%
Optometry	X	X	X	X	X	X		X	X		80%
Outpatient drug therapy services	X	X		X	X		X	X	X	X	80%
Personal care services	X										10%
Physical therapy	X	X	X	X	X	X	X	X	X	X	100%
Physician	X	X	X	X	X	X	X	X	X	X	100%
Podiatry	X	X	X	X	X	X	X	X	X	X	100%

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura	% with Service
Key: X = Covered Service											
Prescribed and OTC drugs	X	X	X	X	X	X	X	X	X	X	100%
Prosthetic and orthotic devices	X	X	X	X	X	X	X	X	X	X	100%
Prosthetic appliances	X		X	X		X	X	X	X	X	80%
Psychiatric, acute inpatient	X			X	X		X		X	X	60%
Psychology	X			X	X		X	X		X	60%
Radiology	X	X	X	X	X	X	X	X	X	X	100%
Registered nurse	X	X		X	X	X	X	X	X		80%
Sign language interpretation	X		X	X	X		X	X	X	X	80%
Smoking cessation	X			X			X	X	X	X	60%
Social worker	X			X	X	X		X	X		60%
Speech therapy	X	X	X	X	X	X	X	X	X	X	100%

Source: DHCS analysis of HCCI county covered services

Note: Kern, Orange, San Diego and Ventura counties have executed contract amendments to covered services since initial contract.

B. Expenditures

1. Total Health Care Services Expenditures and Reimbursements

HCCI counties are allocated federal reimbursement funds for their program as specified in their respective contracts. Reimbursement funds are designed to supplement (rather than supplant) existing funding mechanisms prior to implementation of HCCI. The Total Funds Expenditures (TFEs) are the total costs incurred by a county for HCCI covered services provided to HCCI enrollees under section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration waiver. DHCS negotiates with CMS to determine what expenditures are allowable. Under the waiver, counties must use local funds to incur 100 percent of the costs of providing covered services to HCCI enrollees, prior to claiming their allocated federal reimbursement. In addition, counties may incur TFEs in excess of the amount required to draw down their annual contracted allocation of federal reimbursement funds, for which there is no expectation of reimbursement.

The counties must certify their expenditures to DHCS as Certified Public Expenditures (CPEs) via their approved cost-based reimbursement methodology. In 3 counties, this methodology is based on invoicing, while in the remaining 7 counties, the Interim Hospital Payment Rate Workbook is used to estimate CPEs, as described in Attachment G, Supplement 1 of the Special Terms and Conditions (STCs) amended February 1, 2010. Federal reimbursement is then issued based on the CPE amount and the applicable Federal Medical Assistance Percentage (FMAP), which was 50.0% at program implementation and was raised under ARRA to 61.59% from October 1, 2008 through December 31, 2010. However, this change in FMAP did not have an impact on the total reimbursement funds available from CMS, which were capped at \$180 million per year. As a result of the cost-based reimbursement methods employed, final reconciliation of actual costs incurred will be necessary at the end of the program. Therefore, all reported expenditures should be interpreted as estimates.

Exhibit 12 displays a summary of all health care expenditure and reimbursement data for each county by program year, including: the annual contracted allocation of federal reimbursement funds to counties; the annual amounts of total reported TFEs including both allowable and excess expenditures for each county; the CPE amounts submitted by counties to DHCS via their approved cost-based reimbursement methodology; and, the federal reimbursement funds received by each county as of May 2010.

Some counties have reported excess TFEs beyond the amount required to draw down their allocated federal funds, while others have not yet maximized their contracted allocation amount due to an inability to incur the necessary computable expenditures at the local level. Differences in total funds expenditures reflect a range of differences between participating counties, including but not limited to variations in: enrollment; covered population; program implementation; system of care; type of services delivered; availability of local funds; and, method of cost-based reimbursement and claiming process. Due to the inability of some counties to claim their contracted allocation of reimbursement funds, reallocation of these funds is conducted by DHCS to redistribute unused funds to other counties. The current reallocation of Year 1 reimbursement funds and revised Year 1 allocation amounts are also displayed in Exhibit 12.

Exhibit 12: Summary of Allocations, Expenditures and Reimbursements, Years 1 and 2 by County, as of May 2010.

PROGRAM YEAR ONE

Counties	Allocation of Federal Reimbursement Funds			Reported Expenditures (TFEs)			Submitted Expenditures (CPEs) and Reimbursement			
	Original Contracted Allocation	Reallocated	Revised Allocation	Allowable Reported TFEs	Excess Reported TFEs	Total Reported TFEs	Total Submitted CPEs	Dispersal of Reimbursement Funds	% Original Allocation Received	% Revised Allocation Received
Alameda	\$ 8,204,250	\$ -	\$ 8,204,250	\$ 15,228,350	\$ -	\$ 15,228,350	\$ 15,029,920	\$ 7,514,960	92%	92%
San Diego	\$ 13,040,000	\$ (8,204,090)	\$ 4,835,910	\$ 1,240,822	\$ -	\$ 1,240,822	\$ 1,240,821	\$ 620,411	5%	13%
Contra Costa	\$ 15,250,000	\$ 3,405,179	\$ 18,655,179	\$ 30,500,000	\$ 6,810,358	\$ 37,310,358	\$ 37,310,358	\$ 18,655,179	122%	100%
Kern	\$ 10,000,000	\$ 1,207,868	\$ 11,207,868	\$ 20,000,000	\$ 215,904	\$ 20,215,904	\$ 22,415,736	\$ 11,207,868	112%	100%
Los Angeles	\$ 54,000,000	\$ (559,769)	\$ 53,440,231	\$ 41,661,224	\$ -	\$ 41,661,224	\$ 41,325,504	\$ 20,662,752	38%	39%
Orange	\$ 16,871,578	\$ 8,078,732	\$ 24,950,310	\$ 33,743,156	\$ 16,157,464	\$ 49,900,620	\$ 49,900,620	\$ 24,950,310	148%	100%
San Francisco	\$ 24,370,000	\$ (6,421,584)	\$ 17,948,416	\$ 22,107,656	\$ -	\$ 22,107,656	\$ 19,526,938	\$ 9,763,469	40%	54%
San Mateo	\$ 7,564,172	\$ -	\$ 7,564,172	\$ 11,814,788	\$ -	\$ 11,814,788	\$ 9,667,450	\$ 4,833,725	64%	64%
Santa Clara	\$ 20,700,000	\$ 1,515,188	\$ 22,215,188	\$ 41,400,000	\$ 3,030,376	\$ 44,430,376	\$ 44,430,376	\$ 22,215,188	107%	100%
Ventura	\$ 10,000,000	\$ 978,477	\$ 10,978,477	\$ 20,000,000	\$ -	\$ 20,000,000	\$ 21,956,954	\$ 10,978,477	110%	100%
All Counties	\$ 180,000,000		\$ 180,000,000	\$ 237,695,996	\$ 26,214,102	\$ 263,910,098	\$ 262,804,677	\$ 131,402,339	73%	73%

PROGRAM YEAR TWO

Counties	Allocation of Federal Reimbursement Funds			Reported Expenditures (TFEs)			Submitted Expenditures (CPEs) and Reimbursement			
	Original Contracted Allocation	Reallocated	Revised Allocation	Allowable Reported TFEs	Excess Reported TFEs	Total Reported TFEs	Total Submitted CPEs	Dispersal of Reimbursement Funds	% Original Allocation Received	% Revised Allocation Received
Alameda	\$ 8,204,250	\$ -	\$ 8,204,250	\$ 16,408,500	\$ 2,870,585	\$ 19,279,085	\$ 13,457,976	\$ 8,204,250	100%	100%
San Diego	\$ 13,040,000	\$ -	\$ 13,040,000	\$ 15,549,883	\$ -	\$ 15,549,883	\$ 13,343,885	\$ 8,123,420	62%	62%
Contra Costa	\$ 15,250,000	\$ -	\$ 15,250,000	\$ 30,500,000	\$ 18,033,977	\$ 48,533,977	\$ 24,364,836	\$ 14,770,978	97%	97%
Kern	\$ 10,000,000	\$ -	\$ 10,000,000	\$ 20,000,000	\$ 7,447,577	\$ 27,447,577	\$ 15,000,000	\$ 9,093,625	91%	91%
Los Angeles	\$ 54,000,000	\$ -	\$ 54,000,000	\$ 108,000,000	\$ -	\$ 108,000,000	\$ 78,542,832	\$ 47,615,937	88%	88%
Orange	\$ 16,871,578	\$ -	\$ 16,871,578	\$ 34,099,504	\$ 24,037,594	\$ 58,137,098	\$ 28,241,963	\$ 16,871,578	100%	100%
San Francisco	\$ 24,370,000	\$ -	\$ 24,370,000	\$ 32,337,817	\$ -	\$ 32,337,817	\$ 40,206,517	\$ 24,370,000	100%	100%
San Mateo	\$ 7,564,172	\$ -	\$ 7,564,172	\$ 15,000,001	\$ 3,630,110	\$ 18,630,111	\$ 9,667,451	\$ 5,860,811	77%	77%
Santa Clara	\$ 20,700,000	\$ -	\$ 20,700,000	\$ 41,400,000	\$ 30,758,368	\$ 72,158,368	\$ 31,050,000	\$ 18,823,804	91%	91%
Ventura	\$ 10,000,000	\$ -	\$ 10,000,000	\$ 16,236,402	\$ 8,570,305	\$ 24,806,707	\$ 16,508,056	\$ 10,000,000	100%	100%
All Counties	\$ 180,000,000		\$ 180,000,000	\$ 336,032,802	\$ 95,348,516	\$ 431,381,318	\$ 270,383,514	\$ 163,734,403	91%	91%

Source: Years 1 and 2 revised county progress reports to DHCS; county contracts with DHCS; DHCS personnel.

Note: Expenditure data should be interpreted as estimates. Final reconciliation of costs will be conducted after August 31, 2010.

Reallocation of unclaimed funds is based largely on the ability of counties to certify excess expenditures beyond the amount needed to draw down their original allocation. In Year 1, 5 counties submitted sufficient CPEs to draw down more than 100% of their original Year 1 allocation of reimbursement funds (Exhibit 12). The initial reallocation of Year 1 funds was completed by DHCS in August 2009. At the time of reallocation, these 5 counties were allocated additional funds beyond their original allocation amount (Contra Costa, Kern, Orange, Santa Clara, and Ventura), such that they used their excess CPEs to claim 100% of their increased revised allocation. In contrast, 5 counties were unable to draw down their full original contracted allocation for Year 1. Three of these counties lost a portion of their original allocation at the time of reallocation of funds, and 2 had no change to their allocated amount. All of these 5 counties have remaining unclaimed allocated funds for Year 1 as of May 2010 (Exhibit 12).

The initial Year 1 reallocation resulted in the claiming of an additional \$15,185,444 beyond the total amount claimable under the original allocations, reducing the total unclaimed reimbursement funds for program Year 1 from \$63,783,105 to \$48,597,661. DHCS is currently in the process of completing a second reallocation of first year reimbursement funds to draw down the remaining \$48,579,661 in unclaimed funds from program Year 1. DHCS is also currently conducting an initial reallocation of unclaimed Year 2 reimbursement funds.

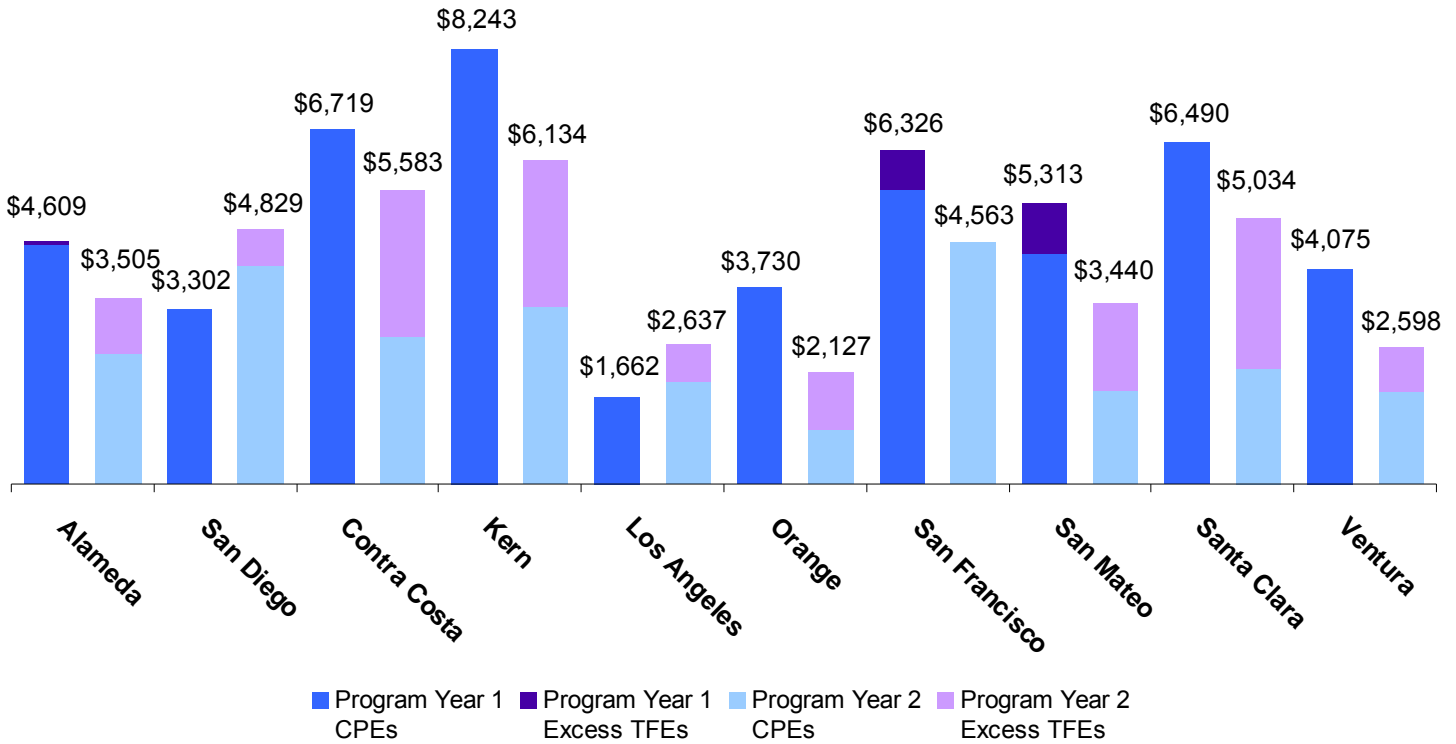
While reallocation of Year 2 reimbursement funds has not yet occurred, 4 counties have currently claimed 100% of their allocated amount for Year 2 (Exhibit 12). As of April 2010, all counties have received reimbursement at the applicable FMAP for all CPEs that have been submitted. In addition, counties may continue to submit CPEs to DHCS for each program year, and may receive additional federal reimbursement funds if they have not yet received their full allocated amount. Counties that have incurred excess allowable TFEs beyond the amount they have already certified to DHCS may be able to certify these expenditures as CPEs and claim additional reimbursement if increased federal financial participation is available to them.

In addition to the receipt of federal reimbursement funds based on their CPEs, HCCI counties are able to generate limited revenue through premiums, enrollment fees, and co-pays. Three counties (Contra Costa, San Francisco, and Ventura) charge enrollees a modest premium, and 7 counties (Alameda, Kern, Orange, San Francisco, San Mateo, Santa Clara, and Ventura) charge some co-pays at the point of service. The maximum amounts of these enrollee payments were defined in the Special Terms and Conditions (STCs). Some counties have used these payments to incentivize specific utilization behaviors, such as use of the primary care medical home.

2. Per Capita Costs

Annualized estimated total expenditures (TFE and CPE) per enrollee are displayed in Exhibit 13. Expenditures certified as CPEs were eligible for reimbursement. In counties where excess expenditures were not certified as CPEs, these added costs per enrollee are added to the total cost per enrollee for each year, as some counties have reported incurring more costs per enrollee than they have submitted as CPEs. For the overall program, the annualized mean total expenditure per enrollee was estimated at \$3,861 in Year 1 and \$3,312 in Year 2 (not shown). The mean expenditure per enrollee by county ranged from \$1,662 to \$8,243 in Year 1 and \$2,127 to \$6,134 in Year 2. Eight of the 10 counties experienced a decrease in the annualized average estimated total cost per enrollee between program Years 1 and 2.

Exhibit 13: Total Estimated Average Annualized Cost per Enrollee by Expenditure Type, Program Years 1 and 2 by County.



Source: Years 1 and 2 revised county progress reports to DHCS; DHCS personnel.

Note: Expenditure data should be interpreted as estimates. Final reconciliation of costs will be conducted after August 31, 2010.

The differences in per capita costs between counties are due to variations in program design and implementation, covered services, differences in method of reporting and claiming expenditures, ability of counties to implement retroactive cost claiming due to delayed eligibility determinations and variation in population characteristics. In addition, differences in the speed with which new individuals were enrolled by the counties may impact the estimated annual per capita cost, if new enrollees are more expensive than continuing enrollees. The increase in per capita cost seen in Los Angeles and San Diego counties may be due to significant increases in new enrollment in both counties during program Year 2, and may also be related to the delay in Year 1 enrollment in San Diego County. Further analysis of per capita costs based on claims data and controlling for program characteristics will be provided in the final evaluation report.

Expenditure data are subject to revision due to cost-based reimbursement methodologies, lags in claim submission and adjudication processes at the time of submission of these data.

C. Expansions to Safety Net Infrastructure

1. *Provider Networks*

HCCI counties are required to establish provider networks using their existing safety-net providers, expand these networks, and provide infrastructure support such as medical record systems, utilization review, and quality monitoring. However, each participating HCCI county adopted a unique approach to network design and implementation. At the start of the HCCI program, counties differed along multiple dimensions, including existence of Medi-Cal managed care provider networks, scope of health information technology, quality monitoring and assurance activities, availability of specialty care, and the extent of formalized relationships with safety-net providers. The structure of safety-net networks under HCCI was investigated in depth by UCLA in a Policy Brief released in December 2009, *Implementation of Safety-Net Based Provider Networks Under HCCI, Interim Findings* (Appendix C).

Throughout the HCCI implementation period, counties have contracted with a range of provider types to construct a network with sufficient capacity to serve program enrollees. Most counties have built upon an existing network of the local county hospital system, except for 2 counties (Orange and San Diego) that lacked a county hospital system and formed new relationships with private and district facilities. Of the 8 that built upon an existing network, only one (San Francisco) has developed a network composed solely of county-owned and operated facilities, while the others have used a combination of public/private partnerships. Networks in 4 counties (Contra Costa, San Francisco, San Mateo, and Santa Clara) are structured around managed-care networks, and 3 counties (San Mateo, San Diego, and Santa Clara) utilize the local health plan as a third-party administrator to capitalize on their existing administrative structures (Appendix C).

At the start of HCCI program implementation, new provider contracts were implemented in most counties to expand the safety-net network. Moreover, all counties further expanded their network during the implementation period to meet increased demand resulting from rising enrollment. (Appendix C). In addition to expansions of the safety net achieved through the addition of new providers, each county has implemented innovations to improve infrastructure support and efficiency. These enhancements include but are not limited to coordination between participating providers through advances in health information technology (HIT) and other tools, use of prospectively determined funding mechanisms to reimburse safety-net care, and enhancement of access to ancillary and specialty services.

2. *Implementation of Medical Home Model*

The concept of a medical home has recently received increased attention as a potential remedy to address system-wide problems of high health care costs and limited access. The assignment of individuals to a medical home, defined in the HCCI request for applications as "... a provider or facility that maintains all of an eligible person's medical information and that is a licensed provider of health care services, and that provides primary medical care and prevention services" is a fundamental feature of the HCCI program. A summary of the implementation of the medical home in each county is presented in Exhibit 14. Counties are required to designate a medical home for each HCCI enrollee. Enrollees are frequently assigned to a medical home at the time of enrollment, but can typically change their medical home at any time. In some instances, the assignment is at the

clinic or clinic-system level, although the clinic may assign patients to a specific physician. Although there is no contractual requirement to do so, some counties can verify that a personal physician is assigned within a clinic. Similarly, 4 out of 10 counties have opted to enforce enrollee adherence to the assigned medical home for all primary care visits, and medical home adherence is encouraged in the remaining 6 counties (Exhibit 14). Since the start of the program, 5 counties have reported increasing the number of medical homes in the network to accommodate enrollment increases.

Exhibit 14: Summary of Medical Home Model Implementation, by County.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura
Level of medical home assignment:										
Clinic-system-level		X					X			
Clinic-level	X	X	X	X	X	X		X	X	X
Physician-level			X			X	X	X	X	
Number of Medical Homes in Network	27	16	165	14	126	259	15	11	27	32
Enforcement of Medical Home Adherence	No	No	No	Yes	No	Yes ¹	Yes	No	Yes	No

Source: Years 1 and 2 revised county progress reports to DHCS; County contracts with DHCS; County personnel. For further information see Appendix D: *Health Coverage in the Safety Net: How California's Coverage Initiative is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings*
 Note: (1) Orange County began enforcing medical home adherence in September 2009.

Counties have had great flexibility in implementation of the medical home within their existing safety-net systems, which has allowed them to meet this requirement while responding to local needs and resources. Although counties are not required to implement all aspects of the ideal medical home model discussed in the literature, many of them attempted to implement multiple features of an ideal medical home. A detailed assessment of implementation of the medical home model under HCCI was conducted by UCLA in the Policy Brief, *Health Coverage in the Safety Net: How California's Coverage Initiative is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings*, released in June 2009 (Appendix D).

Exhibit 15 displays the proportion of enrollees that did not have an assigned medical home during program Years 1 and 2, as reported by participating counties. In most counties, fewer than 5% of enrollees lacked an assigned medical home in either program year. By the end of program Year 2, only 1% of enrollees across all counties were not assigned to a medical home. Those not assigned to a medical home may be new enrollees who have not yet made a medical home selection. Additional factors that may account for this finding include a lack of data on those individuals who selected a medical home after their date of enrollment, or delays in contracting with additional medical homes to achieve sufficient provider capacity. This is the case in Kern County, which experienced a delay in execution of medical home provider contracts during Year 1, and therefore was unable to assign a large proportion of their Year 1 enrollees to a medical home. After contracting with a local community clinic, Kern was able to assign virtually all enrollees to a medical home in Year 2.

Exhibit 15: Number and Percent of Enrollees Without an Assigned Medical Home, by County, Years 1 and 2.

Counties	Program Year 1	Program Year 2
Alameda	0 (0%)	0 (0%)
San Diego	99 (6%)	3 (0%)
Contra Costa	0 (0%)	45 (0%)
Kern	1,551 (39%)	4 (0%)
Los Angeles	44 (0%)	95 (0%)
Orange	0 (0%)	319 (1%)
San Francisco	0 (0%)	0 (0%)
San Mateo	140 (3%)	92 (1%)
Santa Clara	516 (4%)	882 (4%)
Ventura	21 (0%)	0 (0%)
HCCI Total	2,371 (2%)	1,440 (1%)

Source: Years 1 and 2 revised county progress reports to DHCS.

Further explanation of the lack of medical home assignment for some individuals is needed, as some counties that have halted new enrollment continue to report individuals without an assigned medical home.

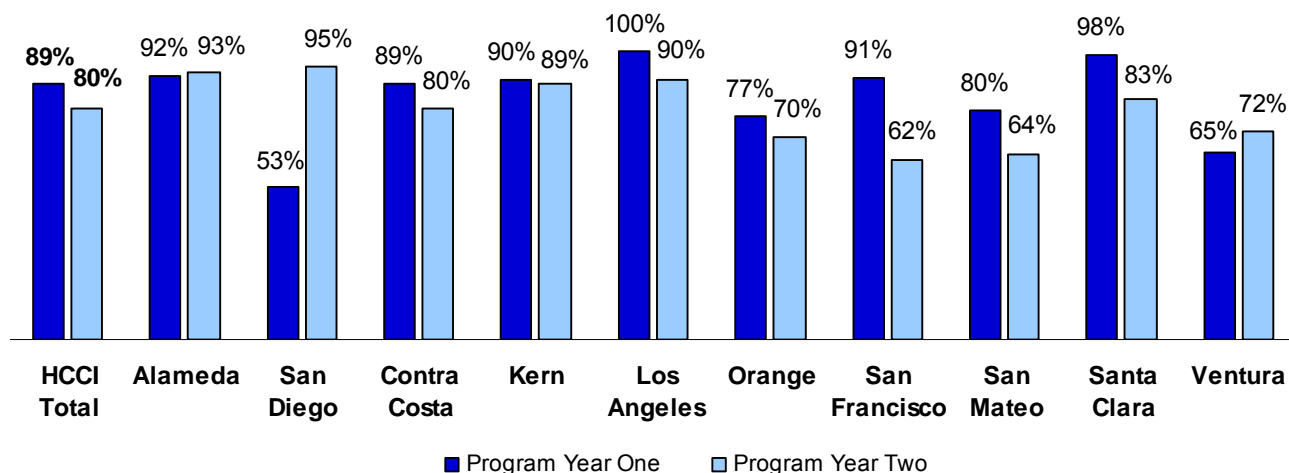
D. Access and Quality of Care

1. Utilization of Health Services

a) Proportion of Enrollees Using Services

Enrollees who have used at least one covered service during a given time period are termed “active” enrollees. Exhibit 16 displays the proportion of HCCI enrollees who were active during each program year, according to county progress reports. In 8 counties, the proportion of enrollees actively using services was above 75% in Year 1, and 7 counties show a decrease in active enrollees in Year 2. This pattern may be partially due to the fact that these counties (with the exception of Santa Clara) principally enroll individuals at point-of-care locations (Exhibit 3), thus providing a covered service at the time of initial enrollment for the majority of newly enrolled individuals. The low proportion of enrollees who were active in Year 1 in San Diego County may be due to the delay in enrollment during that year, as their Year 1 enrollees had fewer months of enrolled time in which to access care.

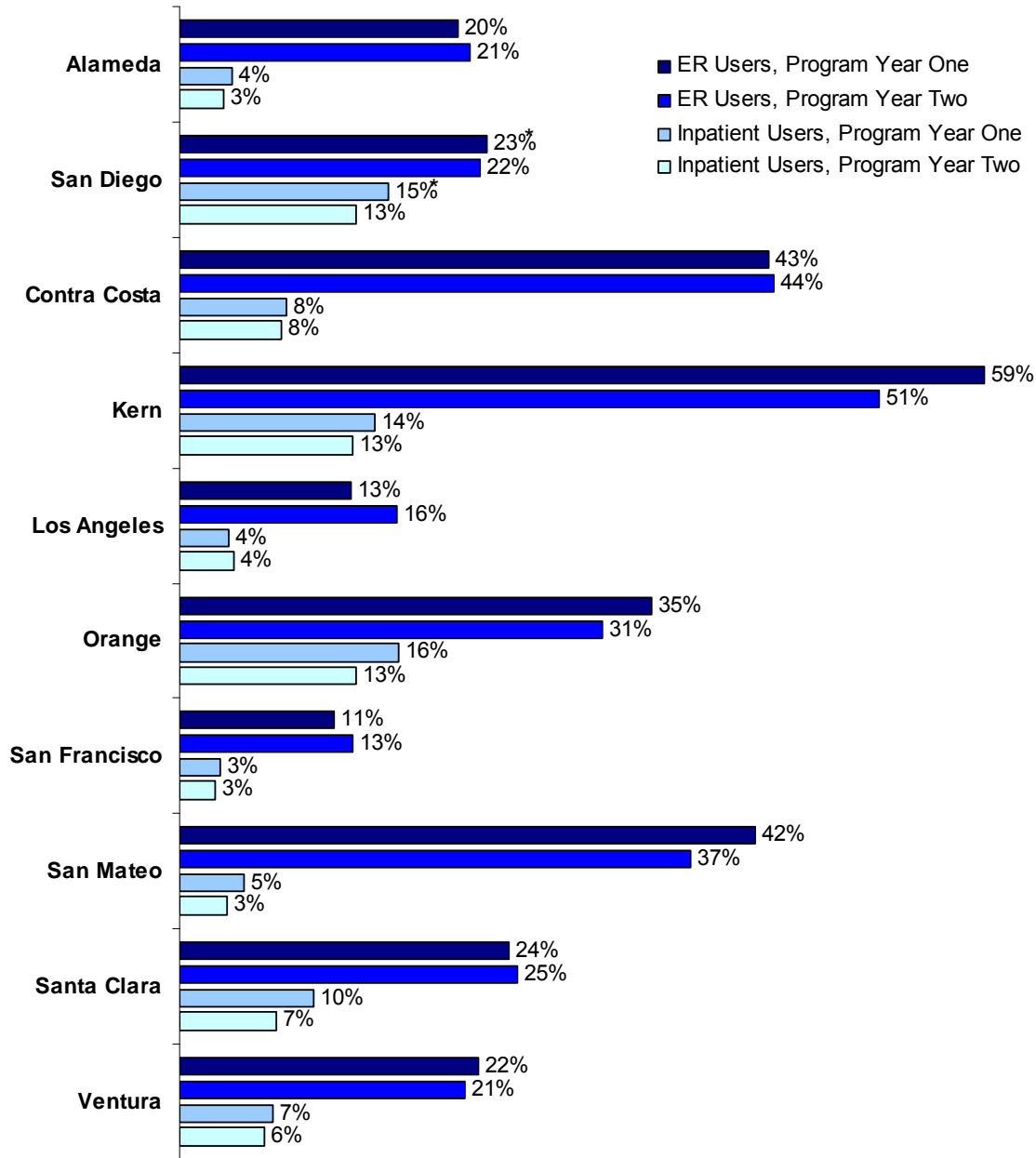
Exhibit 16: Proportion of Enrollees Using at Least One Covered Service (Active), HCCI Total and by County; Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

Among all active enrollees, only a subset used inpatient or emergency room services. Exhibit 17 displays the percent of active users accessing inpatient and ER services during each program year, by county, calculated from health care claims data provided to UCLA. The proportion of enrollees utilizing inpatient care is at or below 16% in all counties; ER services are utilized by a higher proportion of the enrollee population in every county. In all counties, use of inpatient care decreased or did not change between Years 1 and 2. This is a promising preliminary finding, because it represents the type of positive program impact that would be expected from effective HCCI programs. Use of the ER is less uniform, with 5 counties displaying an increase in proportion of enrollees using ER services (Alameda, Contra Costa, Los Angeles, San Francisco and Santa Clara), and the remaining 5 counties showing a decrease. Changes in this measure are generally minimal, and will be investigated further in the final evaluation report.

Exhibit 17: Proportion of Active Enrollees with At Least One Emergency Room or Inpatient Service, by County; Years 1 and 2.



Source: UCLA analysis of HCCI county claims data.

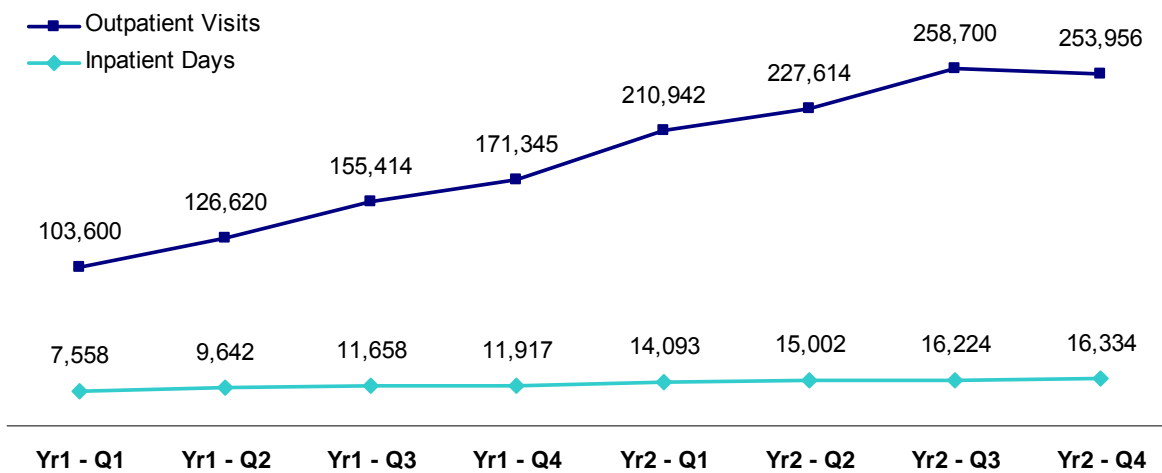
Notes: * Estimate has been annualized.

All analyses are impacted by the availability and clarity of the data. See Appendices A and B for further information.

b) Aggregate Volume of Services Provided

HCCI counties provide data on the total numbers of inpatient days and outpatient visits provided to enrollees in their quarterly progress reports. Outpatient visits include outpatient clinic, hospital and physician visits. The total number of inpatient days and outpatient visits indicates that the HCCI program overall has provided 1,559,833 outpatient visits (including clinic, outpatient hospital, and physician visits) and 107,310 inpatient hospital days during the first two years of the program (Exhibit 18). Total outpatient visits increased at a steady rate throughout most of the program period, reflecting increased enrollment, but a decrease is seen in the final quarter of Year 2, probably due to incomplete data for that quarter. A similarly increasing trend is observed in total hospital days, although this increase is more moderate.

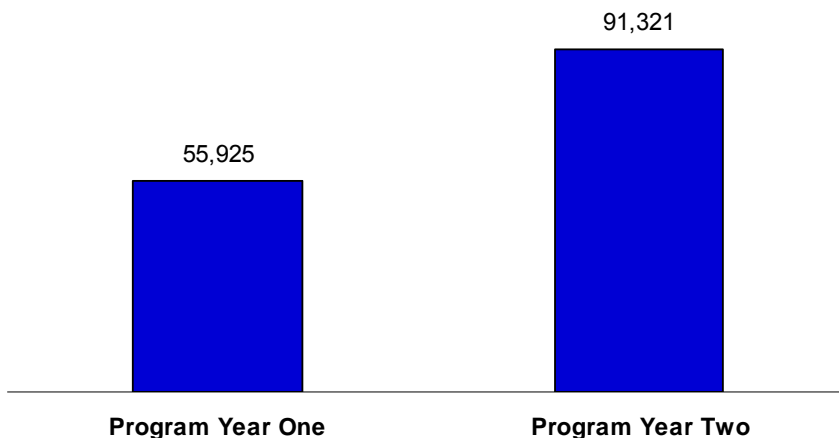
Exhibit 18: Quarterly Total Number of Outpatient Visits and Inpatient Days; Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

Emergency room data are reported annually rather than quarterly. HCCI counties have provided a total of 147,246 emergency visits during the first two years of the program (Exhibit 19).

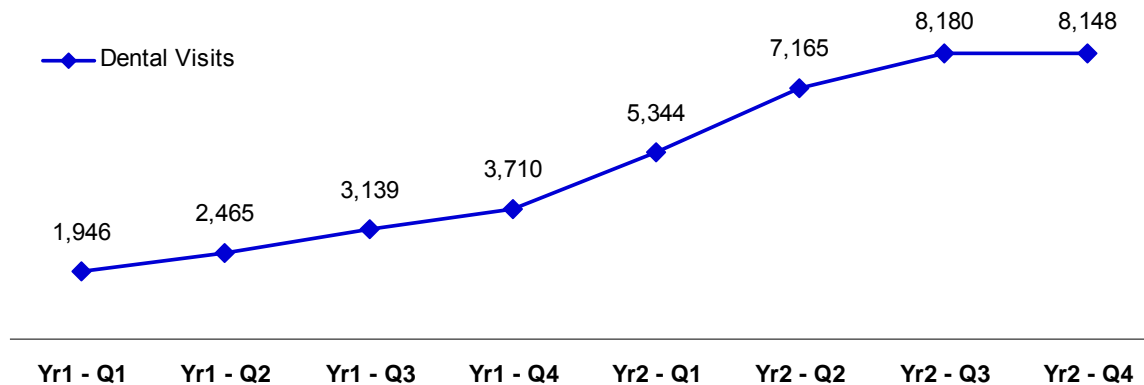
Exhibit 19: Total Number of Emergency Room Visits, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

As of the end of program Year 2, a total of 40,419 dental visits were reported among the 7 counties that provided data (Exhibit 20). Two additional counties (Kern and Santa Clara) cover dental services, but are not able to report data on the volume of services provided. In 1 county where data are available (Ventura), dental care was only covered beginning in program Year 2, contributing to the more rapidly increasing trend seen after the fourth quarter of Year 1. The small decrease in the final quarter of Year 2 may be due to incomplete data for that quarter.

Exhibit 20: Quarterly Total Number of Dental Visits; Years 1 and 2.

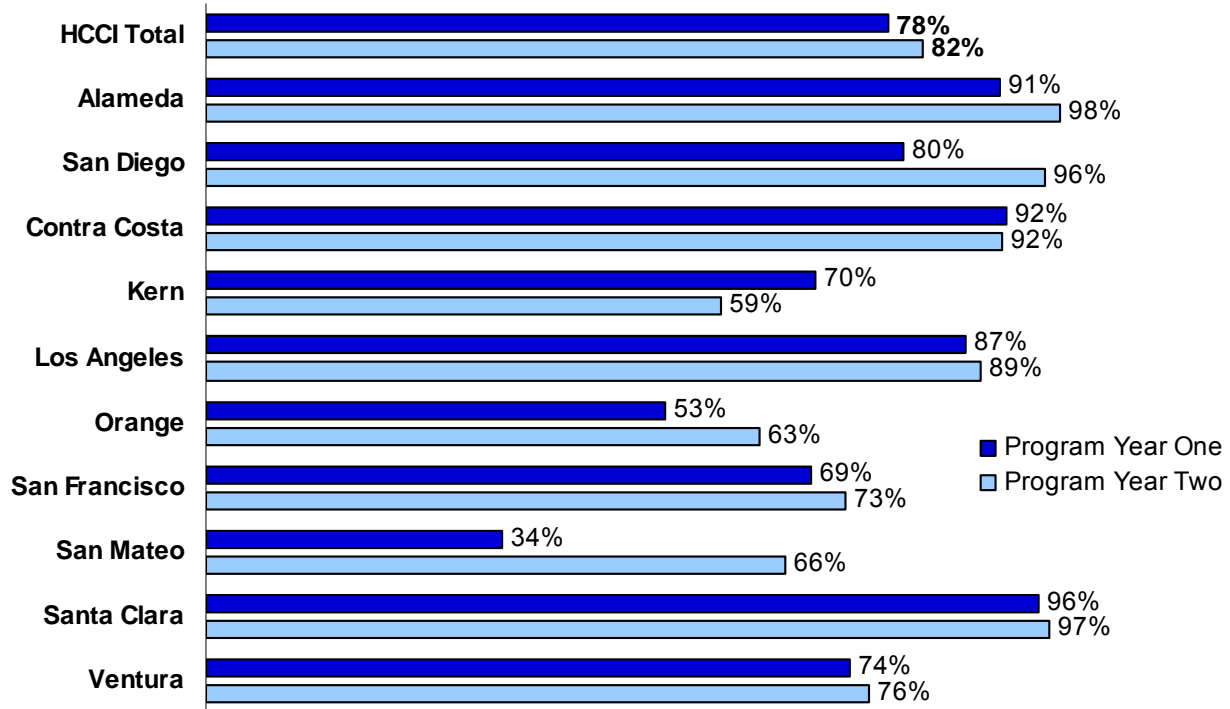


Source: Years 1 and 2 revised county progress reports to DHCS.

c) Medical Home Utilization

Access to care can be enhanced by assignment to a usual source of care. Counties are required by contract to implement the medical home model, and all counties have assigned the great majority of their patients to a medical home (Exhibit 15). Counties report the number of individuals who visited their medical home during each quarter in progress reports to DHCS. Of the total number of individuals enrolled in the HCCI program, approximately 70% of all Year 1 enrollees and 66% of all Year 2 enrollees visited their medical home during the same time period (not shown). However, as seen in Exhibit 16, only a subset of enrolled individuals were active utilizers of at least one health care service during each program year. Therefore, a more meaningful measure of medical home utilization is the proportion of active enrollees who visited their medical home. Exhibit 21 displays this measure by county for each program year.

Exhibit 21: Proportion of Active Enrollees Visiting the Assigned Medical Home, HCCI Total and by County, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

As displayed in Exhibit 21, among enrollees actively utilizing services, the overall proportion visiting the medical home increased between program Years 1 and 2. This trend is also observed for 8 of the 10 counties. In these counties, this positive trend may reflect increased use of the medical home as the source of usual care, representing a beneficial program impact. The opposite trend is observed in Kern County, but this may be attributable to range of reasons including an overall decrease in utilization of services in their enrolled population. No change is seen in Contra Costa County, where the overall medical home utilization among active enrollees remained at a very high level. Further program data will help to clarify these trends.

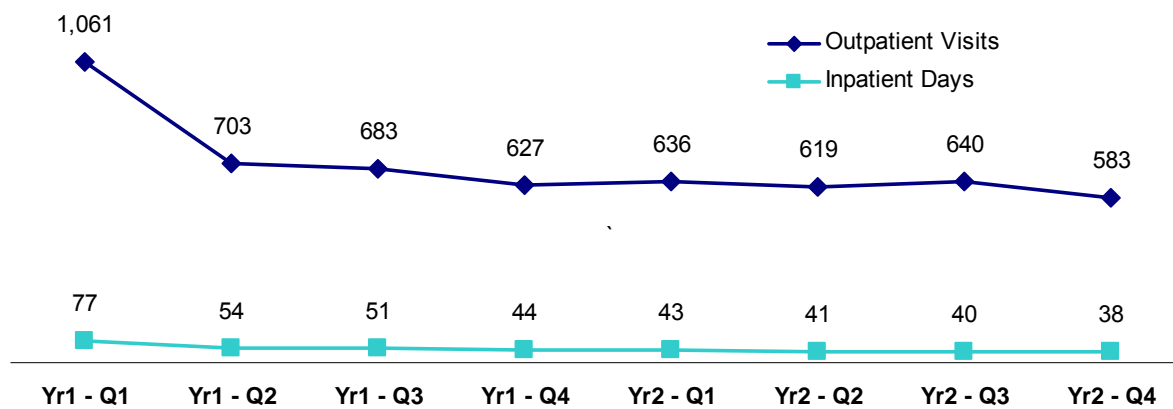
The high proportion of enrollees visiting their medical home during each year may be partially attributable to differing enrollment and medical home assignment strategies by counties. Individuals are frequently enrolled at the time they seek care, and may be assigned to the site at which they enrolled. Some counties define medical home broadly, and therefore most visits can be considered a medical home visit.

d) Outpatient Visits, Hospital Admissions, and Inpatient Days

As calculated from county progress reports to DHCS, the quarterly rates of outpatient visits and inpatient days per 1,000 enrollees per month for the HCCI program as a whole indicate a large initial number of inpatient days and outpatient visits and a gradually declining trend thereafter (Exhibit 22). There are several possible explanations for these trends. First, the method of enrollment in many counties may account for this observed pattern: individuals are often enrolled at point of requesting service. Following the initial visit or inpatient stay, individuals may utilize fewer

services over time. However, the initial high rate of service use is likely also due to a significant amount of pent-up demand for outpatient services for those newly enrolled. Individuals without prior coverage or access to care may seek care which they had previously delayed. Finally, the observed trends may be due to implementation of the medical home and provision of coordinated care and care management services. Many individuals with chronic conditions who are enrolled in the HCCI programs receive coordinated care and care management services designed to improve patient outcomes. These individuals are likely to have more office visits with providers until their condition is under control and the number of visits is reduced to those for periodic check-ups and to receive preventive care. Delivery of appropriate outpatient care is also likely to reduce the rates of inpatient days, especially for ambulatory care sensitive conditions.

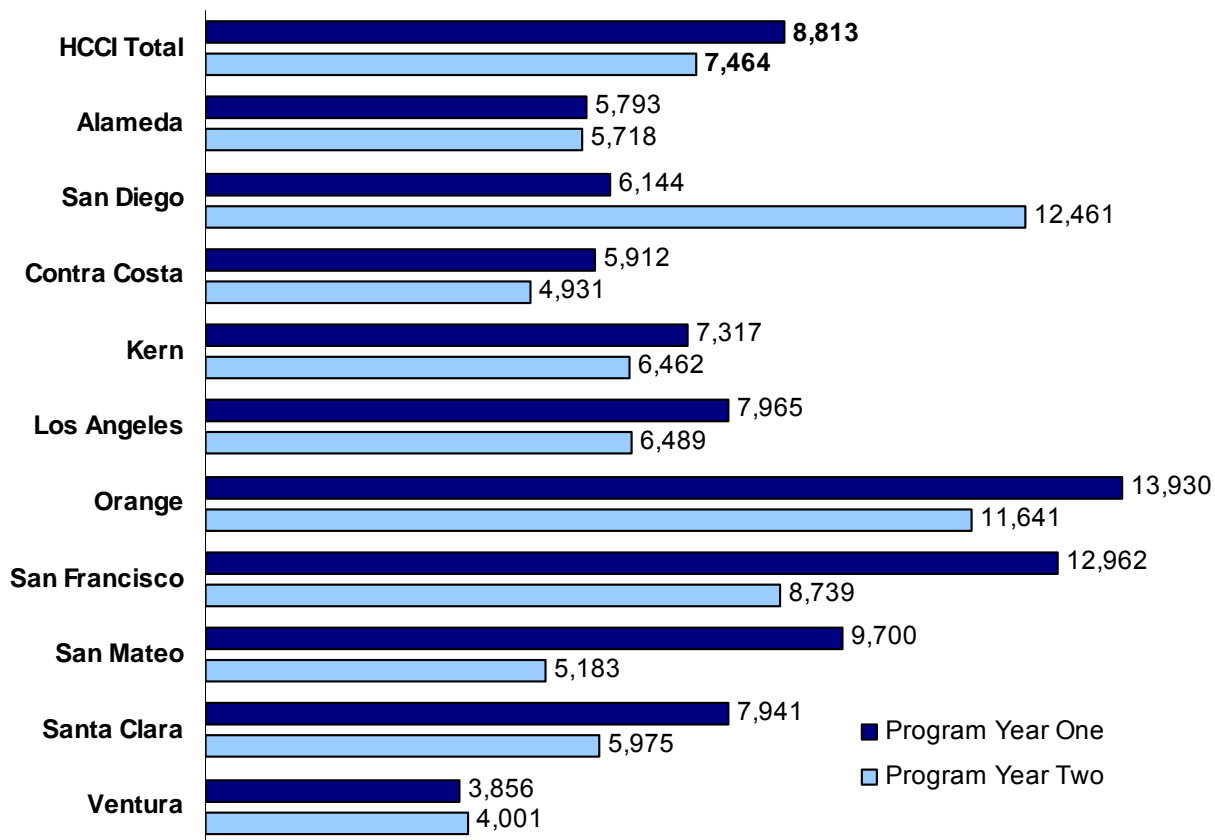
Exhibit 22: Quarterly Outpatient Visits and Inpatient Days per 1,000 Enrollees per Month, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

Exhibit 23 displays the county-specific annualized rates of outpatient visits per 1,000 enrollees, as calculated from county progress reports to DHCS. These data reveal a similar downward trend through the first two years of the program in most counties (Exhibit 23). Some exceptions to this pattern exist. The rate of outpatient visits in San Diego County more than doubled between Years 1 and 2. San Diego experienced delayed enrollment through the third quarter of Year 1, which may impact first year utilization trends as well as limit the length of intervention period received by enrollees, allowing less time for the benefits of increased access to impact behavior. The increase in outpatient visits seen in Ventura County for Year 2 is minimal, and may be due to a shift in utilization from emergency department to outpatient visits. We are currently investigating outpatient claims data provided by HCCI counties, and will provide more detailed analyses in our final report.

Exhibit 23: Annualized Outpatient Visits per 1,000 Enrollees, by County, Years 1 and 2.

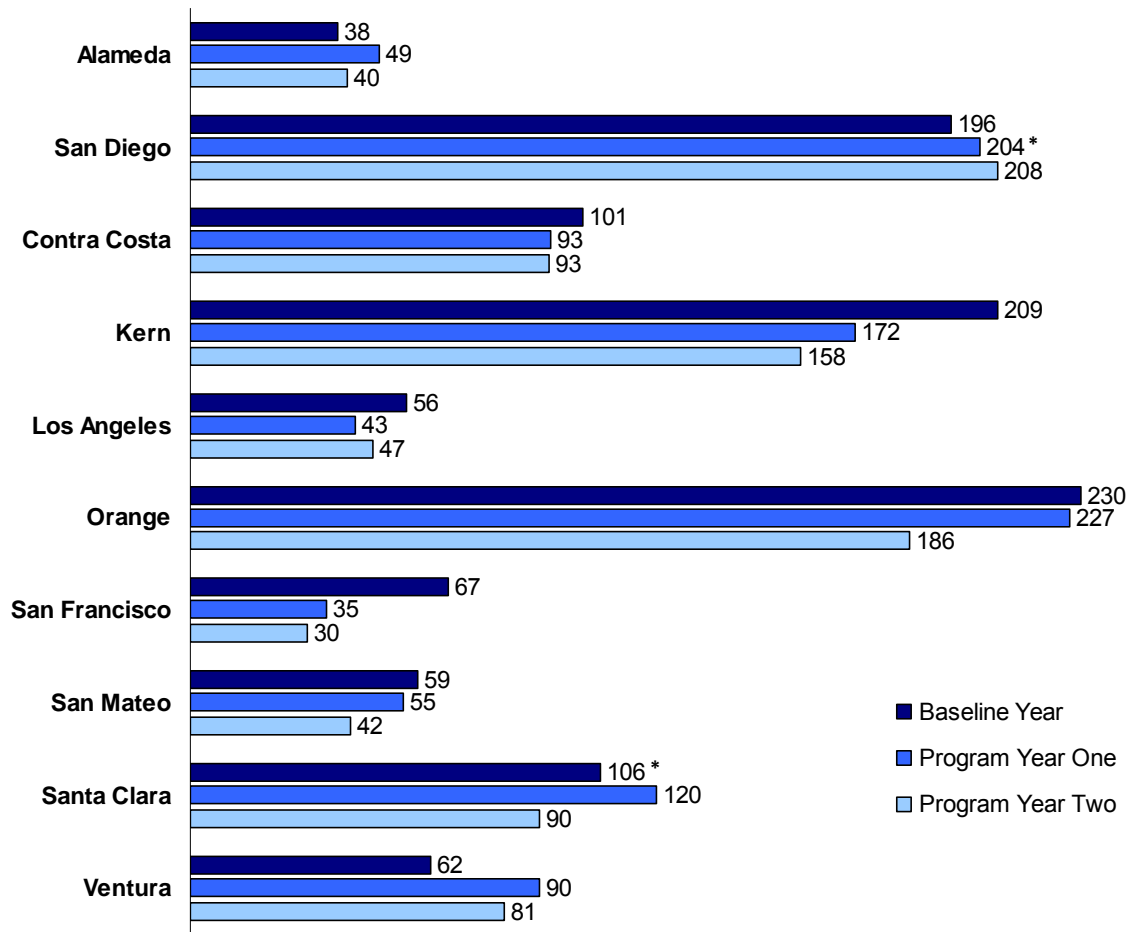


Source: Years 1 and 2 revised county progress reports to DHCS.

A decrease in the number of hospital admissions per person is one potential measure of better management of care in the outpatient setting. The average number of hospital admissions per 1,000 active enrollees as calculated from individual level data is displayed in Exhibit 24. In 7 counties, a decrease in admission rate occurred across all 3 years studied (Kern, Orange, San Francisco and San Mateo), or increased from the Baseline Year to program Year 1 but then decreased in program Year 2 (Alameda, Santa Clara and Ventura). In Contra Costa County, the admission rate decreased from the Baseline Year to program Year 1, but did not change in program Year 2. In Los Angeles County, the rate decreased from the Baseline Year to program Year 1, but then increased in program Year 2. An increase across all 3 years is seen in San Diego County. Delayed enrollment in San Diego County may account for this finding.

Differences in the trends seen within some counties may reflect a lack of access to care for enrollees prior to the HCCI program, causing individuals to postpone needed care until they were enrolled. It is important to note that the baseline period is a subset of the program year population and may not be directly comparable. Therefore, changes between the Baseline Year and program Year 1 are not necessarily meaningful. Further analysis of inpatient admissions is planned, and will control for enrollee characteristics and length of enrollment.

Exhibit 24: Inpatient Admissions per 1,000 Active Enrollees, by County, Baseline Year and Program Years 1 and 2.



Source: UCLA analysis of HCCI county claims data.

Notes: * Estimate has been annualized.

The admission rates in this Exhibit do not adjust for differences in length of enrollment by enrollee.

Baseline Year analyses are based on a subset of HCCI enrollees. Comparability of baseline data is under investigation.

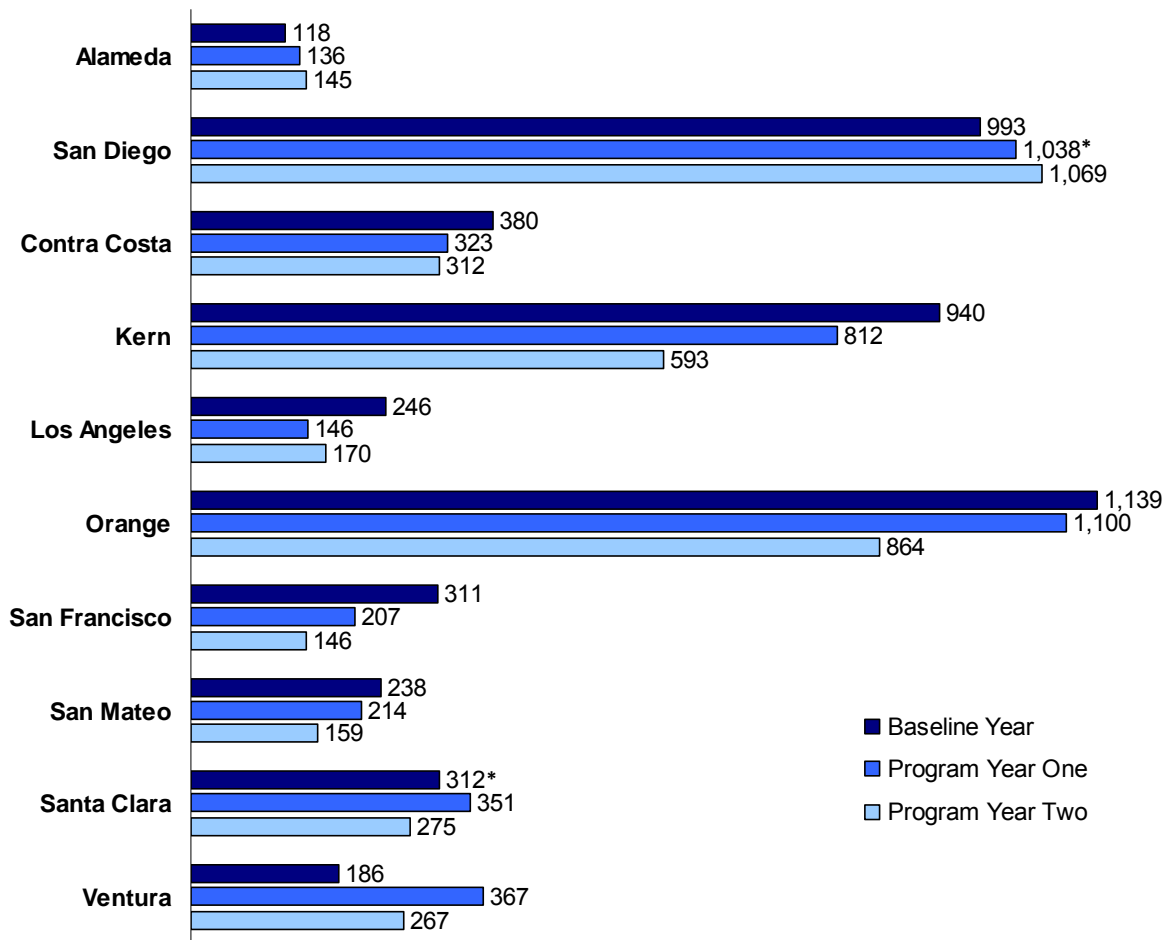
All analyses are impacted by the availability and clarity of the data. See Appendices A and B for further information.

Inpatient days are one of the most expensive components of health care, and effective primary care programs such as HCCI are likely to reduce the use of inpatient days over time. Exhibit 25.1 displays information on the annualized number of inpatient days per 1,000 HCCI enrollees within each county based on claims data; Exhibit 25.2 reports similar rates controlled for length of enrollment, but is based on aggregate program data reported by the counties in their progress reports to the State. According to analysis of claims data, (Exhibit 25.1), 7 counties either experienced a declining trend across all 3 years studied (Contra Costa, Kern, Orange, San Francisco and San Mateo) or an increase from the Baseline Year to program Year 1 followed by a decrease in Year 2 (Santa Clara and Ventura). In Los Angeles County, the number of inpatient days decreased from the Baseline Year to Year 1 and slightly increased in Year 2. Only Alameda and San Diego counties experienced an increase in number of inpatient days per 1,000 active enrollees across all 3 years studied. Delayed enrollment in San Diego County may account for this finding. In addition, Alameda and San Diego counties enrolled a significantly higher proportion of chronically ill individuals when compared to other counties, which may partially explain this trend (Exhibit 6). As

with other measures, differences in the trends seen within some counties may reflect a lack of access to care for enrollees prior to the HCCI program, causing individuals to postpone needed care until they were enrolled.

In contrast, analysis of progress report data indicates a decrease in inpatient days between Years 1 and 2 for all 10 counties (Exhibit 25.2). Further investigation of these trends using inpatient claims data and controlling for enrollee characteristics and length of enrollment is currently underway, and will be provided in the final report.

Exhibit 25.1: Inpatient Days per 1,000 Active Enrollees, by County, Baseline Year and Years 1 and 2.



Source: UCLA analysis of HCCI county claims data.

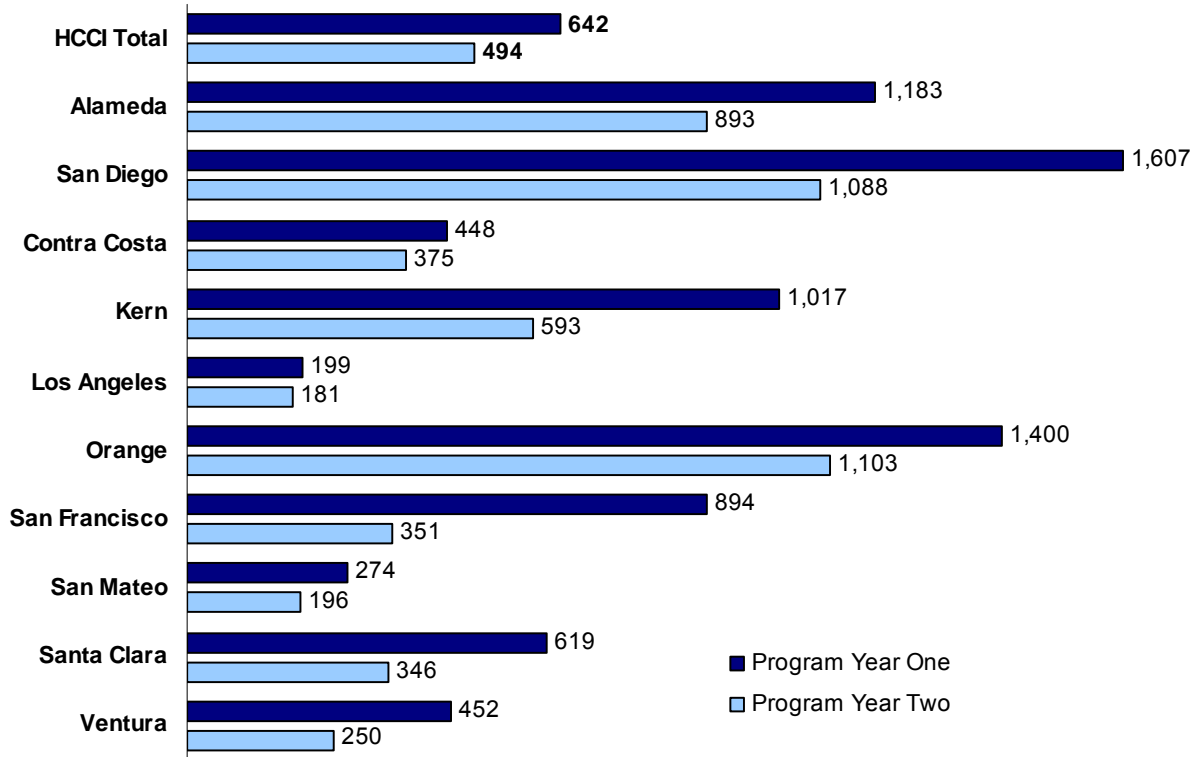
Notes: * Estimate has been annualized.

The admission rates in this Exhibit do not adjust for differences in length of enrollment by enrollee.

Baseline Year analyses are based on a subset of HCCI enrollees. Comparability of baseline data is under investigation.

All analyses are impacted by the availability and clarity of the data. See Appendices A and B for further information.

Exhibit 25.2: Annualized Inpatient Days per 1,000 Enrollees, by County, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

e) Emergency Room Visits

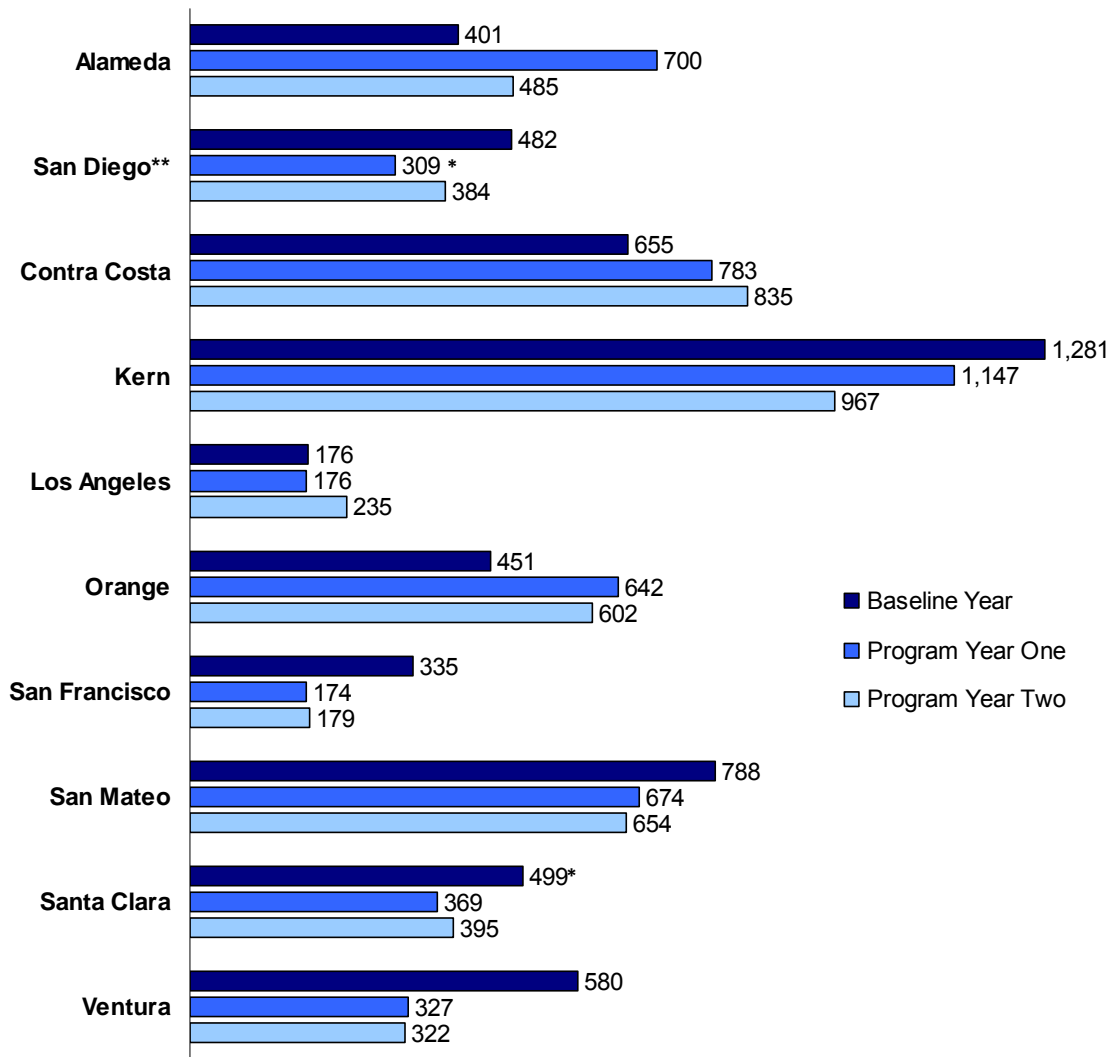
Emergency room (ER) visits are costly and frequently avoidable. Chronically ill patients without a usual source of care often visit the ER for conditions that are exacerbated due to lack of access to primary care. However, patients can be redirected to a more appropriate level of care with teaching from the primary care provider, as well as through availability of urgent care or after-hours care centers, or through a 24/7 nurse advice line (NAL). All counties cover urgent care services, and 5 have a NAL (Contra Costa, Orange, Los Angeles, San Mateo, and Santa Clara).

The annualized rate of ER visits per 1,000 enrollees by county from progress report data (Exhibit 26.2) indicates that overall, utilization of the ER has decreased during the first two years of the HCCI program. However, somewhat divergent trends are seen in analysis of claims data (Exhibit 26.1) compared to program progress report data (Exhibit 26.2). Differences in the construction of the measures may partially account for the different results seen in each analysis. Exhibit 26.1 examines ER visits only among active users of services and does not account for the length of their enrollment period, while Exhibit 26.2 includes all enrollees but is controlled for estimated enrollment time. In addition, our analyses of claims data in San Diego County are limited to ER visits that did not result in hospitalization, while all visits regardless of outcome are included in the progress report data. Finally, it is important to note that these analyses do not account for chronic conditions of enrollees.

Exhibit 26.1 indicates that among active enrollees (i.e., those with at least one health care claim), 5 counties either experienced a decrease in use of the ER across all 3 years studied (Kern, San Mateo

and Ventura) or an increase from the Baseline Year to program Year 1, followed by a decrease in the program period (Alameda and Orange). Five counties showed an increase in ER use between program Years 1 and 2. In Contra Costa County, this increase was seen across all 3 years studied, while the remaining 4 counties (San Diego, Los Angeles, San Francisco and Santa Clara), experienced either no change or a decrease in ER use between the Baseline Year and program Year 1 prior to the increase seen in program Year 2. It is important to note that the baseline period contains a subset of the program year population and may not be directly comparable. Therefore, changes between the Baseline Year and program Year 1 are not necessarily meaningful. However, higher ER utilization during the baseline year may be attributable to lack of access to routine care during the period prior to the HCCI program. Further investigation of ER claims data is underway.

Exhibit 26.1: Emergency Room Visits per 1,000 Active Enrollees, by County, Baseline Year and Years 1 and 2.



Source: UCLA analysis of HCCI county claims data.

Notes: * Estimate has been annualized.

** ER visits resulting in hospital admission are not included.

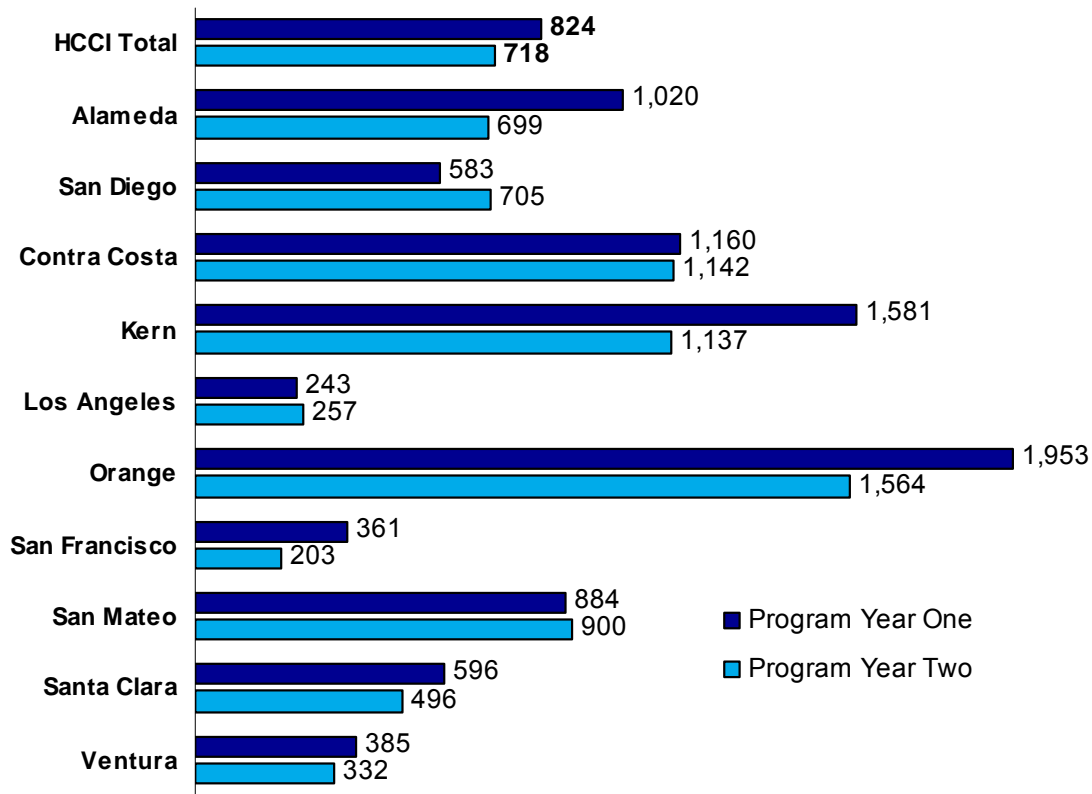
The rates in this Exhibit do not adjust for differences in length of enrollment by enrollee.

Baseline Year analyses are based on a subset of HCCI enrollees. Comparability of baseline data is under investigation.

All analyses are impacted by the availability and clarity of the data. See Appendices A and B for further information.

According to progress report data (Exhibit 26.2), ER visits increased in San Diego, Los Angeles and San Mateo counties between program Years 1 and 2, and declined in the remaining 7 counties. In San Diego, the increase is likely due to delayed enrollment in program Year 1. In San Mateo and Los Angeles counties, the increase is minimal, and requires further investigation.

Exhibit 26.2: Annualized Emergency Room Visits per 1,000 Enrollees, by County, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

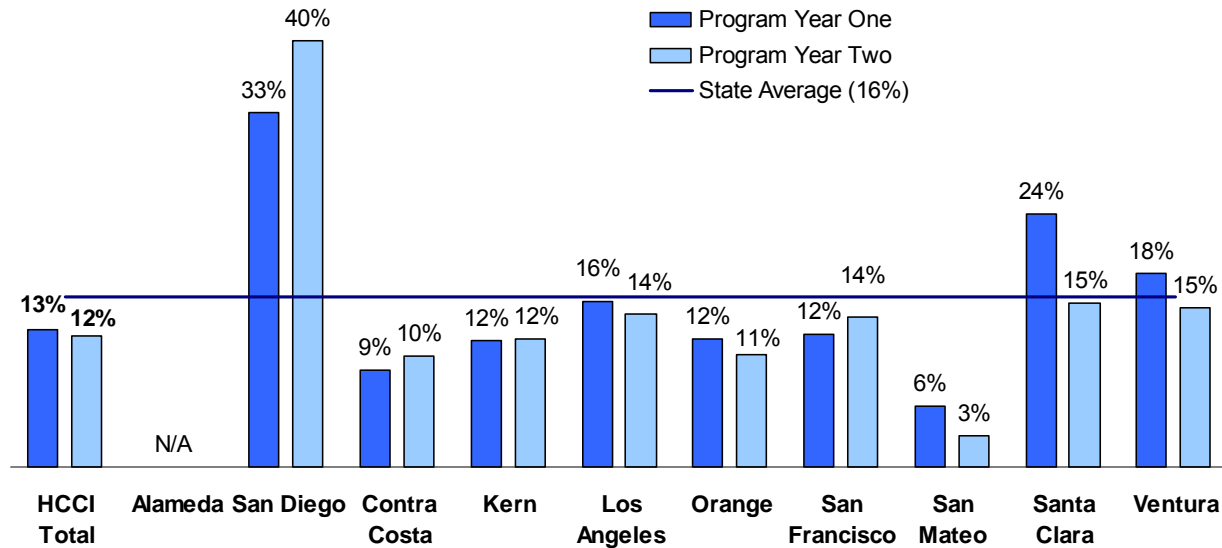
ER visits for ambulatory care sensitive conditions can be reduced with appropriate primary and preventive care. When an ER visit results in a hospitalization, this often indicates that the visit was for a severe condition requiring a higher level of care. Therefore, an increase in the proportion of visits resulting in hospitalization may reflect a more appropriate use of emergency as well as primary care services.

As displayed in Exhibit 27, the overall proportion of ER visits resulting in hospitalization for Year 1 was 13%, and 12% for Year 2. The overall rate for the entire state of California in 2007 was 16%.¹ The proportion of ER visits resulting in hospital admission varies by county, with 6 counties at or below the statewide rate in Year 1 and 8 counties reporting rates at or below the statewide average rate for the program Year 2 (Exhibit 27). It is important to note that the reported proportions do not account for differences in illness severity or other characteristics of the enrollee populations in each county. Notably, 98% of enrollees in San Diego and 91% in Alameda had a chronic condition (Exhibit 6), a much higher rate of chronic illness than in other counties for which data are available.

¹ (Source: http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/Hospital_Utilization.html 2007, pivot profiles).

Further analysis of ER visit outcomes using claims data is underway, and will be provided in the final evaluation report.

Exhibit 27: Proportion of Emergency Room Visits Resulting in Hospital Admission, by County, Years 1 and 2.

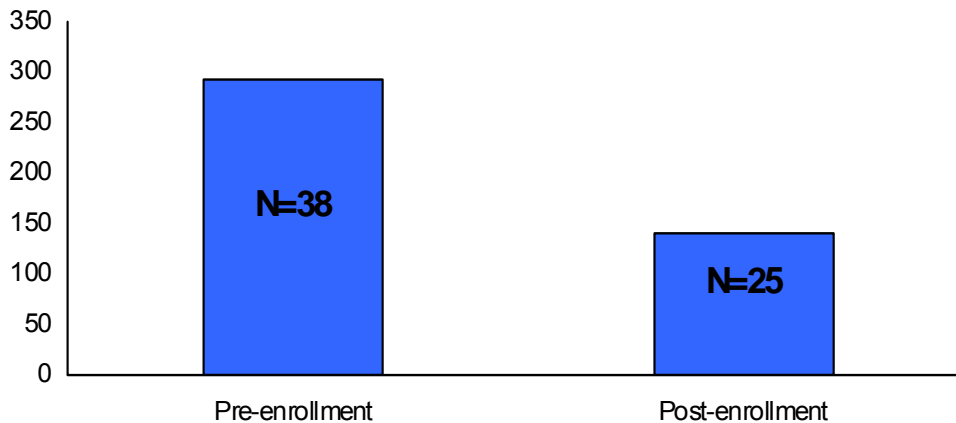


Source: Years 1 and 2 revised county progress reports to DHCS.

Note: Alameda County does not report this statistic.

Specific data from Kern County (Appendix E) provide further insight into whether the HCCI program has influenced ER visit rates (Exhibit 28). Among the subset of Kern County enrollees who were identified as high users, had been enrolled for a minimum of 6 months, and received case and disease management services, annual ER visits decreased by more than 50%. The data were based on 292 visits in the pre-enrollment period generated by 38 patients. After enrollment and with case management, only 25 of these patients visited the ER, generating 139 visits.

Exhibit 28: Annual Emergency Room Visits for Actively Care Managed Patients, 6 Months Minimum Enrollment, Kern County.



Source: Kern County, Appendix E.

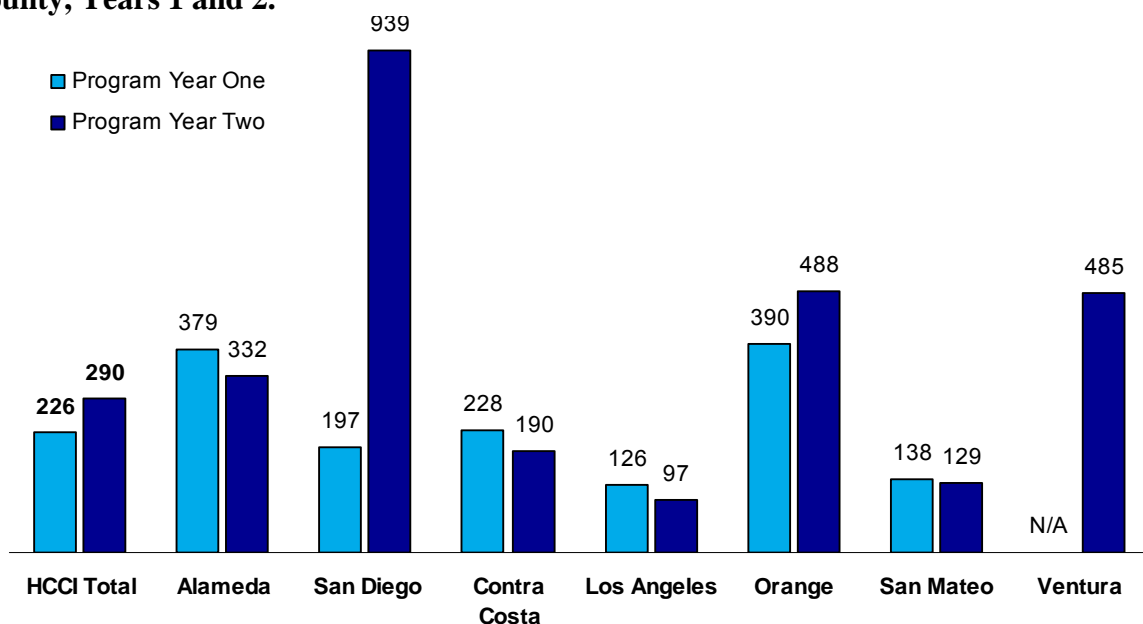
Differences in ER utilization patterns among HCCI counties, and between the HCCI program and the general population demonstrate varied success in influencing the frequency and urgency of ER visits, and may indicate a continuing tendency of HCCI enrollees to use the ER for primary care services. However, this difference may be insignificant, and requires further investigation. Many HCCI enrollees may require a higher level of intervention to improve their health status resulting from their lack of prior access to care. Therefore, a maximum of 2 years of intervention may be too little to effect any change in this measure. Further decreases in overall use of the ER, and increases in proportion of ER visits resulting in hospital admission may be seen in program Year 3. The availability of a nurse advice line and urgent care services may also impact the use of ER services. Additional analyses of ER visits will be included in the final report.

f) Dental Services

Nine counties include at least limited coverage of dental services in their programs according to their contracts, and 7 report data on dental services to DHCS. Kern County covers dental extractions through a sub-contract with a community clinic. However, data on the volume of services provided are not available at the time of this report. Santa Clara County was also unable to collect data on the volume of dental services delivered.

Exhibit 29 displays the annualized rates of dental visits per 1,000 enrollees for program Years 1 and 2. In 4 of the 7 counties for which data are available, dental visit rates declined from Year 1 to 2. Dental services were not covered in Ventura County until program Year 2. San Diego County reported a large increase in dental services in Year 2 coinciding with significant new enrollment in that year. Similarly, Orange County experienced an increase in use of dental services in year 2, leading the county to restrict dental care in the covered services in program Year 3.

Exhibit 29: Annualized Dental Visits per 1,000 Enrollees in Counties with a Dental Benefit, by County, Years 1 and 2.



Source: Years 1 and 2 revised county progress reports to DHCS.

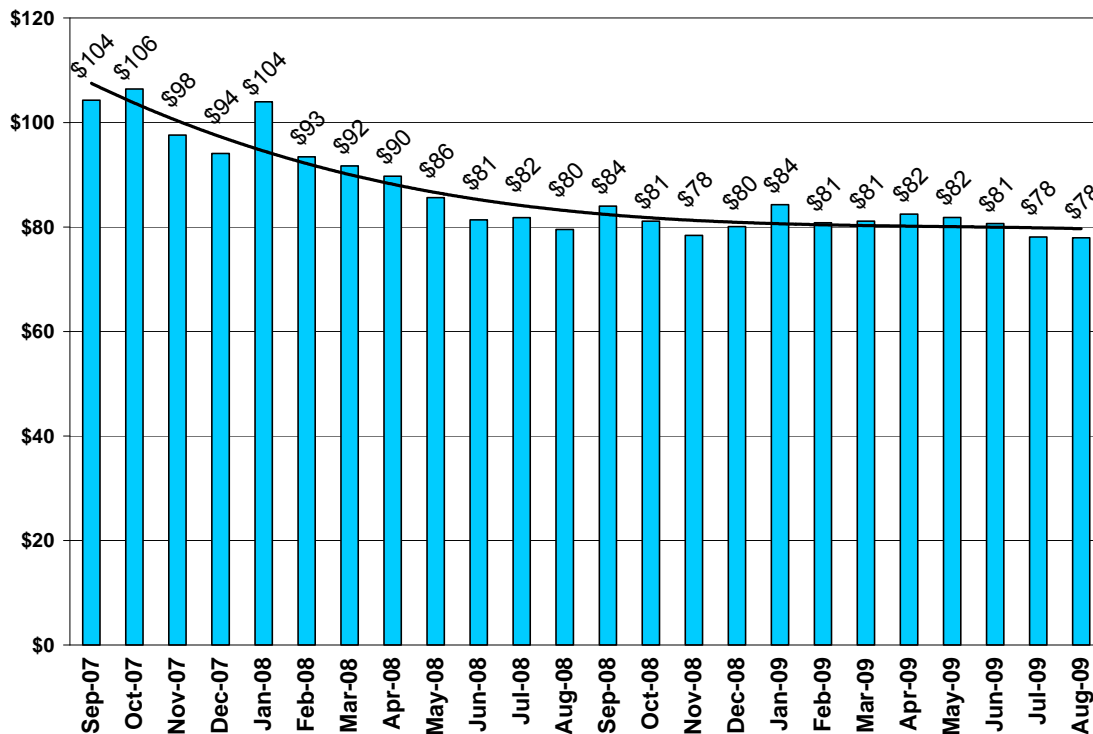
Note: Ventura County began covering dental services in program Year 2. Orange County significantly limited dental benefit in August 2009.

Since access to dental services was significantly restricted for the uninsured population prior to the HCCI program, there may be significant pent-up demand for dental care initially. Those with poor oral health may require multiple visits for restorative care before transitioning to receipt of periodic preventive care. The lack of decline in dental visits through the end of Year 2 in some counties may indicate poor oral health status of the continuously enrolled population, as well as enrollment of new individuals into the program. Further program data are required to clarify the reasons for these trends. Further analyses are planned for the final report to adjust all utilization rates for each individual's length of enrollment (i.e., months of intervention received) and demographic characteristics.

g) Prescription Drug Services

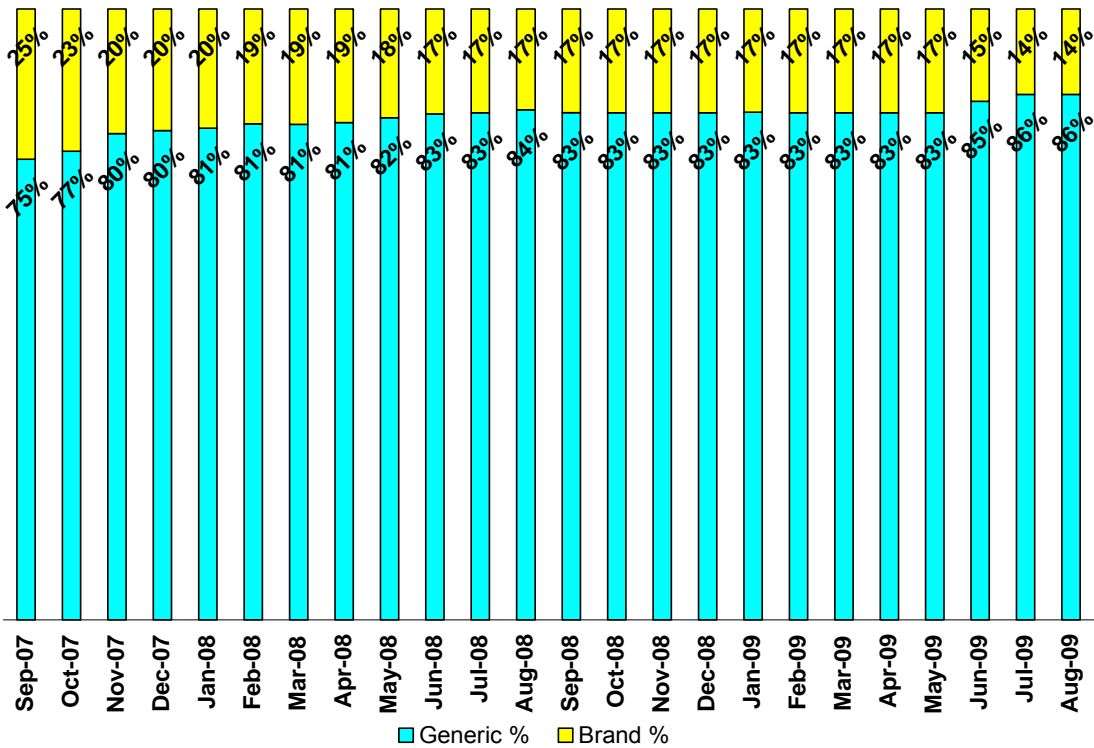
Preliminary analysis of individual-level prescription drug utilization data could not be completed in time for this report. However, Orange County provided supplemental data on prescription drug utilization, displayed below and included in Appendix F. Orange County has focused on quality monitoring and utilization review of pharmacy medications and has conducted extensive formulary modification and pharmacy benefit management activities leading to a number of positive trends. Monthly data from Orange County indicate a consistent increase in number of enrollees receiving prescriptions per month, but a small reduction in number of prescriptions per user, leading to a nearly \$36 reduction in average monthly cost per individual served in the first two years (Exhibit 30). One likely reason for this decline in the monthly per enrollee cost of prescriptions is an 11% shift from use of brand name to generic prescriptions in the first two program years (Exhibit 31). We anticipate providing similar analyses for other counties in our final report.

Exhibit 30: Average Monthly Cost per Enrollee Receiving Prescriptions, Orange County.



Source: Orange County, Appendix F.

Exhibit 31: Percentage of Total Dispensed Prescriptions, Generic vs. Brand Name, Orange County.



Source: Orange County, Appendix F.

2. Quality of Care

Quality of care is assessed at three levels: structure, process, and outcomes. Structural measures include availability of infrastructure, such as data systems, guidelines, personnel, and services required for delivery of high quality care. Process measures refer to receipt of care in concordance with clinical care guidelines, including receipt of condition, gender and/or age specific services, and the timeliness of the services provided. Outcome measures refer to various measures of impact of the delivery of care on patients, and the clinical responses to care. Outcomes can be measured as the changes in clinical status of the patient (such as lower blood glucose level), changes in patient quality of life, or changes in perception of and satisfaction with care received.

a) Structural Measures

In general, the key structural measures of quality available for evaluating the HCCI program include the availability of data systems, databases, and clinical guidelines developed or used by participating counties. Exhibit 32 presents the strategies adopted by HCCI counties to implement the following structural measures of quality: evidence-based guidelines, disease registries, electronic health information, availability of data sources for measuring quality and outcomes, including HEDIS measures, and medical record chart review.

Exhibit 32: Adoption of Structural Measures of Quality, by County, Years 1 and 2.

	Alameda	San Diego	Contra Costa	Kern	Los Angeles	Orange	San Francisco	San Mateo	Santa Clara	Ventura
Evidence Based Guidelines	X	X	X	X	X	X	X	X	X	X
Disease Registries										
Diabetes	X	X	X	X	X	X	X	X	X	X
Asthma			X	X	X	X	X	X		
Heart Disease				X	X	X	X			
Hypertension		X				X		X		X
Hyperlipidemia		X					X	X		X
Immunizations			X	X				X		
Other						X		X		X
Electronic Health Information										
Electronic Medical Record				X				X	X	
Lifetime Clinical Record							X	X	X	
Other	X	X	X	X	X	X				X
Availability of Quality / Outcomes Data										
Claims or Administrative Data	X	X	X	X	X	X	X	X	X	X
Use of HEDIS Measures	x	x	x	x	x	x	x	x	x	
Pharmacy Data	X	X	X	X		X	X	X	X	X
Lab Results		X		X	X	X	X		X	
Patient Satisfaction Surveys	X	X	X	X		X	X	X	X	X
Chart Reviews	X	X	X	X	X			X		X

Source: County contracts with DHCS; county personnel; UCLA Policy Briefs (Appendices C and D).

Currently, all counties have access to some form of electronic patient information. Four counties have access to electronic medical records (EMRs) and/or a lifetime clinical record (LCR) at some network sites. Other counties report utilizing limited-content electronic documents, such as electronic summary sheets, to capture and share patient information. Most counties utilize multiple disease registries, while 2 counties use only one disease registry for their HCCI population. In 6 counties, disease registries are available to all or nearly all provider types, and in other counties registries are available to PCPs alone or to PCPs and specialists. Specific disease registries, such as diabetes, hypertension, or immunization registries, are available systemwide in 4 counties. However, in most counties, registries are unique to specific clinics and practice sites (Appendices C and D).

Systemwide adherence to guidelines for chronic conditions is valuable in ensuring consistent improvements in patient care. Currently, all counties report dissemination of evidence-based guidelines as a key quality improvement activity. Guidelines support appropriate care of chronic diseases, and can assist providers in management of conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension and dyslipidemia (abnormal amounts of lipids in the blood, such as elevation of total cholesterol).

- Appropriate management of diabetes includes glycemic control (i.e., control of blood sugar level) to prevent the development of related complications including, but not limited to, cardiovascular disease, renal disease, ophthalmologic conditions, peripheral vascular disease, and neuropathy (nerve damage leading to numbness). These complications may lead to kidney failure, non-traumatic amputation, retinal disease and blindness, myocardial infarction and cerebrovascular disease. The current recommendations for diabetes management include: optimal blood sugar level (Hemoglobin A1c) of 7.0 or lower; a low-density lipoprotein (LDL) level below 100; blood pressure control with systolic blood pressure below 130mmhg; annual dilated retinal exam; annual microfilament exam (screen for peripheral neuropathy - to detect numbness in extremities); and annual screening for proteinuria (protein in the urine as an indicator of renal disease). In addition, individuals with diabetes should receive usual preventive health care including annual influenza shots and a pneumonia vaccination every five years. Counseling regarding nutritious eating, weight control and physical activity should also take place.²
- Appropriate care for asthma and chronic obstructive pulmonary disease (COPD) includes: receipt of influenza and pneumonia vaccinations to reduce the risk of serious infection; the development of an action plan with one's provider based on symptoms; and pharmaceutical treatment where indicated either for daily control of symptoms and/or control of symptom flares.³
- Control of congestive heart failure (CHF) requires optimization of cardiac functioning and the avoidance of preventable complications, including blood pressure control, daily monitoring of weight, adherence to a low-sodium diet, the use of appropriate medications and LDL control, as well as use of ER services and hospitalization when indicated.⁴
- Hypertension control requires blood pressure control and reduction in associated complications including cardiac risk factors. Blood pressure monitoring, use of appropriate pharmaceuticals, and cholesterol monitoring and control are key. Dietary and weight loss interventions are also important to achieving these goals.⁵
- The basis of dyslipidemia quality of care is the reduction of cardiac risk, primarily for people with specific risk factors (e.g., diabetes or hypertension), but also for prevention in individuals with other risk factors such as obesity and tobacco use. Monitoring of dyslipidemia is performed via fasting lipid panels with a specific focus on LDL and triglyceride levels and treatment.⁶

In many cases, HCCI participating counties have developed specific goals for their providers based on quality guidelines. Exhibit 33 provides an example of some of the goals developed by San Mateo County for management of chronic illnesses (Appendix G).

² Diabetes Guidelines: <http://www.guideline.gov/browse/browsemode.aspx?node=7546&type=1>

³ Asthma and COPD Guidelines: <http://www.guideline.gov/browse/browsemode.aspx?node=2530&type=1>;
<http://www.guideline.gov/browse/browsemode.aspx?node=22693&type=1>

⁴ Congestive Heart Failure Guidelines: <http://www.guideline.gov/browse/browsemode.aspx?node=37139&type=1>

⁵ Hypertension Guidelines: <http://www.guideline.gov/browse/browsemode.aspx?node=13510&type=1>

⁶ Dyslipidemia Guidelines: <http://www.guideline.gov/browse/browsemode.aspx?node=47506&type=1>

Exhibit 33: Clinical Guidelines and Goals for Chronic Disease Management, San Mateo County

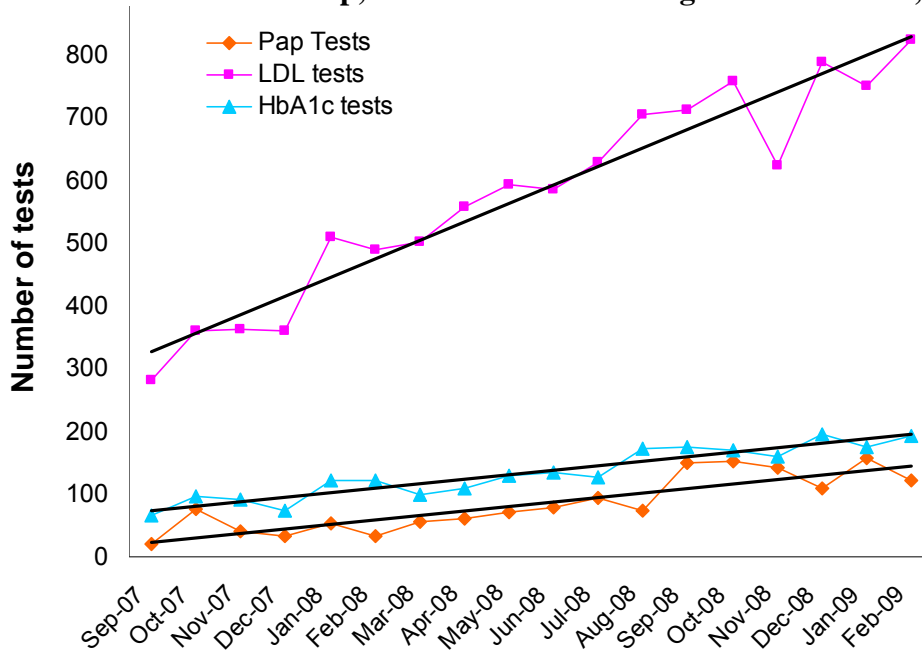
Chronic Disease Management	Target	Goal %
HbA1C	<7.0	60%
LDL	<100	70%
Pneumovax		80%
Flu Vaccine		80%
Eye Exams		80%
Foot Exams		80%
Self Management Goals		80%
ASA		80%
Blood Pressure	<130/80	60%

Source: San Mateo County, Appendix G.

b) Process Measures

Availability of guidelines and setting specific goals are the first steps in delivering high quality care. The next step is to ensure that services are delivered according to guidelines. Available evidence from Orange County (Appendix F) indicates that the volume of guideline concordant primary and preventive care services delivered has increased throughout the program implementation period. This includes increases in the total number of cervical cancer screenings (Pap smears), cholesterol tests, blood glucose tests (Exhibit 34), tetanus shots, flu and pneumonia vaccines, prostate specific antigen (PSA) tests and mammography screenings (Appendix F).

Exhibit 34: Number of Pap, Cholesterol and Hemoglobin A1C Tests, Orange County



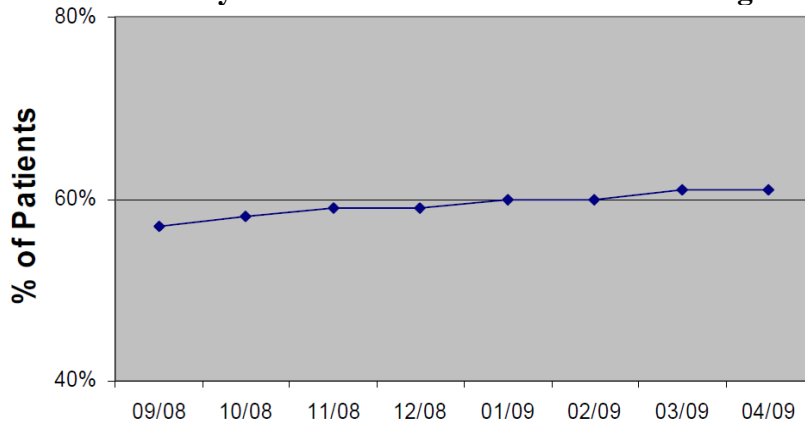
Source: Orange County, Appendix F.

The increase in volume of preventative and diagnostic services in Orange County indicates an expansion of access to care. However, due to increases in enrollee population throughout the

program period, a corresponding increase in the total number of services delivered may not necessarily represent a change in proportion of patients receiving appropriate care. Therefore, further analysis of delivery of appropriate services according to the health status of enrollees is needed. Although these data are not available for all HCCI programs at this time, data on guideline concordant service delivery among specific populations are available from selected counties.

Data from San Mateo County’s diabetes registry for Year 2 (Appendix G) show a gradually increasing rate of pneumonia vaccinations among the 1,400 patients in the diabetes registry (Exhibit 35).

Exhibit 35: Monthly Pneumonia Vaccination Rates among Diabetics, San Mateo County.

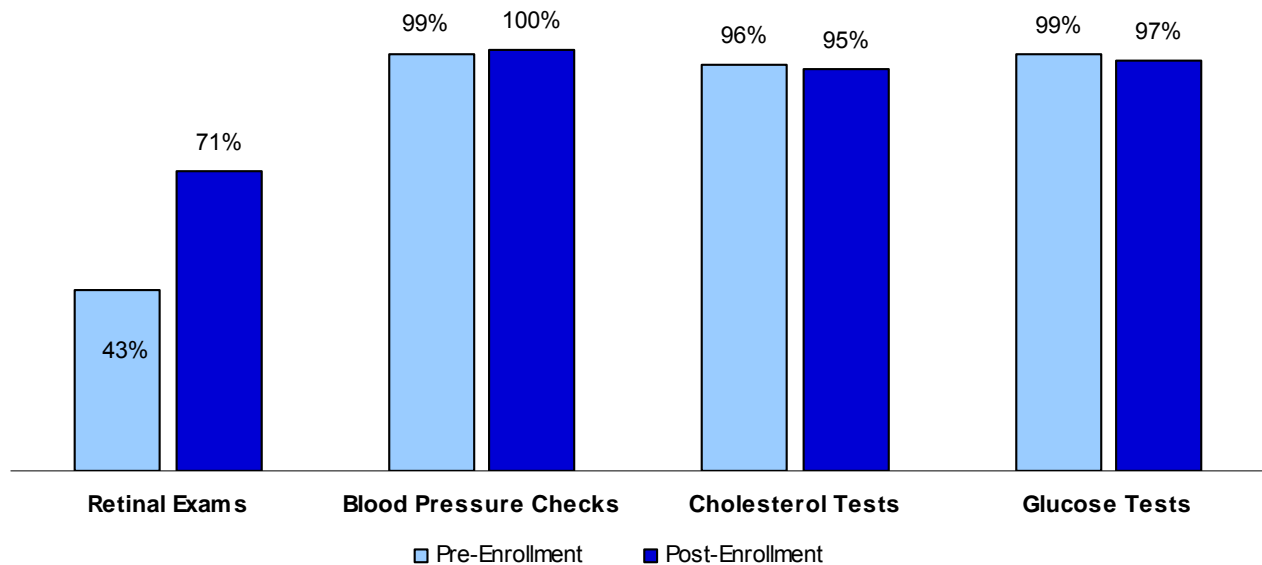


Source: San Mateo County, Appendix G.

Similarly, analysis of immunization and claims data provided by San Francisco County indicates that 67% of diabetics have received a flu shot since their enrollment, and 49% have received a pneumonia vaccination (not shown).

Data from San Diego County from February 1, 2008 to April 30, 2009 (Appendix H) reveal a significant growth in the percentage of patients with diabetes who received retinal exams, and a very high rate of receipt of other screenings in both the pre- and post-enrollment periods (Exhibit 36). There data are from 484 patients in the pre-enrollment period and 408 in the post-enrollment period.

Exhibit 36: Percentage of Patients Receiving Recommended Screenings Pre and Post HCCI Enrollment, San Diego County.



Source: San Diego County, Appendix H.

The retinal exams were conducted under a specific research project that sent a mobile retinal screener to Whittier/Project Dulce clinics over an 18-month period (Appendix H). This effort largely accounts for the success in improving retinal exam rates shown in Exhibit 36, and may be a cost-effective and replicable strategy for other providers in San Diego County as well as other HCCI counties. The high screening rates for blood pressure, cholesterol, and blood glucose levels remained relatively constant in the pre and post HCCI enrollment periods. Because enrollment in the HCCI program in San Diego County is limited to diabetic patients, it is likely these individuals received these screening services from providers in a variety of settings, including emergency departments, prior to HCCI implementation.

Further discussion of provision of guideline concordant services in all HCCI counties will be presented in detail in the final evaluation report.

c) Outcome Measures

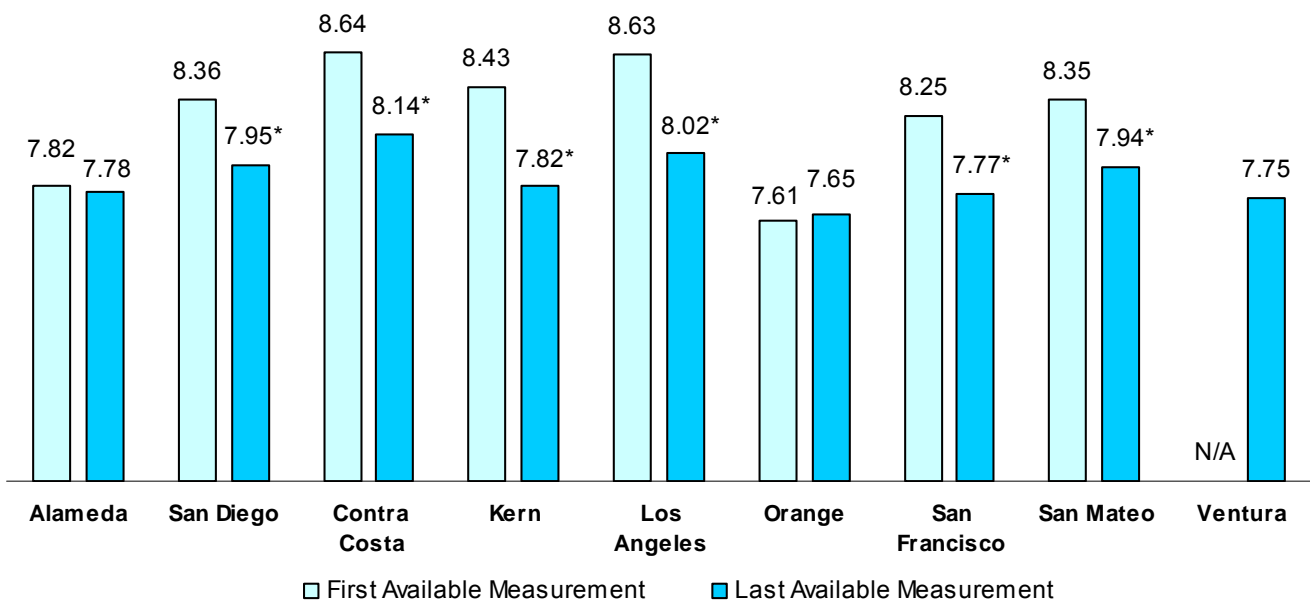
Outcome measures are arguably the most important measures of quality because they focus on the ultimate goals of health care delivery, namely, improving patient health, satisfaction, and quality of life. Changes in specific clinical measures indicate whether the guideline concordant management of patients (provision of recommended screenings and services) has had a perceptible impact on their clinical health status. Multiple measurements of clinical outcomes over time are required to assess such changes, particularly since patient adherence to provider recommendations requires frequent reinforcement during visits and other interactions with the multidisciplinary staff. Although these data are not available for all counties at this time, examples of clinical outcome measures are available from selected counties.

According to clinical guidelines, diabetic patients should receive careful monitoring of their hemoglobin A1c (HgA1c) level. This indicator represents the average blood sugar control over the

previous three months, with a level under 7.0 considered optimal for diabetics. Laboratory result data provided by 9 counties were analyzed to determine the mean HgA1c level among enrollees with diabetes (Exhibit 37), as well as the proportion of diabetic patients with poorly controlled diabetes (i.e., HgA1c above 8.0) (Exhibit 38). No laboratory data from Santa Clara County were available to UCLA. The first and last available lab tests for each diabetic enrollee were used, and are displayed as initial and follow-up measurements. In Ventura County, initial measurements were not available. The analysis did not control for elapsed time between the measurements.

Initial and follow-up average HgA1c levels are displayed in Exhibit 37. In 6 of the 8 counties where repeated measures were available, there was a statistically significant improvement in the mean HgA1c level over time (Exhibit 37), and no significant change was found in Alameda and Orange counties. This finding suggests improved management of the condition, although in all counties the mean score remained above the optimal level at the time of both measurements. The mean HgA1c score at most recent measurement in Ventura County was comparable to the scores in the other counties studied.

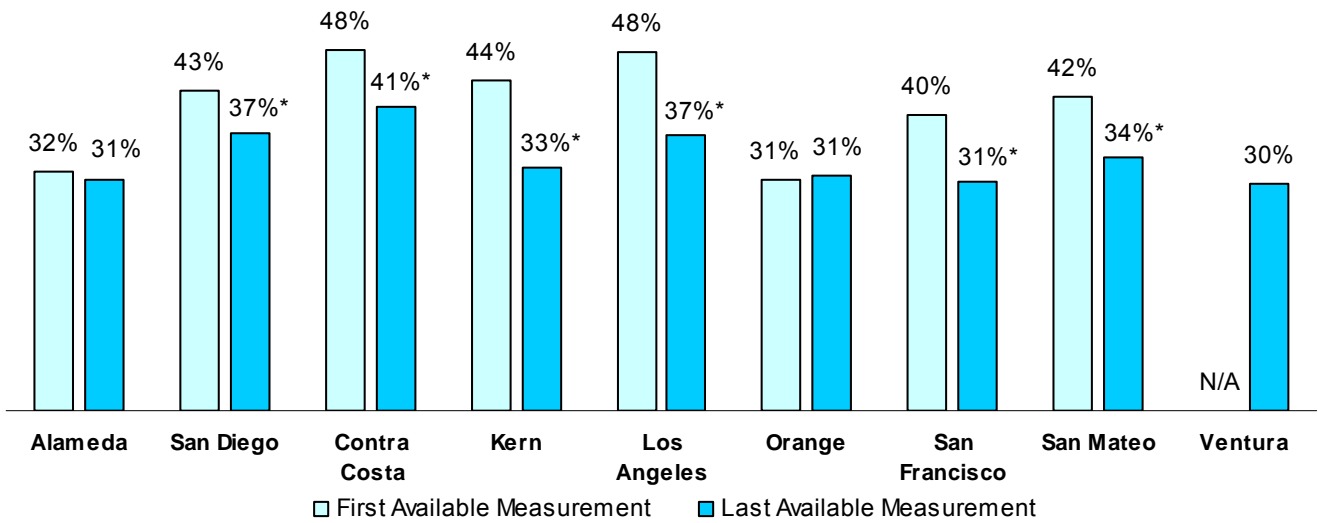
Exhibit 37: Mean Hemoglobin A1c Level (including 95% Confidence Interval) among Diabetic Patients Receiving Screening, by County; as of May 2010.



Source: UCLA analysis of county laboratory and claims data.
 Note: * indicates change that is statistically significant at the 95% level.

The proportion of diabetic enrollees who had poorly controlled diabetes (i.e., HgA1C above 8.0) at initial and final measurements is displayed in Exhibit 38. Findings in 6 of the 8 counties where repeated measurements were available indicate a significant decrease in the proportion of diabetics with an uncontrolled blood sugar level between the initial and follow-up measurements (Exhibit 38), and no significant change was found in Alameda and Orange counties. In Ventura County, the proportion of diabetic enrollees with an uncontrolled blood sugar level at the most recent measurement was comparable to the most recent measurement in other counties.

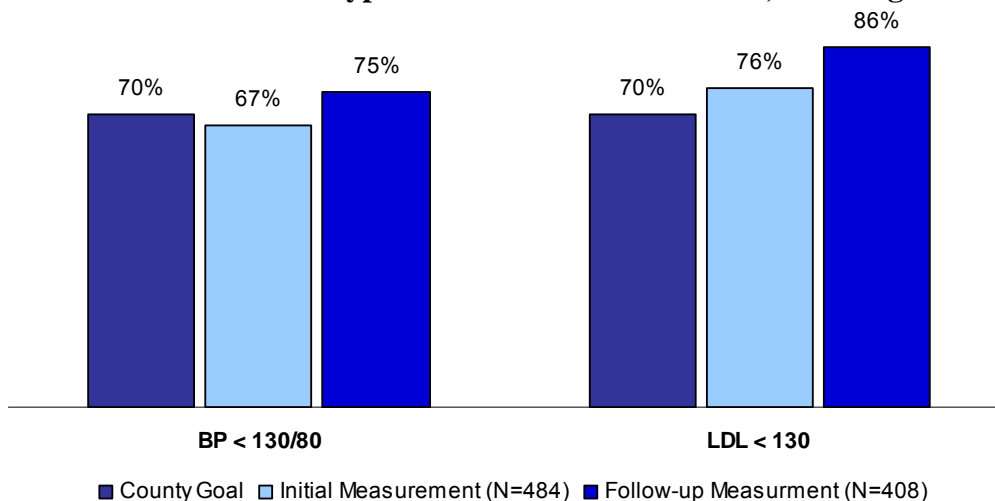
Exhibit 38: Proportion of Diabetic Patients with Hemoglobin A1c Level Above 8.0, by County; as of May 2010.



Source: UCLA analysis of county laboratory and claims data.
 Note: * indicates change that is statistically significant at the 95% level.

According to clinical care guidelines, cholesterol level is an important indicator of health for diabetic patients, and blood pressure is similarly important for patients with a diagnosis of hypertension. Patients with a diagnosis of diabetes should maintain the Low Density Lipoprotein (LDL) under the recommended level of 100, and a blood pressure under 130/80 is recommended for patients with a diagnosis of hypertension. Exhibit 39 provides data on these clinical outcomes from San Diego County (Appendix H), although the LDL level investigated by the county was 130 (above the guideline-recommended level). The proportion of enrollees with blood pressure and cholesterol scores meeting the goal investigated by the county increased between initial measurement at enrollment and follow-up measurement after receipt of disease management services. For both outcome measures, the proportion of enrollees with blood pressure and LDL under control exceeds the county goal.

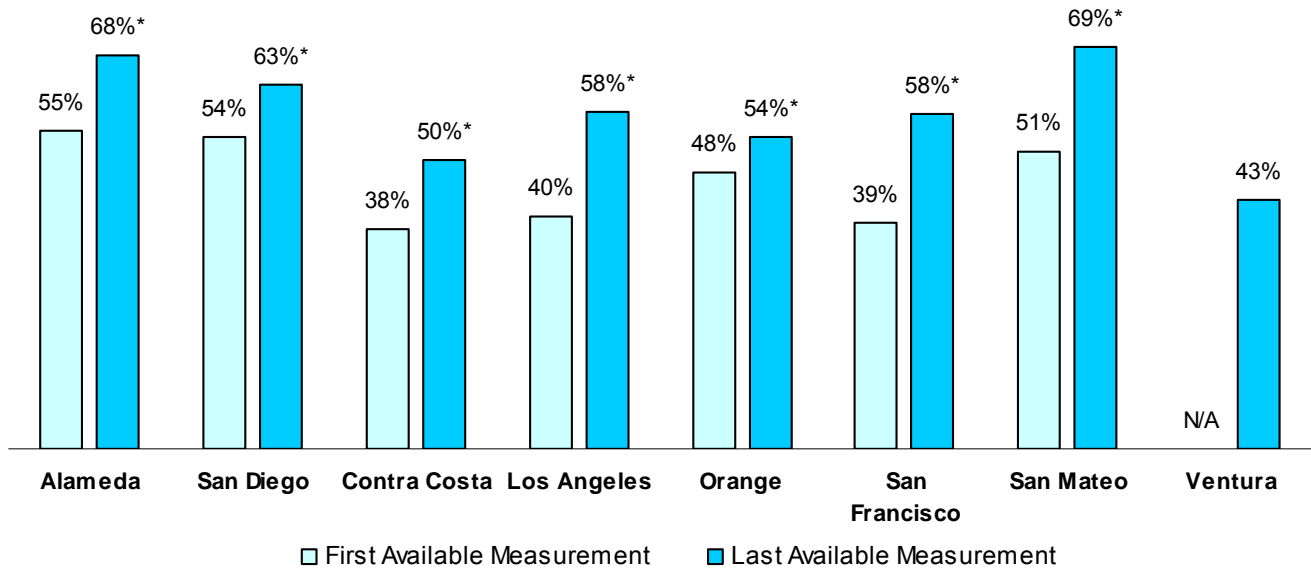
Exhibit 39: Diabetes and Hypertension Clinical Outcomes, San Diego County.



Source: San Diego County, Appendix H.

UCLA analysis of available laboratory data from 8 counties indicate that the proportion of enrollees with a diagnosis of diabetes who have an LDL score at the recommended level (under 100) has significantly increased throughout the project period to date in all 7 counties where repeated measurements are available (Exhibit 40). Data on LDL levels were not available in Kern County, and no laboratory data were available from Santa Clara County.

Exhibit 40: Proportion of Diabetic Patients with LDL Score Under 100, by County; as of May 2010.



Source: UCLA analysis of county laboratory and claims data.
 Note: * indicates change that is statistically significant at the 95% level.

Quality-of-life and patient satisfaction measures provide a different perspective on the impact of delivery of care on patients. Improvements in clinical outcomes should coincide with improvements in patients’ perceptions of their health as well as positive experiences during receipt of services. Patient satisfaction surveys have been carried out by 9 counties with at least a subset of their population, although many counties collect satisfaction data anonymously to protect patient privacy. Counties provided summary data from patient satisfaction surveys in program progress reports to DHCS. Selected examples of the reported findings of patient satisfaction surveys completed by the HCCI demonstration counties indicate a high level of satisfaction with the programs:

- Contra Costa County completed a mail-based satisfaction survey during Fall 2008 with approximately 540 respondents. The results indicate that 92.3% of respondents were satisfied or very satisfied with the services received in all areas, with almost 90% using at least one service since enrollment.
- In the fourth quarter of Year 2, Kern Medical Center Health Plan conducted a patient satisfaction survey of HCCI enrollees, with 307 surveys collected. Respondents were asked to rank their experience for a range of measures. The total average score across all measures was above 4 on a scale of 0 to 5, with 5 being best.

- Orange County's patient satisfaction surveys have recently focused on assessment of medical home implementation. Results reported in the Year 2 annual progress report indicate that nearly 87% of patients surveyed knew the location of their assigned medical home. Of these patients, about 31% had visited their medical home at least three times in a six-month period. Enrollees were also asked to rank on a scale of 1 to 5 their proximity to their medical home (average score of 4.4), whether their medical home assists with specialty referrals or not (average score of 4.2), if their health had improved since they were assigned to their medical home (average score of 4.2), and their overall satisfaction with the MSI Program (average score of 4.6).
- San Francisco County conducted a single-sample telephone survey of Healthy San Francisco enrollees with assistance from the Kaiser Family Foundation. The survey was based on a random sample of 1,026 enrollees enrolled as of March 31, 2009 with at least four months of continuous enrollment. The survey indicated 94% of enrollees were satisfied with the program. The majority of respondents (86%) reported having a usual source of care, and almost 40% reported an improvement in meeting their health needs since joining Healthy San Francisco.

Source: county progress reports to DHCS.

E. Efficiencies

The Coverage Initiative has created expansions or enhancements to the safety net in multiple areas including the delivery of care, infrastructure development, and financing. These expansions are expected to produce efficiencies in program operations, improved patient outcomes, reductions in inpatient hospitalizations, unnecessary emergency department visits and the cost of providing care to the uninsured, and improvements in enrollee health status, appropriate utilization and access to care. It is important to assess the efficiency and potential sustainability of this model of health care delivery for low-income individuals over time, as the source and extent of future funding for safety net health care is somewhat uncertain, although the prospects for further improvements in the safety net have improved with the recent passage of national health reform. At this stage in program implementation, evidence of efficiencies exists primarily in the areas of enrollment and system redesign. Additionally, preliminary evidence of efficiencies in the areas of health care costs and service delivery/quality of care are presented. However, two years of program implementation may be insufficient to achieve or demonstrate substantive efficiencies in health care costs and quality.

1. Enrollment and Outreach

One goal of the HCCI program is to strengthen other public programs in demonstration counties, including Medi-Cal and Healthy Families. Early evidence exists to suggest that HCCI programs have been effective in meeting this goal. Through innovative strategies, counties have enrolled a broad group of eligible individuals into the HCCI program, and have used HCCI enrollment and outreach strategies to simultaneously support other local public programs.

a) Innovations

The methods of outreach by HCCI counties were displayed previously in Exhibit 3. A number of these techniques represent innovative approaches that allow each county to successfully enroll eligible populations that are not captured with more traditional approaches. These techniques include: multilingual program announcements; presentations to labor groups, churches, temples, schools, chambers of commerce, faith-based organizations, and community-based organizations; participation in community events; neighborhood canvassing; employment of outreach staff representatives (promotores) from the county's diverse communities; enrollment announcements at clinics within the provider network; and direct contacts with small businesses, homeless individuals, and college students.

Several counties succeeded in recruiting from hard-to-reach populations, such as homeless individuals and students, and worked through other existing health care programs to recruit enrollees. Examples include:

- Contra Costa County program staff, who oversee services to the homeless in a program called "Homeless Outreach Projects to Encampments (HOPE)," were trained to assist homeless individuals in enrolling in HCCI.
- Ventura County hired public health nurses, who are well connected with the community, to conduct outreach at a local tent community where homeless individuals reside. They also created a weekly "one-stop shop" where homeless individuals can receive a number of services including health care.

- Orange County conducted outreach efforts focused on the homeless, including events with providers that provided care to homeless patients and at homeless shelters.
- Contra Costa County screened students at five Contra Costa Community Colleges who sought primary care or mental health services on campus for HCCI eligibility.
- Ventura County held enrollment events at local junior colleges and the California State University, Channel Islands.
- Contra Costa County screened parents of children enrolled in Medi-Cal or Healthy Families and provided assistance with completing enrollment forms for eligible individuals. Special attention was placed on promoting HCCI to parents when they brought their children to County Health Centers. First-time mothers and individuals with HIV/AIDS and tuberculosis were also targeted.
- Ventura County included HCCI related information for the uninsured who are seeking medical care in the “2-1-1 Ventura County” program. The program is operated by Interface Children Family Services and provides 24-hour county-wide comprehensive information and referral services for assisting the community in finding available resources.
- San Francisco County developed a partnership with the City and with the county’s 3-1-1 system to provide public information about the program, and collaborated with the Human Services Agency to also provide information about the program on their website.
- San Diego County provided information on the HCCI program on San Diego 2-1-1, including eligibility criteria and contact information.

b) Referral to Other Public Programs

These innovative enrollment and outreach strategies have impacted the efficiency of enrollment into other public programs in each county. While data on actual enrollment levels for Healthy Families, Medi-Cal, or the Access for Infants and Mothers (AIM) programs before and after HCCI program implementation are not available at this time, counties report some data to assess the impact of HCCI on enrollment in these other public programs, including the number of applicants to HCCI who were denied coverage or disenrolled due to eligibility for one of these programs. Exhibits 8 and 10 presented data on referrals to other public programs provided by counties to date. As of the end of program Year 2, a total of 14,994 individuals were identified as eligible for another public program through the application and enrollment processes used for HCCI. Of these individuals, 10,254 were referred at the time of application to the HCCI program, while 4,740 who were initially eligible for and enrolled in HCCI were later disenrolled due to becoming eligible for another public program.

2. *System Design Innovations*

The stated goals of the HCCI program require a significant level of system redesign and innovation. Of the seven goals, strengthening and building upon the local health care safety net system, improving access to high quality health care, creating efficiencies in the delivery of health services, and providing grounds for long-term sustainability of the programs are heavily dependent on shifting the paradigm of health care delivery within the safety net. During program Years 1 and 2, HCCI counties pursued a number of innovative strategies to create safety net systems of care and redesign health care delivery. Three such major innovations and redesign efforts are discussed below, including implementation of the medical home model; creation of provider networks; and redesign of delivery of specialty care.

a) Medical Home Implementation

The concept of the medical home was first introduced in 1967 and has been further enhanced and revised in subsequent years. The concept was most recently renamed and refined in 2007 as the “Patient-Centered Medical Home” (PCMH).⁷ Parallel to the development of the medical home model, the “chronic care model” (CCM) was first proposed as an effective means of providing primary care to patients with chronic illness.⁸ The latest iteration of CCM developed in 2006 was called “advanced medical home” (AMH), and further aligned the CCM and PCMH concepts.⁹

These concepts call for a redesign of care delivery for all patients and are intended to address the shortcomings of the current system of care. Many patients, including uninsured as well as privately and publicly insured individuals lack a usual source of care that ensures continuity of care. As a result, they visit multiple providers treating different problems without simultaneously considering overall health; receive duplicative and uncoordinated services; receive care that is not concordant with guidelines and may not be of high quality; have limited access to primary care providers potentially leading to unnecessary use of other services such as emergency rooms; and lack supportive services that improve their participation in self-management of chronic conditions. An effective medical home redesign must address these problems and provide the financial incentives to providers to deliver the additional services that would be required as the personal physician responsible for all the patient’s health care needs, who takes on the leadership for a team of providers to deliver integrated and coordinated care.

The implementation of the medical home concept is an ideal that is as of yet unattained for the majority of the population of the United States. Existing models are frequently pilot projects that have implemented some aspects of the medical home concept in limited populations within pre-existing systems.¹⁰ The information on success of these programs in improving patient outcomes is gradually forthcoming but currently limited and not clearly duplicable in other settings.¹¹ These factors highlight the innovative nature of the implementation of the medical home concept within the safety-net system and the HCCI program.

HCCI counties are required to assign all enrollees to a medical home, although the definition of the medical home in HCCI is general and does not incorporate all of the concepts of the ideal medical home model discussed in the literature. Nevertheless, the counties have elected to implement multiple aspects of the ideal medical home concept, taking different approaches to this innovative strategy to provide primary and preventive care in the safety net. Some counties have focused more closely on chronically ill populations with greater emphasis on quality of care, while others have focused on integration of a larger population of enrollees with greater emphasis on enhanced access. A thorough discussion of the ideal medical home model proposed in the literature and analysis of the implementation of the ideal medical home concept in the HCCI program including

⁷ AAFP, AAP, ACP, AOA. Joint Principles of the Patient-Centered Medical Home. March 2007.

⁸ Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. *JAMA*, 2002; 288(14):1775-1779.

⁹ American College of Physicians (ACP). “The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care.” Policy Monograph. January 2006.

¹⁰ Beal, AC, Doty, MM, Hernandez SE, Shea KK, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care. The Commonwealth Fund. June 2007.

¹¹ Sidorov JE. The Patient-Centered Medical Home for Chronic Illness: Is it Ready for Prime Time? *Health Affairs*. 2008; 27(5):1231-1234.

recommendations for possible further enhancements has been conducted by UCLA. These findings are provided in Appendix D in the Policy Brief titled: *Health Coverage in the Safety Net: How California's Coverage Initiative Is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings*.

b) Creation of Provider Networks

Organized provider networks have been developed as a method of achieving efficiencies in the delivery of health care, and to reduce problems such as limited access to specialty and tertiary care, fragmentation and duplication of services, low-quality care and poor patient outcomes. Organized provider networks have been used by commercial insurers as part of managed care, and are being adopted increasingly by Medicaid and Medicare as an important aspect of an effective health care delivery system.¹² Research indicates that collaborative care delivery networks can enhance the capacity of local primary care and safety-net systems, improve access to care, and lead to efficiencies in care delivery, thereby leading to improved health outcomes.¹³

In contrast to the private sector, networks based on safety-net systems are less common. The limited development and implementation of provider networks within the safety net are due to numerous challenges. Safety-net systems vary considerably in size, scope and organization. Most systems provide fragmented and episodic care and are burdened with compromised quality and high costs.¹⁴ Specific barriers include limited access to primary care services; emergency room overcrowding; lack of access to specialty care, mental health care, and dental care; and financial pressures on patients and providers.

The HCCI program has allowed demonstration counties to make significant progress in developing safety net provider networks. The structure of safety net networks under HCCI was investigated in depth by UCLA in a Policy Brief released in December 2009 and entitled *Implementation of Safety-Net Based Provider Networks Under HCCI, Interim Findings* (Appendix C). By organizing and/or formalizing provider networks, counties have enhanced the efficiency of care delivery within the local safety net.

c) Specialty Care Redesign

One of the most challenging aspects of health care delivery to uninsured low-income populations using the safety-net system has been provision of specialty care. Timely access to specialty care is of particular concern, with many primary care clinics unable to provide specialty services onsite or to refer patients to specialty providers and coordinate such care.¹⁵ These problems are exacerbated by a limited supply of specialists in some regions, many of whom are not willing to accept uninsured or Medicaid patients.¹⁶

¹² Commonwealth Fund Commission on a High Performance Health System. Framework for a high performance health system for the United States. August 2006

¹³ Regenstein M, Nolan L, Wilson M, Mead H, Siegel B. Walking a Tightrope: The State of the Safety Net in Ten U.S. Communities. *Urgent Matters*. May 2004

¹⁴ Baxter RJ, Mechanic RE. The Status of Local Health Care Safety-Nets. *Health Affairs*. 16.4 (1997): 7-23

¹⁵ Felland LE, Felt-Lisk S, McHugh M. Health Care Access for Low-Income People: Significant Safety Net Gaps Remain. Issue Brief No. 85: Center for Studying Health System Change. June 2004

¹⁶ Regenstein M, Nolan L, Wilson M, Mead H, Siegel B. Walking a Tightrope: The State of the Safety Net in Ten U.S. Communities. *Urgent Matters*. May 2004

Within the safety net was a whole, structural inefficiencies are common, including lack of electronic referral and tracking systems; unavailability of medical records accurately documenting patient history and previously provided services; and lack of guidelines for delivery of care to chronically ill populations within the primary care environment to reduce the need for specialty referrals. Lack of systematic oversight of providers operating under different systems or no systems, and reimbursement mechanisms that do not provide the needed incentives for management of chronic conditions contribute to challenges in specialty care delivery under the safety-net system.¹⁷

Advances in the implementation of medical home in HCCI counties have provided a number of tools for improving delivery of specialty care, including:

- Use of clinical decision-support tools. Five counties currently utilize decision-support software for some or all providers.
- Use of electronic medical records (EMR). While the availability of fully implemented EMRs among HCCI participating counties is currently limited, currently all counties have access to some form of electronic patient information. Counties without comprehensive EMR systems utilize other tools such as registries, summary sheets, or other electronic care records to improve continuity and data availability.
- Implementation of electronic referral systems. At least six counties have incorporated electronic specialty referral capacity in their systems.
- Availability of on-site specialty care.

While availability of such tools among participating HCCI counties is not widespread as of yet, the impact on patient care among counties with these tools is likely to be significant.

At least two HCCI participating counties have conducted more intensive efforts in redesigning delivery of specialty care. These efforts have focused on expanding the scope of practice of primary care providers to improve management of specific conditions in the primary care setting. Innovations in primary care provider training and support may be able to reduce unnecessary specialty care referrals and create efficiencies in delivery of care.

Alameda County provided one week, hands-on training in clinical management of diabetes in specialty clinics. Primary care providers learned to conduct further diagnostic work-up and minor procedures in the primary care setting before referring patients to specialists. Within their own clinics, these physicians can advise other physicians in management of such conditions. Furthermore, trainings provided opportunities for more direct professional interaction between primary care providers and specialists in the form of phone consultations where specialists could recommend the best course of action in management of complicated problems in the primary care setting without requiring a specialty referral. Alameda County has also implemented telemedicine with UC Berkeley's optometric clinic, improving access to optometry services.

Kern County implemented a "mini-fellowship" program in spring 2009. Under this program, selected HCCI primary care providers undergo training with a Kern Medical Center (KMC) specialist to gain the clinical expertise necessary to implement and follow the *consensus care*

¹⁷ Solomon NA. Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties. California Health Care Foundation. May 2009

guidelines. Training begins with a pre-test for primary care providers, a lecture from the specialist, a review of relevant literature, and then a visit to the specialty clinic. At the conclusion of the training, there is a post-test. Upon completion of the fellowship, some primary care providers are certified as *Specialty Champions*, and are reimbursed for phone consultations and chart reviews to evaluate patients with a specialist. Furthermore, *Specialty Champions* within community clinics have responsibility to assure proper use of and compliance with *consensus care guidelines* within their practice site, and are compensated at an enhanced rate if they provide a champion visit for another provider in their group. In Kern County, this approach is particularly effective, as the dispersal of the population and the centralization of specialty care within the county necessitate significant travel for many specialty appointments.

Further efforts to improve access to specialty services include additional contracting with community providers in several counties, aimed at increasing the supply of specialists. Collectively, these efforts are anticipated to significantly reduce number of referrals and waiting times for specialty care.

d) Other Examples of Innovation in System Redesign

Pilot Medical Home Model: Innovative Care Clinic (ICC) of San Mateo County

San Mateo County's HCCI program (ACE) established the ICC as a pilot initiative. ICC aims to redesign the care delivery system by developing a team-based approach and focusing on preventive care and early intervention. ICC is the largest adult clinic in the program and is designed to encompass multiple elements of the medical home. ICC provides patient-centered care, improved access, high quality evidence-based medicine, improved management of chronic conditions, and care coordination. Each patient at the clinic is assigned to a provider team that delivers care, handles scheduling, and provides advice by telephone. Team members are encouraged to promote flexibility in the definition of their team roles.

ICC has also undertaken a diabetes disease management program. At each visit for a patient with diabetes, staff collect clinical measures and enter them into the diabetes registry, and provide patient education. Diabetes disease management is promoted in the clinic waiting room with flyers including information about diabetes and invitations to attend diabetes group classes. ICC transitioned to "Advanced Access" scheduling in 2009 to decrease wait times for appointments. Under Advanced Access, a portion of each team's appointment time is kept open for unscheduled patients to avoid turning patients away. Advanced Access is designed to facilitate consistent care with the same provider by keeping provider schedules mostly open at the beginning of the day. The model of care delivery in ICC is gradually being implemented in the rest of the San Mateo system of care.

Chronic Care Model: Panel Patient Management

Alameda County implements the chronic care model in delivery of care to HCCI patients. The county has incorporated panel management, an innovative approach to systematic delivery of primary care to groups of patients with specific chronic illnesses or at high risk. Panel management is conducted by dedicated support staff that maintain and use a registry to identify populations of patients at risk or with specific chronic conditions and assess their level of need and gaps in services

required for their clinical management. Panel managers interact with patients to enforce compliance with care protocols including regular visits for prescription refills and follow-up calls to patients with poor clinical outcomes. Panel managers provide such patient information to primary care teams including physician team leaders and thus assist in improved management of these patients.

Targeted Service Delivery: Disease Management

The San Diego HCCI program focuses on the populations with diabetes and hypertension. The program targets low-income uninsured individuals who visit emergency rooms or participating community clinics in the county for these conditions and delivers health care services to them. High-risk and high-use individuals are identified and managed intensely. Disease management services are comprehensive and delivered through trained nurses, health educators, and peer educators.

3. Decrease in Medical Costs

While it is too early to conclusively demonstrate efficiencies in the area of cost savings, some evidence of decreases in cost of care per enrollee is available at this time. The per capita costs presented in the Section II.B above demonstrate a decrease in health care cost per enrollee in HCCI overall and in 8 counties between program Years 1 and 2. However, final reconciliation of program expenditures will not occur until after August 31, 2010, and therefore these data must be considered preliminary estimates.

Specific data from individual counties may provide further information in this area. An example from Orange County indicates that the cost of prescription medications per enrollee has decreased over the project period, largely due to a shift towards use of generic drugs (Exhibits 30 and 31). Other evidence includes reductions in the utilization rates for inpatient days and ER visits in many counties in Year 2, which are two of the most expensive components of health care. However, a maximum of 2 years of enrollment time may be too little to impact the cost of care for enrollees, and further assessment of the cost of care is needed to verify the existence of cost savings. This assessment will be presented in the final evaluation report.

4. Delivery and Quality of Care

Efficiencies in the delivery of care can lead to improved patient outcomes, reductions in inpatient hospitalizations and unnecessary ER visits, lower costs, and improved access to care. Preliminary evidence of increases in appropriate utilization was presented in Section II.D above. Decreases in rates of inpatient days, outpatient visits, and ER visits per 1,000 enrollees were seen between program Years 1 and 2 in most HCCI counties, and trends are expected to continue as data for program Year 3 become available (Exhibits 22-29). Moreover, early evidence of increases in the provision of guideline concordant patient care and corresponding improvements in patient health status exist (Exhibits 32 – 40).

Due to ongoing new enrollment and the characteristics of the enrolled population, the effects of program interventions may be masked in aggregated data provided in this report. Further analyses investigating individual-level changes in utilization patterns, and the effect of length of enrollment period on access, process, and outcome measures are planned.

F. Sustainability

Long-term sustainability of the Coverage Initiative depends on expansions to the safety net system, including expansions in enrollment and scope of services, infrastructure, and financing. As discussed in earlier sections of this report, infrastructure may be expanded through increases in the number and type of safety net providers and availability of expanded network support mechanisms such as health information technology (HIT) and quality improvement programs. Some infrastructure and administrative innovations, such as HIT and administrative policies and procedures, are relatively permanent and sustainable even if the waiver were not renewed.

All counties have already implemented innovative expansions that promote the sustainability of the services provided under HCCI, as discussed throughout this report. Further developments and expansions that continue to promote sustainability are in various stages of implementation in most HCCI counties at the time of this report. These activities predominantly fall into the areas of infrastructure support tools and system design innovations, although some modifications in provider networks, medical home implementation, reimbursement agreements, and covered services are also planned. These efforts include:

- updating and enhancing HIT systems (all counties);
- increasing access to electronic patient information systems for providers across the network (Alameda, Contra Costa, Kern, San Diego, San Mateo and Santa Clara counties);
- establishing or enhancing electronic referral systems (Alameda, Contra Costa, Orange, San Mateo and Ventura counties);
- implementing or further developing disease management programs for HCCI enrollees (Contra Costa, Orange and Ventura counties);
- increasing provider access to disease registries (San Francisco and Los Angeles counties);
- augmenting provider networks to meet patient demand (Orange and Kern counties);
- updating provider/service payment agreements to increase the probability of program sustainability (Alameda, Kern, Orange, San Diego and Ventura counties);
- implementing or enforcing cost sharing for enrollees for primary and specialty care visits and pharmacy and ER services (Orange, Kern, Santa Clara and Ventura counties);
- increasing access to specialty care (Kern, San Mateo, San Diego and Ventura counties); and
- implementing a dedicated nurse advice line (San Francisco County).

Despite the successes of the demonstration counties in promoting program sustainability in select areas, the overall sustainability of the HCCI programs in the 10 demonstration counties without ongoing supplemental funding is questionable, particularly because the majority of HCCI counties have increased enrollment, scope of services, and provider reimbursement levels. The existing federal 1115 waiver, which led to the implementation of the HCCI program, is set to expire on August 31, 2010, and the State is currently in the process of preparing an application to renew the waiver. Under the existing waiver, counties were required to halt enrollment in their HCCI program as of March 1, 2010. However, as of February 2010, DHCS received approval from CMS to allow counties to continue enrolling new individuals until August 31, 2010.

G. Implementation

1. Milestones

One goal of the HCCI demonstration project was that programs should be implemented in an expeditious manner. Exhibit 42 displays the major milestones in the implementation of the HCCI program. The State issued the request for proposals for the Coverage Initiative demonstration in November 2006. Notification of HCCI allocations to selected counties was provided at the end of March 2007, and the programs began on September 1, 2007. In total, approximately 36 months of program planning and implementation have elapsed, from the time counties were notified of their selection through the middle of program Year 3. At this time, it is too early to assess full implementation of the county programs, as each program is being continuously refined throughout the ongoing demonstration. Therefore, this section will evaluate whether the crucial elements of the program have been put in place, such that the counties are able to meet their contractual requirements and to deliver services to their eligible enrolled population.

Implementation after September 1, 2007 varied between counties, as the execution of county contracts with DHCS, hiring of local program staff, development of enrollment systems, provider subcontracts, and other administrative issues were resolved. County contracts with DHCS were executed between 3 and 24 months after the start of the program, with 8 contracts executed during program Year 1: Kern (December 2007), Ventura (February 2008), Alameda and San Mateo (March 2008), Santa Clara and Orange (April 2008), San Diego (May 2008), and San Francisco (June 2008). The contracts for Contra Costa (October 2008) and Los Angeles (September 2009) were the last to be executed.

a) Network Development

At the start of the HCCI program, counties differed in the extent of formalized relationships with safety-net providers, and consequentially conducted varied subcontracting activities to meet local needs. Eight counties had an existing safety-net network prior to HCCI that included a county hospital system, while Orange and San Diego counties had to form new relationships with private and district facilities to build their provider network.

Despite variation in network capacity prior to HCCI, all counties report significant expansions in the network as a result of program implementation. Each county executed a range of subcontracts for health care and administrative services prior to program implementation, and all counties have continued to add new contracts throughout the program period to further expand their network. Most counties have reported having sufficient provider supply to meet enrollee health care demand throughout the program period. An exception is Kern County, where contracting with local community clinics was significantly delayed, leading to shortages of medical home providers in the first program year.

Further discussion of the timing and nature of network expansions can be found in the UCLA Policy Brief released in December 2009 and entitled *Implementation of Safety-Net Based Provider Networks Under HCCI, Interim Findings* (Appendix C).

b) Enrollment

Most counties began implementation and enrollment prior to contract execution with DHCS. Enrollment began on September 1, 2007 in 8 of the counties. San Diego County began enrollment approximately 3 months later in November of 2007, and Kern began enrollment in February of 2008.

Exhibit 41: Summary of Milestones in Enrollment and Expenditures by County.

Counties	Program Year 1		Program Year 2	
	% of Enrollment Goal Met	% of Federal Allocation Claimed	% of Enrollment Goal Met	% of Federal Allocation Claimed
Alameda	103%	92%	149%	100%
San Diego	54%	13%	112%	62%
Contra Costa	102%	100%	147%	97%
Kern	114%	100%	181%	91%
Los Angeles	36%	39%	52%	88%
Orange	118%	100%	203%	100%
San Francisco	70%	54%	131%	100%
San Mateo	207%	64%	370%	77%
Santa Clara	98%	100%	176%	91%
Ventura	71%	100%	100%	100%
HCCI Total	63%	73%	100%	91%

Source: Years 1 and 2 revised county progress reports; DHCS personnel.

Five counties met or exceeded their target enrollment level during program Year 1, and an additional 4 counties met or exceeded their target during program Year 2 (Exhibits 41 and 42). As of the second quarter of program Year 3, Los Angeles County has not met its enrollment target. The amended STCs approved in January 2010 and effective February 1, 2010 increased the eligible population in Los Angeles County up to 200% of federal poverty level, which will likely lead to a rapid increase in enrollment in HWLA during the remaining program period. While most counties report some loss of enrollees due to the requirement to recertify eligibility (Exhibit 8), all counties have successfully implemented the recertification requirement on an annual basis, with Contra Costa County additionally verifying some aspects of eligibility every 6 months. As of March 2010, 5 counties have elected to halt new enrollment, despite notification (issued in February 2010) that the programs may continue to enroll new individuals throughout the remainder of the demonstration period (Exhibits 2 and 42).

c) Assignment to the Medical Home

Counties were required to assign enrollees to a medical home. As displayed in Exhibit 15, approximately 2% of enrollees overall were without an assigned medical home in program Year 1, and this dropped to 1% by the end of program Year 2. Ongoing new enrollment, variation in how medical home assignment was implemented, and the timing of subcontracts to build a sufficient provider network led to differing levels of medical home assignment in the counties. Notably, Kern County experienced delays in local subcontracting that account for the high level of un-assignment in the first year. Kern County executed contracts with local community clinics in the first quarter of program Year 2 and subsequently assigned virtually all enrollees to a medical home. Further

investigation of those cases where less than 100% of enrollees have an assigned medical home will be presented in the final evaluation report.

d) Claiming of Federal Reimbursement

Delays in achieving targeted enrollment levels were partially responsible for the inability of some counties to incur the total computable expenditures required at the local level to draw down \$180 Million in reimbursement funds available each year. Other factors that have impacted county ability to claim their allocated reimbursement include but are not limited to: delays in execution of local subcontracts; delays in local implementation activities; challenges in identifying retroactively claimable health care costs back to September 1, 2007; lack of ability to expend sufficient local funds due to budgetary or other issues; and, lower than expected per capita cost of care.

Of the 5 counties that were able to draw down the full amount of their Year 1 reimbursement allocation, 3 had met or exceeded their enrollment target during the first year and Santa Clara County had very nearly met its target (Exhibit 41). Ventura County was able to draw down its full Year 1 allocation despite missing its enrollment target by 29%. Conversely, Alameda and San Mateo were not able to incur adequate expenditures to claim their full Year 1 reimbursement allocations although they exceeded their enrollment targets. While submission of CPEs and claiming of Year 2 reimbursement is currently ongoing, 4 counties have already met both their enrollment and reimbursement targets for the second year. In addition, reallocation of Year 2 reimbursement funds is anticipated.

Those counties that have reported additional uncertified TFEs in 1 or more years, but that have already claimed their full allocated reimbursement amount may be able to certify their excess TFEs to draw down additional reimbursement funds, should such funds become available.

2. *Challenges*

In addition to documenting important milestones in program implementation, the timeline of HCCI shown in Exhibit 42 identifies several challenges faced by HCCI participating counties in planning, enrollment, and funding. The implementation challenges described below provide valuable lessons for waiver renewal.

a) Program Planning

HCCI participating counties had a short amount of time available for program planning. Counties were notified of their participation in the HCCI program approximately five months prior to the program start date of September 1, 2007. Counties were at different levels of preparedness at time of program implementation. Counties without existing systems of care had to establish new networks by contracting with new providers or negotiating new contracts with existing provider networks. Negotiating new contracts and interactions with existing networks posed challenges specific to the HCCI program, such as the need for implementation of extensive and shared data systems that may not have been required in previous collaborations. Several counties were unable to start enrollment in September 2007 due to these factors.

b) Enrollment

Many HCCI counties reported barriers to enrollment related to DRA requirements, particularly in the first year of the program. HCCI programs must comply with requirements of section 6036 of the Deficit Reduction Act of 2005. Counties reported that verification of eligibility and obtaining documentation have both been costly and time consuming tasks leading to significant delays in enrollment. These challenges included difficulties in identification of citizenship for individuals born both in and outside California without satisfactory documentation (e.g., homeless) and those born in the U.S. but not California.

In addition, counties were notified that they had to comply with the income verification requirement six weeks after the program implementation, which required HCCI eligible individuals to supply proof of income below 200% FPL both at enrollment and recertification periods. Some counties reported loss of applicants due to this requirement, and clinic or county staff had to spend resources securing income documentation from all individuals who had been previously enrolled. In addition, eligible individuals had to supply a self-declaration regarding prior insurance status. This crowd-out stipulation requires that individuals with an income between 101% - 200% FPL who meet other eligibility criteria “shall not have had health insurance in the three months prior to enrollment in the CI” unless the individual had employer-sponsored insurance that was lost due to a loss of job, move, or similar event. Some counties also reported difficulties in enrollment due to this provision.

Counties resolved barriers in meeting DRA requirements in various ways. Most HCCI participating counties obtained the California Birth Certificate Index database from the State Vital Statistics Program. Some counties, such as Alameda and Orange, integrated the Index into their electronic enrollment programs so that citizenship could be confirmed at enrollment. However, the Index database is not sufficient when applicants are born outside of California. In Los Angeles County, only 7% of patients within the Department of Health Services were present in California Birth Certificate Index. To resolve this problem, Los Angeles County reimbursed clinics for the cost of ordering out-of-state birth certificates. Alameda County also provided some funding to clinics to assist in obtaining birth certificates. Similarly, San Francisco County provided some assistance to potential enrollees in obtaining birth certificates and State identification.

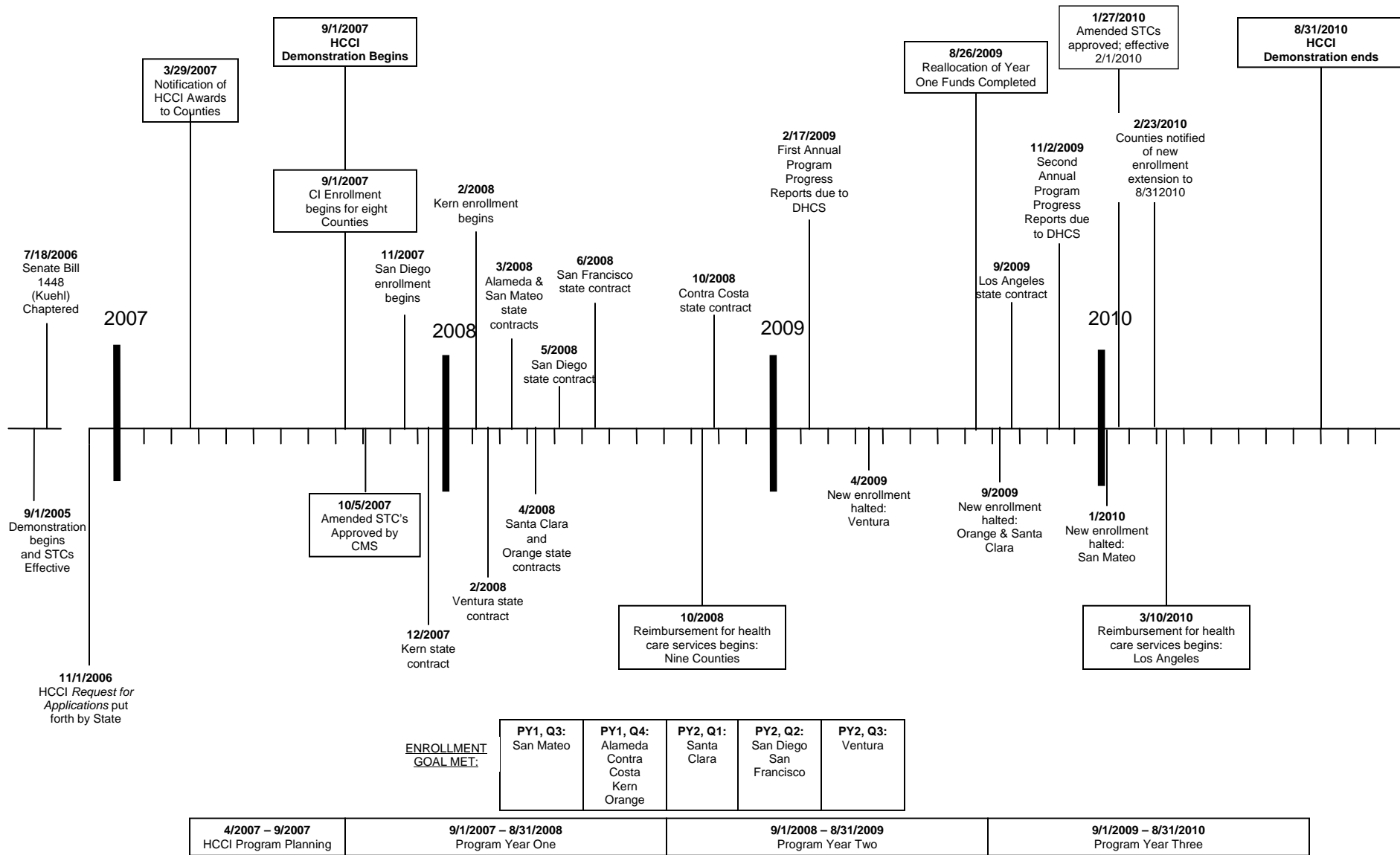
CHIPRA flexibilities as described in the amended Special Terms and Conditions (STCs) approved by CMS January 27, 2010 and effective February 1, 2010, can greatly reduce barriers to enrollment surrounding the DRA requirements, and may improve access to care for populations such as homeless individuals in particular.

c) Delays in Reimbursement

HCCI counties agreed at the time of their contracts to take on the risks associated with incurring both health care and administrative costs at a local level. Yet, for some HCCI counties the burden of administrative and start-up costs has been a challenge. Reimbursement for the HCCI program expenditures was delayed during DHCS and CMS negotiations regarding health care and administrative costs. Once reimbursement protocols were approved, reimbursement for health care costs began in October 2008, 14 months after program implementation and enrollment, for all counties except Los Angeles. Los Angeles did not receive its first health care costs reimbursement payment until March 2010, more than two and a half years into the three-year demonstration

project. In addition, many counties are expending enhanced amounts for the care provided under HCCI beyond the amounts they would have incurred through their statutory obligation under California Welfare and Institutions Code section 17000 had they not participated in the HCCI program, and are therefore further impacted by the delay in receipt of reimbursement. Reimbursement for administrative expenditures by HCCI counties has not been received to date. The State is making a number of efforts to expedite the process of reimbursing counties for administrative costs.

Exhibit 42: Timeline of HCCI Program Implementation, March 2007 to April 2010.



III. CONCLUSIONS

The data presented in this interim evaluation report indicate that the HCCI program has met a number of its goals in the first and second years of its implementation in all 10 demonstration counties. The HCCI program has made progress in improving the health status of low-income uninsured individuals, while strengthening local safety net systems, improving access to care and quality of care, creating efficiencies in health care delivery, and promoting sustainability of HCCI funded programs. Based on the data presented throughout this report, the following conclusions regarding each of the 6 program goals can be drawn:

Significant expansions in health care coverage have been achieved by the HCCI counties.

Evidence of expansions in both services and population exist in all 10 counties. The HCCI program expanded health care coverage to previously uninsured populations. The size of the covered population has more than tripled since the start of the program period, and the target enrollment level has been met or exceeded by the program overall and 9 of the 10 HCCI counties. As of May 2010, 4 counties that have already met or exceeded their enrollment target currently continue to enroll new individuals. Increased access to health care services under the HCCI program is evidenced by the significant observed first year utilization, likely due to pent-up demand for health care, followed by a declining trend in the rate of service utilization thereafter, which is seen in most counties and for the majority of measures investigated. The high volume of services provided under HCCI to date, and increasing trends in service utilization seen throughout the program period highlight the success of counties in creating enhanced capacity to serve this population. New covered services, as well as increased availability of providers and facilities, are evidenced in all counties.

Strong evidence exists to demonstrate enhancement of the local health care safety net system.

The counties have strengthened local safety net systems significantly. This has been achieved by increasing the number and type of providers available to enrollees, increasing the connectivity between these providers, and increasing the administrative, quality improvement, information technology, and financial supports to the safety net. Major redesign of specialty care has occurred in many counties, including access to on-site, remote-access telemedicine or mobile specialty care in several cases. All counties have implemented medical home assignment for their enrollees, and many counties have voluntarily adopted additional aspects of the medical home model to enhance the effectiveness and scope of this innovation.

The HCCI program has resulted in improved access to high quality health care and health outcomes.

Pent-up demand for health care among populations lacking access to needed health services is a well-known phenomenon. The data on health care utilization provided in this report reveal a higher level of service use in the short term after program implementation, relative to the baseline period, and a slight downward trend in the second program year for many indicators.

All counties have improved access to and quality of care for the low-income uninsured adult population through expansions in services and enhancements to the safety net system. It is important to note, however, that many counties report that demand for care continues to exceed supply, and some counties have had to restrict program services and enrollment due to lack of necessary local or federal funds and other issues. Moreover, the counties continue to expand or amend their provider networks as needed to meet local needs. Further funding and additional provider supply are needed in most counties, as the eligible population continues to grow as a result of increasing unemployment and uninsured rates.

All counties have implemented quality improvement measures, which may include use of evidence based guidelines, practice management systems, electronic health records, HEDIS measures, and quality improvement committees or meetings. Many counties have also implemented a number of system design innovations to improve quality of care, such as use of care or case managers, multidisciplinary team-based care, or disease management programs. The limited analyses of health outcomes that have been conducted so far indicate statistically significant improvements in health status and control of chronic disease in accordance with clinical care guidelines in all counties where data are available.

Early evidence of decreases in overall utilization of services and improvements in quality exists, but further investigation of these trends among enrollees is needed.

Counties have achieved efficiencies in delivery of care. However, it is too early to conclusively demonstrate savings in health care costs as a result of these efficiencies.

Partial evidence of increased efficiencies has been found across the HCCI counties. In the areas of outreach, enrollment, and referral to Medi-Cal, Healthy Families, and Access for Infants and Mothers programs, the counties have demonstrated significant success. Data that will become available in the future will be used to investigate whether these successes have had a demonstrable impact on local uninsurance rates and the level of enrollment into other public programs.

The counties have also made significant gains in the area of system design innovation to promote efficiency. Many of the structural gains made by counties in the areas of access to care and system redesign are likely to lead to efficiencies in delivery of care. For example, enhanced access to health information technology is likely to reduce duplication of services and unnecessary referral, and may lead to cost savings. A number of counties are highlighted as particularly strong innovators in this area, through efforts in the areas of provider network creation, specialty care redesign, and implementation of medical homes, disease management programs, or team-based care models. Data on these factors continue to be investigated.

The increased efficiencies achieved by counties are expected to lead to reductions in cost of care per enrollee. At this time, all expenditure data are preliminary and are awaiting final reconciliation after August 31, 2010. However, early evidence of reductions in the cost of care per enrollee are seen in 8 of the 10 counties and in the program overall. Further data from program Year 3 will enhance the understanding of this measure and clarify trends in

expenditures. Savings may be achievable to sustain HCCI in the future, but such savings have not yet been demonstrated. Enrollment in and out of the HCCI program is dependent on income and residence eligibility and is more fluid than traditional health insurance programs. Thus, achievable savings within the first two years of program implementation or the full three-year program period may be difficult to document.

Long-term sustainability of the gains made under HCCI may be limited.

In the absence of continued federal financial participation, many of the gains made by the HCCI counties in health care coverage, provider networks, access to and quality of care and savings in health care costs may be lost. Counties report that selected gains may be maintained in the absence of federal funding, such as dissemination of information technology, improvements to enrollment systems, and availability of evidence based guidelines and other quality improvement tools. However, without the ability to offer enhanced reimbursement to providers some aspects of the program that are key to improving health status and achieving long-term cost savings may be lost, such as increases in covered services, expansions to the provider network, and implementation of the medical home model.

Despite limited program planning, implementation of the programs has been largely successful.

Most counties were able to begin enrollment into the program on September 1, 2007, after only 5 months of program planning. Local sub-contracts and administrative activities were carried out quickly, and all counties have continued to respond to local needs by contracting with additional medical and administrative agencies throughout program Years 1 and 2. Although the program has not yet been able to claim the full amount of available federal financial participation, the counties continue to certify their expenditures to DHCS, and re-allocation of federal reimbursement funds is ongoing to achieve draw down of the full \$180 million available annually. Despite delays in claiming the full amount of federal funds, preliminary data suggest that in fact, additional federal funds could be claimed by the HCCI counties, were such funds to be available.

The experiences of the participating HCCI counties in implementing the program have been vast and should be replicable in other counties. The diversity of the HCCI participating counties is an advantage for participation of other California counties that are likely to find replicable strategies among existing HCCI programs. The HCCI pilot program has paved the way for feasible expansion of the program state-wide. A number of significant challenges in implementing the program have been addressed, including testing and implementation of reimbursement procedures; overcoming enrollment challenges and barriers; and progress in implementing innovations in care delivery and system redesign. However, counties continue to experience challenges, and further evidence of success in meeting the program goals is needed.