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The Remaining Uninsured in California's Rural and Smaller Counties: CMSP's Pilot Projects and Where to Go from Here

INTRODUCTION*

As an early adopter of the Affordable Care Act and one of the country's most successful states in enrolling persons in health coverage, California has experienced a fundamental shift in its health coverage landscape in the last two years. The expansion of Medi-Cal to non-disabled adults without dependent children and the availability of subsidized insurance through Covered California slashed California's uninsured rate. But as of 2015 there were still approximately 5 million remaining uninsured.[1] Many of those uninsured Californians depend on county indigent safety net programs for health services.

This paper focuses on the unique situation of California's primarily rural and smaller-sized counties and how they provide health care to their indigent and uninsured residents through the County Medical Services Program, known as CMSP. CMSP serves 35 of California's smaller and rural counties by providing uninsured residents with either no-cost health coverage or health coverage with a monthly share of cost, depending on a person's income. County residents who are U.S. citizens or otherwise lawfully present receive full-

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[1] Diertz, Pourat, Hadler, Lucia, Roby and Jacobs, "Affordability and Eligibility Barriers Remain for the Uninsured," March 2016, available at http://healthpolicy.ucla.edu.

scope CMSP benefits; county residents who are undocumented immigrants receive emergency-only CMSP benefits.

CMSP has changed with the shifting health coverage landscape by launching several pilot projects in 2016 to expand its reach to the remaining uninsured. This paper provides a brief background about CMSP and its structure, a description of these pilot projects, and ends with three recommendations for what CMSP and its participating counties can do to ensure those who are left out of health reform have access to needed medical care.

These recommendations focus on utilizing CMSP's substantial budget reserve to further expand the program's eligibility criteria so county residents with undocumented immigration status receive full-scope CMSP benefits; leveraging the pilot programs to improve access to care for CMSP members and potential members; and conducting outreach and enrollment campaigns to boost CMSP's enrollment under the current eligibility criteria.

CMSP'S BACKGROUND AND LEGAL STRUCTURE

The County Medical Services Program serves 35 of California's predominately rural and smaller counties by providing health services to those counties' indigent and uninsured adult populations. CMSP is a public entity, authorized by statute at Section 16809, et seq. of the Welfare and Institutions Code, and is defined as the "program by which health care services are provided to eligible persons in those counties electing to participate in the CMSP…"[2] While CMSP acts on behalf of its participating counties across many regions of the state, it functions and is defined as a singular county program.[3]

CMSP'S GEOGRAPHIC REACH IN CALIFORNIA

*Map courtesy of CMSP and used with permission.

[2] Welf. & Inst. Code § 16809.4(j)(1).
[3] CMSP Governing Board Regulations (Gov. Bd. Reg.), Section 1(d), available at CMSP's website at www.cmspcounties.org.

CMSP is overseen by a Governing Board that is primarily comprised of county officials from CMSP participating counties.[4] The Governing Board decides all aspects of the administration of CMSP, from setting the budget to determining program eligibility criteria and the scope of benefits.[5] The Governing Board also has the authority to establish pilot projects and test alternative products with varying levels of eligibility criteria and benefits that differ from those of CMSP as a whole.[6]

CMSP'S BASIC ELIGIBILITY CRITERIA, ENROLLMENT HISTORY, AND RECENT ENROLLEE ESTIMATES

In addition to meeting the income and property requirements that are described in the following section, to qualify for CMSP an applicant must be:

- a resident of a CMSP county;
- between 21 and 64 years old;
- ineligible for full-scope Medi-Cal;
- and, if applying during a Covered California open enrollment period or if the applicant is eligible for a Covered California special enrollment period, the person must concurrently apply for Covered California.[7]

In the lead up to California's implementation of the Affordable Care Act in 2014, CMSP made a concerted push to increase its enrollment by creating a Low-Income Health Program (LIHP) known as Path2Health, with the knowledge that the majority of Path2Health enrollees would ultimately transition from CMSP to Medi-Cal. At its enrollment height in December 2013, CMSP served over 80,000 enrollees.

But as anticipated, with California's expansion of Medi-Cal to cover childless adults in January 2014, the number of people who qualified for CMSP's services dramatically declined. Under California implementation of the ACA, over 60,000 of those estimated 80,000 CMSP enrollees transitioned to Medi-Cal.[8]

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[4] Welf. & Inst. Code § 16809.4(b) and (d)(2).
[5] A list of the Governing Board's powers is at Welfare and Institutions Code Section 16809.4(e)(1).
[6] Welf. & Inst. Code § 16809(j)(1)(C)(ii); Gov. Bd. Reg., Sections 11 and 12.
[7] CMSP Eligibility Manual (Elig. Manual), 3-012.3. CMSP's Eligibility Manual can be accessed on CMSP's website www.csmpcounties.org.
[8] CMSP's income eligibility criteria in 2013 was at 200% FPL so while most CMSP enrollees under 139% FPL became eligible for Medi-Cal, the other CMSP enrollees with income between 139% FPL and 200% FPL became eligible for subsidized

As of mid-2016, 30 months into health reform, it is estimated that CMSP serves approximately 700 enrollees across its 35 participating counties.[9] According to data collected in 2014, the number of people in CMSP counties who remain uninsured ranged from 315,000 to 447,000 people.[10]

CMSP'S EFFORTS TO REACH MORE OF THE REMAINING UNINSURED

In June 2015, CMSP held a Strategic Planning Meeting where CMSP developed a two-year pilot with the intent to reach more of the remaining uninsured.[11] Under the pilot, CMSP would amend its eligibility rules and create a new set of benefits for certain CMSP enrollees.

Broader and More Consumer-Friendly Eligibility Rules

Of the changes made under the pilot program, CMSP's broadened eligibility rules are likely to have the greatest impact on increasing access to healthcare for the remaining uninsured in California's rural counties. The changes expand the financial eligibility criteria for the program, and make the eligibility and enrollment process more consumer-friendly.

For many years CMSP had an income limit of 200% of the Federal Poverty Level, or $1,980 per month, to qualify for CMSP services. In addition, CMSP mirrored pre-ACA Medi-Cal property rules by limiting an individual to $2,000 in assets and a couple to $3,000. Furthermore, once determined eligible for CMSP, beneficiaries with income over a "maintenance need level," which for a single person is $600, were required to pay a share of cost.

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insurance through Covered California. The number of former CMSP enrollees who ultimately enrolled in coverage through Covered California is not known.

[9] Because CMSP works across multiple counties which use different computer systems to enroll people in CMSP, it is difficult to get a precise count of current CMSP enrollees. The 700 enrollee estimate was provided by CMSP policy consultant Lee Kemper at a CMSP Planning and Benefits Committee meeting on May 26, 2016.

[10] *See* UCLA Center for Health Policy Research. AskCHIS 2014. Currently Insured (all 35 CMSP counties). Available at http://ask.chis.ucla.edu. Exported on August 10, 2016. *See also* American Community Survey 2010-2014 5-year Estimates, Health Insurance Coverage, U.S. Census, available at http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[11] CMSP's Governing Board has the authority to establish pilot projects or test alternative products with varying levels of eligibility criteria and benefits out of CMSP.

But as of May 1, 2016 CMSP expanded its financial eligibility rules, raising those income and property limits and significantly reducing the share of cost requirement.

Expanded Financial Eligibility Rules

a. Income Limit

Applicants with an income of up to 300% of the Federal Poverty Level, or $2,970 per month for a single person, can now qualify for CMSP.[12]

b. Property Limit

CMSP now waives the property limit for applicants with income below 138% FPL. For applicants with income between 139% FPL and 300% FPL, CMSP the property limit is now $20,000, for an individual and $30,000 for a couple.[13]

c. Share of Cost

CMSP eliminated cost sharing for beneficiaries with income at or below 138% FPL, or $1,367 a month in 2016. In other words, CMSP enrollees who make less than $1,367 receive CMSP services for free.

CMSP enrollees above 138% FPL, however, continue to have a "share of cost" but the new eligibility rules reduce those costs by 75%.[14] For example, under the old share of cost rules a CMSP enrollee with a $1,485 monthly income, which is 150% FPL, would have had a share of cost of $885. But with the new 75% share of cost reduction, that person's monthly share of cost is $221.[15]

Consumer-Friendly Enrollment Policies

In terms of making the eligibility and enrollment process more consumer-friendly, two additional policies under the pilot may alleviate some potential

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[12] Elig. Manual, 1-112.
[13] Elig. Manual, 7-029.
[14] Elig. Manual, 10-012(C).
[15] A share of cost is what enrollees must pay toward their healthcare every month before CMSP will pay for covered services. Elig. Manual, 1-103. For more information on how the share of cost is applied, see CMSP's Eligibility Manual, Section 10-010, et seq. A person's share of cost is calculated by taking the person's net nonexempt income – in the example, $1,485 – and then subtracting the maintenance need for the income - $600 for an individual – and then multiplying that amount by .25. Elig. Manual, 10-012(C).

medical debt of beneficiaries and will help beneficiaries retain their CMSP-eligible status for a longer period of time, avoiding gaps in coverage.

d. Retroactive Eligibility

Starting June 1, applicants who are eligible for CMSP are entitled to one-month of retroactive CMSP eligibility, so long as they would have been eligible in that month.[16] This is an important benefit because healthcare or pharmacy services a person paid for out of pocket or was billed for in the month before applying may be paid by CMSP for any CMSP-covered services.

e. Six-month Enrollment

As of May 1, CMSP's enrollment term is extended to a period of six months. Prior to this policy change, CMSP enrollment terms were limited to two or three months. A longer enrollment period frees consumers from the bureaucratic burden of having to reapply on a more frequent basis and allows them to focus their time and resources on accessing services and maintaining or improving other aspects of their lives. Consumers are also more likely to remain continuously covered by the program without gaps in coverage that could lead to medical bills and debt.

CMSP'S SCOPE OF SERVICES AND THE NEW PRIMARY CARE BENEFIT

Citizenship and immigration status, together with income level, determines an applicant's scope of benefits and, as previously discussed, whether they may access services for free or with a share of cost. An applicant may be eligible for either Full-scope CMSP benefits or Emergency Services-only CMSP, along with the new add-on Primary Care Benefit, or they may be ineligible for CMSP altogether because they are eligible for no-cost Restricted Medi-Cal.

a. Full-scope CMSP

U.S. citizens, nationals, and lawfully present immigrants are eligible for Full-scope CMSP services.[17] Full-scope CMSP provides a wide arrange of services, from physician and hospital services, limited dental care, lab and radiology services, durable medical equipment, and physical therapy.[18]

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[16] Elig. Manual, 3-015.
[17] Elig. Manual, 5-010; Aid Code 88 (no SOC) or 89 (SOC).
[18] CMSP posts its summary of benefits on its website at http://www.cmspcounties.org. Go to the tab "For Counties" and click on the link for forms; the summary of benefits is CMSP Info. Notice 1 (05/16).

b. Emergency Services-only CMSP with a Share of Cost or Restricted-scope Medi-Cal

The exception to the general rule that immigration status determines scope of benefits and not eligibility is where CMSP applies its policy to those at the lowest income levels. A person who is an undocumented immigrant who makes over 138% FPL qualifies for Emergency Services-only CMSP with a share of cost.[19]

But a person who is an undocumented immigrant with income *below 138% FPL* is ineligible for CMSP altogether under the rationale that the person is eligible for restricted-scope Medi-Cal.[20]

c. CMSP's New Primary Care Benefit: An Add-On Benefit to CMSP Beneficiaries with a Share of Cost

As of May 1, CMSP beneficiaries with a monthly share of cost are eligible for CMSP's new Primary Care Benefit pilot program.[21] The Primary Care Benefit is in addition to whatever is the beneficiary's "standard" scope of benefits, whether that is Full-scope services for those who are U.S. citizens, nationals or legally resident immigrants, or Emergency Services-only for persons who are undocumented.[22]

Under the Primary Care Benefit, an eligible CMSP beneficiary can, during a single enrollment period, have up to three medical visits with a primary care provider or specialist, minor office procedures, specific diagnostics tests and preventive health screenings, at no-cost.[23] The Primary Care Benefit also includes up to $1,500 in prescription drug coverage, with a $5.00 co-pay per prescription.

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[19] Eligib. Manual 5-014(B) and 5-016; Aid Code 50.
[20] Elig. Manual, 5-016; *see also* CMSP Letter No. 16-02 (Apr. 27, 2016) at p.3 ("Category eliminated as applicants have access to coverage under ER only Medi-Cal").
[21] *See* CMSP Letter No. 16-03 (Apr. 27, 2016) for CMSP's guidance to county welfare directors regarding the new Primary Care Benefit.
[22] *Id.* at pg. 4 ("The new Primary Care Benefit provides [benefits] <u>*in addition to*</u> coverage provided to Aid Code 89 and Aid Code 50 members under the CMSP Standard Benefit") (emphasis in the original).
[23] Primary care benefits include physical therapy, specific X-rays and ultrasounds, EKGs, preventive screenings, routine lab tests, and screenings for certain STDs, depression, alcohol misuse, obesity counseling, and tobacco use intervention. See CMSP Letter NO. 16-03 at p.4, Table 1 for a summary of the services available under the Primary Care Benefit and the services requirements.

TABLE 1: CMSP'S ELIGIBILITY CRITERIA AND BENEFITS UNDER THE TWO-YEAR PILOT

ELIGIBILITY CRITERIA As of May 1, 2016 through April 30, 2018	**SCOPE OF BENEFITS**	**AID CODE**
U.S. Citizens; Legal Residents; Lawfully Present Aliens • **Income ≤ 138% FPL** ($16,395/year for an individual) • **No property limits**	**Full-scope CMSP, no share of cost**	**Aid Code 88**
OR • **Income > 138% FPL and ≤ 300% FPL** ($16,396 - $35,640/year for an individual) • **Property limits:** $20,000 for an individual and $30,000 for a couple	**Full-scope CMSP, with a share of cost;** *and* **Primary care benefit**	**Aid Code 89**
Undocumented Immigrants • **Income ≤ 138% FPL** ($16,395/year for an individual)	**Ineligible for CMSP** Based on rationale the applicant qualifies for restricted-scope Medi-Cal	**None; restricted Medi-Cal**
OR • **Income > 138% FPL and ≤ 300% FPL** ($16,396 - $35,640/year for an individual) • **Property limits:** $20,000 for an individual and $30,000 for a couple	**Emergency services-only CMSP, with a share of cost;** *and* **Primary care benefit**	**Aid Code 50**

CMSP'S WELLNESS AND PREVENTION PILOT PROJECT

In addition to the new eligibility rules and expanded benefits pilot, in May 2016 CMSP's Governing Board approved another pilot project with the goal of promoting community wellness in CMSP counties.[24] The wellness pilots, in contrast to the eligibility and benefits pilot which is CMSP-wide, will be county-based. Under the "Wellness and Prevention Pilot Project," CMSP will provide a set amount of funds, based on county population, to interested counties in order "to test the effectiveness of providing local-level wellness and prevention services to CMSP eligible and potentially eligible persons."[25] CMSP has allocated a total of $7.65 million to be given to participating counties over three years toward this pilot. The current timeline for the pilot is for counties who are awarded funding to begin implementation of their pilots in January 2017, with an end date of December 2019.

CMSP has made this funding available for pilot projects that address any or all of three project areas: community wellness, whole person care, and social determinants of health.[26] Community wellness pilot programs are intended to develop community-based interventions aimed at providing wellness and prevention services for uninsured county residents, with a focus on potential CMSP enrollees.

Whole person care projects are intended to develop integrated systems within local health and human service delivery systems to better serve current and potential CMSP enrollees and other publicly funded populations.

Projects aimed at addressing the social determinants of health are intended to bring together local efforts to work across five areas that can promote healthy environments and behaviors among uninsured residents, including potential CMSP enrollees: economic stability, education, social and community context, health and health care, and neighborhood and built environment.

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[24] A third CMSP pilot program is focused on developing a healthcare workforce in CMSP counties by working with the Office of Statewide Health Planning and Development (OSHPD) to extend loan repayment to providers working in underserved communities. Given the scarcity of providers in many of CMSP's counties, this is an important project for CMSP to undertake to help ensure enrollees have meaningful access to services, but it is beyond the scope of this paper.

[25] *See* CMSP, CMSP County Wellness & Prevention Pilot Project, http://www.cmspcounties.org/about/grant_projects.html (last visited Jul. 13, 2016) (providing CMSP's RFP on the Wellness and Prevention Pilot, budget guidelines, and templates, and more).

[26] *Id.*

CMSP released its Request for Proposal and related application materials to CMSP counties on Friday, July 8, 2016; county pilot applications are due September 2, 2016.

BY THE NUMBERS: THE REMAINING UNINSURED AND CMSP'S BUDGET

It has been estimated that in 2014, among the 35 counties that CMSP serves there were anywhere from 315,000 to 447,000 people with no private or public health coverage.[27] As noted earlier, CMSP has gone from an enrollment high point of serving over 80,000 people in 2013, to recently serving approximately 700 people.

In contrast to the declining number of people enrolled in CMSP, CMSP's financial solvency over the past two years has significantly increased. Due to the foresight and strategic planning of the Governing Board and CMSP's staff and the influx of federal matching funds that CMSP received from aggressively promoting its Path2Health program, CMSP has significantly built up its financial reserves. In fact, CMSP is projected to close out the 2016 fiscal year with a $256 million fund balance. [28]

And CMSP's economic prospects are anticipated to continue to grow. For fiscal year 2016-2017, CMSP projects a beginning fund balance of $264 million.[29] Revenues are expected to total $32.4 million, with $30 million coming from state realignment, $2 million in interest, and the remainder from grants and recoveries such as third party liens. Total expenditures in 2016-2017 are projected at $16.8 million, which includes approximately $7.3 million in medical provider payments, $1.5 million in pharmacy provider payments, $1.2 million in CMSP administration and staff expenses, and outreach and enrollment costs of $120,000.

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[27] *See* UCLA Center for Health Policy Research. AskCHIS 2014. Currently Insured (all 35 CMSP counties). Available at http://ask.chis.ucla.edu. Exported on August 10, 2016. *See also* American Community Survey 2010-2014 5-year Estimates, Health Insurance Coverage, U.S. Census, available at http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[28] *See* CMSP FY 2015-2016 Actual Budget and FY 2016-2017 Proposed Program Budget, attached as Agenda Item VIII for CMSP's May 26, 2016 Governing Board Meeting.

[29] The difference between the projected end balance of $256 million for FY 2015-2016 and the projected fund balance of $264 million for FY 2016-2017 is because the actual fund balance for FY 2015-2016 is exceeding projections.

With estimated net revenue of $15.6 million, CMSP is projected to end fiscal year 2016-2017 with nearly $280 million.[30] Just over $264 million of that balance is allocated as an "other contingency reserve."

Reflecting the healthy financial position of CMSP, the Governing Board approved waiving, for the second year in a row, the annual participation fee that is typically required from counties to CMSP. Those fees range anywhere from the low-end of $661 (Alpine) to the higher end of $809,548 (Solano), $718,947 (Sonoma), and $576,233 (Marin).[31] How those fees are re-allocated by the counties in their budget is left to the individual county's discretion.

WHERE TO GO FROM HERE: RECOMMENDATIONS FOR SERVING THE REMAINING UNINSURED IN CMSP COUNTIES

1. **CMSP's Governing Board should further expand CMSP's eligibility criteria to provide full-scope CMSP benefits to undocumented immigrant residents.**

With the decreasing number of low-income Californians who must rely on county health programs because they are Medi-Cal eligible or qualify for subsidized insurance from Covered California, several counties across the state have taken steps similar to CMSP's to widen their county's indigent health eligibility rules.

In 2015, the Board of Supervisors of three counties – Monterey, Sacramento, and Contra Costa – voted to expand their indigent health programs to provide limited-benefits and/or enrollment capped pilot programs for residents who are uninsured and undocumented.[32] Along with CMSP, those counties join nine others – Alameda, Fresno, Los Angeles, Riverside, San Francisco, San Mateo, Santa Clara, Santa Cruz, and Ventura – in offering at least some non-emergency health services to persons who are undocumented.[33]

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[30] *Id.*

[31] Welf. & Inst. Code § 16809.3 (listing the CMSP participation fees by county)

[32] Health Access, "Profiles of Progress: California Counties Taking Steps to a More Inclusive and Smarter Safety-Net," May 2016, available at http://www.health-access.org/images/pdfs/2016_Health_Access_Profiles_of_Progress_County_Report_5_31_16.pdf.

[33] *Id*.

As previously mentioned, CMSP's Governing Board is to be commended for making its program more inclusive and taking the affirmative step to join the other twelve counties in providing some non-emergency health services to undocumented indigent adults through the new primary care benefit to those who are above 138% of the Federal Poverty Level. But CMSP can, and should in light of its budget reserves, further expand its program and provide full-scope CMSP to undocumented persons under 138% of the Federal Poverty Level. Or in the alternative, to the extent that that population is assumed to be enrolled in restricted-scope Medi-Cal, CMSP could possibly offer a non-emergency primary benefit package as a wrap-around. Such a benefit could cover routine primary and specialty care, preventive services, a range of non-emergent medical procedures, and prescription drugs – benefits that are not covered in restricted-scope Medi-Cal.

In order to effectively advocate for this policy change, CMSP counties and their stakeholders must impress upon the Governing Board and CMSP staff the need in the community for such coverage and interest in seeing such a change happen. Providing public comment at the quarterly Governing Board meetings, participating in CMSP's two committee meetings – the Eligibility Committee and the Planning and Benefits Committee – and sharing local insight into the need for and the attendant advantages for the counties if CMSP further broadened its eligibility criteria, are all ways in which the counties can urge the Governing Board in this direction. As evidenced by the successes in Contra Costa, Monterey and Sacramento, getting counties to take the next step toward expanding their indigent health programs takes grassroots involvement and greatly benefits from coordinated input from the community. Such advocacy should also include advocating that CMSP keep detailed data regarding its enrollment numbers and the utilization rates for the Primary Care Benefit, as such data will help in assessing how best to further expand the program.

A CMSP county can influence the future direction of CMSP policy most directly by having a county officer serve on the Governing Board. CMSP's Governing Board is made up of ten county officials from various CMSP counties, and a non-voting, ex-officio member appointed by the Secretary of the Health and Human Services Agency.[34] Board members serve three-year terms; counties are limited to having one person on the Board at a time. As the Governing Board is the ultimate decisionmaker for CMSP, holding a seat on the Board is one way to help direct the future of CMSP policies.

[34] Welf. & Inst. Code § 16809.4(b) and (d)(2).

2. **CMSP counties should take the opportunities presented by the Wellness and Prevention Pilot Project and the retention of their participation fees to serve residents who are CMSP enrollees and potentially eligible for CMSP and explore ways they can serve the remaining uninsured in their own counties.**

CMSP counties have the chance to take advantage of two different opportunities presented by CMSP to create innovative approaches in their communities to serve the remaining uninsured. The first opportunity stems from the Governing Board's decision to waive the county CMSP participation fee for a second year in a row. For CMSP counties with larger populations like Marin, Solano and Sonoma, for example, that comes to a savings over the past two years of $1.152 million, $1.619 million and $1.44 million, respectively.

As those funds are traditionally due annually as mandated by statute, all of the CMSP counties presumably set their participation fee aside every year for their budgets. The Governing Board's decision to essentially give this money "back" to the counties is a chance for the counties to use those funds for their intended purpose: to provide health services to their remaining uninsured residents.

The counties could use those retained participation fees in combination with the second opportunity presented by CMSP: the Wellness and Prevention Pilot Project. The Wellness and Prevention Pilot is a non-competitive grant program that the Governing Board has allocated $7.65 million dollars to be spent over the three-years of the pilot. Grant allocations are based on total county population size and range from $375,000 to $75,000. Counties with approved pilot projects will receive one-third of its allocation each program year.

TABLE 2: WELLNESS AND PREVENTION PILOT PROJECT GRANT AMOUNTS

COUNTY POPULATION RANGES	WELLNESS GRANT AMOUNT
Greater than 400,000 residents - Sonoma and Solano	$375,000
Between 400,000 and 100,000 residents - Butte, El Dorado, Humboldt, Imperial, Kings, Madera, Marin, Napa, Shasta, and Yolo	$300,000
Between 100,000 and 50,000 residents - Lake, Mendocino, Nevada, San Benito, Sutter, Tehama, Tuolumne, Yuba	$225,000
Between 50,000 and 5,000 residents - Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modo, Mono, Plumas, Siskiyou, and Trinity	$150,000
Less than 5,000 residents - Alpine and Sierra	$75,000

A pilot's target population "must include people who are potentially eligible for CMSP or enrolled in CMSP … and may also include persons who are potentially eligible for or enrollees of other public programs."[35] With three pilot project areas of focus from which to choose – community wellness, whole person care, or addressing social determinants of health – the counties have broad areas within which to develop innovative indigent health care programming and extend their reach with the uninsured beyond the four-corners of CMSP's current eligibility criteria.

CMSP counties have the benefit of CMSP's support both administratively and financially in meeting the counties' obligation to serve as the healthcare "provider of last resort" for their low-income and uninsured residents. California's counties are mandated by Welfare and Institutions Code Section 17000 to provide health services to their indigent residents who are not

[35] Wellness and Prevention Pilot RFP, at p.2, available at http://www.cmspcounties.org/about/grant_projects.html.

"supported and relieved" by others and do not have the means to pay for all or part of their subsistence care.

A commonly held view is that CMSP counties fulfill their Section 17000 obligation by contracting with CMSP to provide those health services. Under that perspective, CMSP administers the counties' collective Section 17000 indigent health programs and the counties are completely relieved of their 17000 obligations.

CMSP counties have generally operated under this view for years. And in practice, that model has to some degree worked, in that CMSP eligibility criteria encompasses some of the counties' uninsured and indigent residents as defined by Section 17000, and those who have enrolled have benefitted from CMSP. CMSP provides a cohesive and well-funded program across a large swath of California, with uniform eligibility rules and procedures that cross county lines; holds regular public meetings regarding its policies; and maintains a knowledgeable and invested staff. At its peak, CMSP served over 80,000 residents out of an approximate general population of 3.4 million. The CMSP model is arguably preferable to having 35 different county indigent health programs with variations in eligibility rules, procedures, enrollment periods, benefits, etc.

But there is much room for improvement, particularly with CMSP's enrollment hovering around 700 people and its strong financial projections of a $280 million fund balance in 2017. CMSP counties are in a unique position to fill the gaps in serving the remaining uninsured in their counties that CMSP is either not reaching, or as a matter of policy is not covering.

It is a common misperception that CMSP wholly satisfies a county's 17000 responsibilities. CMSP's authorizing statute explicitly rejects such a proposition: "Nothing in this paragraph shall be construed to relieve any county of the obligation to provide health care to indigent persons to Section 17000…"[36] CMSP's Governing Board regulations also unequivocally reject the notion that CMSP fulfills a county's 17000 duty by requiring that the participation contracts between a county and CMSP include "an acknowledgment that the contract does not relieve a county of its indigent health care obligation under Section 17000 … and that the contract shall not be construed to establish standards for such health services."[37]

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[36] Welf. & Inst. Code § 16809.4(f)(1). *See also Brown v. Crandall*, 198 Cal.App.4th 1, 5 at fn. 3(2011) (noting that CMSP's role is to simply "*assist* smaller, rural counties with their duty to provide health care to indigent adults" in an opinion holding that Humboldt County had a duty to evaluate a resident for 17000 eligibility after she had been denied CMSP) (emphasis added).

[37] CMSP Governing Board Regulations, Section 4(a)(1).

Given the fact that CMSP does not supplant the counties' Section 17000 obligations, there is no legal barrier to prevent the counties from developing their own programs – either in conjunction with the Wellness and Prevention Pilot or not – to explore serving the remaining uninsured who are ineligible for CMSP. Such an endeavor by a county will require the county to allocate administrative as well as financial resources. But as required by state law, every non-CMSP county in California manages its own Section 17000 indigent health program, and CMSP counties have the benefit of CMSP's assistance in taking on most of the counties' remaining uninsured population. Under the shift to greater coverage options brought on by the ACA, CMSP counties should do what they can do on their own, as a complement to the services offered by CMSP, to cultivate a culture of coverage in their communities and fulfill their Section 17000 mandate.

3. **To increase the number of people CMSP serves, CMSP and its participating counties should aggressively promote CMSP's newly expanded eligibility criteria and conduct community outreach and enrollment events.**

Under CMSP's new eligibility criteria, an uninsured resident can now have an income of up to $35,640 a year to qualify for CMSP services. This is an increase of over $11,000 from the previous income eligibility limit. And CMSP's property limits are now waived for persons who make less than $16,395 a year, and for persons who make above that, the property limits have been increased to $2,000 for a single person and $30,000 for a couple. These significant increases in financial criteria allow CMSP to serve a broader swath of the remaining uninsured population than in years past.

With an estimated enrollment of 700 people before these new eligibility criteria went into effect out of an estimated general population of 3.4 million people,[38] CMSP's success in serving the remaining uninsured was limited. It is commendable that CMSP has taken the much-needed step to broaden its reach by expanding its program, but more should be done to serve the remaining uninsured.

Because the old income and property limits are longstanding ones, county residents may mistakenly believe they are over-income or over-resourced to

[38] 2010-2014 American Community Survey 5-year Estimates, U.S. Census, available at http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml. The 3.4 million population estimate for the 35 counties represents the collective total population of those counties, and not the number of people eligible for CMSP, which would be a much smaller number, but certainly larger than 700.

qualify. Or it is very possible that in the emphasis over the last two years to promote enrollment in Medi-Cal and Covered California, residents may be simply unaware of the availability of CMSP as an alternative.

Given these challenges, it will take a concerted, thoughtful, and aggressive outreach and enrollment strategy to meaningfully increase CMSP'S enrollment numbers. CMSP and its participating counties should work closely together to promote the expanded eligibility rules, as well as the new add-on Primary Care Benefit program. Such promotion should focus on in-person outreach and contact with residents within the communities where there is a high-likelihood of interaction with residents who are potentially eligible for CMSP.

Studies of successful health care enrollment strategies show that effective outreach and enrollment efforts needs strong leadership from public officials and collaboration from key stakeholders; a combination of broad mass-marketing efforts with localized grassroots efforts; and personalized, one-on-one assistance through trusted community partners.[39] Studies also show that in-person contact, with at least two to three follow-up contacts by phone, were particularly effective for getting more difficult to reach populations, such as young people, enrolled in coverage.[40]

Another model enrollment strategy specifically for rural areas recommends not only working with traditional community partners such as hospitals, free clinics, and mental health providers with outreach, but also with organizations and businesses that may be non-traditional partners in health but are areas in the community where potentially eligible persons may gather.[41] Examples of non-traditional outreach partners include public libraries, United Ways, YMCAs, re-entry coalitions, small family owned businesses, parent/teacher organizations, laundry mats, and drug stores. For media outreach, meeting with local TV and radio health reporters at news stations and reporters with the local newspapers and smaller news ledgers, writing letters to the editor, phone banking, and utilizing social media have all

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[39] Artiga, Rudowitz, and Tolbert, "Outreach and Enrollment Strategies for Reaching the Medicaid Eligible But Uninsured Population," Mar. 2, 2016, Kaiser Family Foundation, available at http://kff.org.

[40] "State of Enrollment: Lessons Learned from Connecting America to Coverage, 2013-2014," p. 39-40 (June 2014), available at Enroll America's website at www.enrollamerica.org. Enroll America is a non-profit, non-partisan organization that works in all 50 states with partner organizations to help maximize the number of people who enroll in and retain health coverage under the Affordable Care Act.

[41] Powerpoint presentation by "Engaging Small Town Communities – What's Worked and Challenges that Remain," presentation by Hospital Council of Northwest Ohio and Toledo/Lucas County CareNet, at Enroll America's 2016 State of Enrollment conference, available at https://www.enrollamerica.org/soe2016/.

been shown to be effective strategies for getting the word out about health coverage options and boosting enrollment. Finally, any successful outreach and enrollment strategy must take into account the language needs of the community and provide linguistically and culturally appropriate services for the area.

With CMSP's sizeable budget, CMSP counties should urge the Governing Board to allocate more money toward such outreach and enrollment efforts. For FY 2015-2016, the budget allocated $400,000 in that area and as of April 30, 2016 CMSP had spent just over $285,000.

Particularly in light of the new eligibility criteria, the outreach and enrollment budget should be increased, not decreased. But the FY 2016-2017 budget only sets aside $120,000 for outreach and enrollment. The remaining uninsured in CMSP counties and the counties would be better served if CMSP invested more resources and time to this area.

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