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California's Local Community Health Plans:

A Story of Cost Savings, Quality Improvement, and Community Leadership

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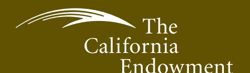

Pacific Health Consulting Group

Pacific Health Consulting Group (PHCG) provides management consulting services to public sector safety net healthcare organizations. With a focus on managed care development and healthcare delivery service improvement, Pacific Health Consulting Group's clients include state and local health agencies, public hospitals, locally owned and controlled Medi-Cal managed care plans, ambulatory care centers, community clinics, and other organizations that deliver or finance healthcare services. PHCG was founded by experienced safety net consultants and business partners Bobbie Wunsch, MBA and Tim Reilly, MA in 1998.

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COMMUNITY

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Introduction

Since the first local publicly sponsored health plans were established in California in the late 1970s, they have provided high-quality, cost-effective Medi-Cal services to millions of people in their communities. Currently numbering 13 and serving over 2 million Californians, these local community health plans hold a unique position in their communities, and have emerged as important players in community-based efforts to solve a variety of health and health care problems.

This report focuses on how these local community health plans are distinguished from other Medi-Cal health plans in origin and purpose, market impact, and accomplishment. The key conclusions are:

- Local community health plans have saved money for the state of California by providing Medi-Cal benefits at a lower cost than the Medi-Cal fee-for-service program.
- Local community health plans have been the vehicle for all of the state's recent successful efforts to expand Medi-Cal managed care. For example, County Organized Health System (COHS) plans expanded into the counties of San Luis Obispo in 2008, and Merced and Sonoma in 2009. These expansions have added over 100,000 Medi-Cal eligibles to Medi-Cal managed care.
- More than 61 percent of Californians in Medi-Cal managed care are in local community health plans – more than two

million people. Two new local community health plans, one Local Initiative and one County Organized Health System, covering four counties, are expected to be fully operational by the end of 2010. These new local community health plans will enroll an additional 200,000 Medi-Cal members, increasing the market share of local community health plans to more than 66 percent.

- Seven out of 10 new Medi-Cal beneficiaries choose to enroll in the Local Initiative in Two-Plan Model counties where the Local Initiative, the local community health plan, competes with a commercial plan.
- Quality measures for local community health plans are as good or better than for commercial plans participating in Medi-Cal managed care based on standardized plan performance measures mandated for reporting by the DHCS.
- COHS plans have an extensive record of serving seniors and persons with disabilities (SPDs) successfully for many years through mandatory enrollment. Since their inception, Local Initiatives have welcomed the voluntary enrollment of SPDs. To meet the needs of SPDs, local community health plans offer programs like medical homes, disease management, information technology, provider network requirements, innovative customer service programs, channels for policy and program input, and targeted community investments.
- Local community health plans have a stake in the stability and competitiveness of local safety-net providers, and their investments in this system demonstrate that commitment.
- Because they are governmental entities, subject to the Brown Act and other public disclosure rules, local community health plans have earned respect for transparency and local control, and use their standing to broker community-wide discussion of local health care and health promotion strategies, beyond those affecting just the Medi-Cal population.

State and National Significance

California has long been the national leader in providing Medicaid (Medi-Cal) services to vulnerable populations through managed care. In fact, California has more individuals enrolled under Medi-Cal managed care than any other state. The local community health plans discussed in this paper were pioneered in California, and dominate Medi-Cal managed care enrollment.

The Medi-Cal program is now poised for a major change: moving many of its most vulnerable populations from a fee-for-service system into managed care. AB X4 6, enacted as part of the FY 2009-10 California State budget agreement, commits the Department of Health Care Services (DHCS) to pursue a Section 1115 Federal Demonstration waiver that will restructure the organization and delivery of health care services for high-need, high-cost individuals – in particular, seniors and people with disabilities, Medicare and Medicaid dually eligible individuals, and children and adults with serious mental illnesses.

For reasons described throughout this paper, local community plans are well positioned to serve the four broad initiatives of AB X4 6:

- Promote organized delivery systems of care;
- Strengthen and expand the health care safety net;
- Implement value-based purchasing strategies; and
- Enhance the delivery system for the uninsured to prepare for national health reform.

Local Community Health Plans Defined

Medi-Cal provides health care services through two broad systems: "fee-for-service" and managed care. Fee-for-service is the default organization of Medi-Cal service delivery. Under fee-for-service Medi-Cal, administered by DHCS and its fiscal intermediary, a Medi-Cal beneficiary is given an identification card that is then presented to participating Medi-Cal providers. The beneficiary shoulders the responsibility of finding a provider willing to accept Medi-Cal—a difficult task in many communities. The Medi-Cal fee-for-service system provides no customer service and does not measure either the quality of service provided to, or the satisfaction of, fee-for-service beneficiaries. At this time, approximately half of all Medi-Cal beneficiaries in California receive care through this system.

All other beneficiaries are enrolled in a managed care plan. Several different managed care models operate in California, but in all of them contractors take full financial and operational risk for providing the mandated services. The model used in any one county is based on the interaction of federal and state laws and policies, and the preference of the county boards of supervisors. (**Appendix A** describes the characteristics of each model.)

In nine counties, Medi-Cal managed care is organized under the "Two-Plan Model." In those counties, two Medi-Cal plans operate and compete with each other. One is a public plan, called a "Local Initiative (LI)," and the other is a Commercial Plan. Each not only meets the Medi-Cal requirements, but also is regulated by the California Department of Managed Health Care. A multi-county Local Initiative can be formed through the joint action of more than one county board of supervisors.

Currently, eight Local Initiatives have enrolled 1,436,638 Medi-Cal beneficiaries. A new Local Initiative, covering the counties of Fresno, Kings, and Madera, is expected to begin operations by the end of 2010 and enroll more than 120,000 beneficiaries.

A County Organized Health System (COHS) is a single public plan, established by the county board of supervisors and governed by an independent commission. Two or more counties may also jointly form a single COHS. A COHS serves the entire Medi-Cal population of its region without a commercial plan competitor. Enrollment is mandatory for nearly all Medi-Cal beneficiaries in a county, including for seniors and people with disabilities. Currently, five COHSs operate in 11 counties and serve 621,000 members. In the last two years, three different COHSs have expanded into three adjoining counties. A new County Organized Health System for Ventura County is expected to begin operations by the end of 2010, adding about 100,000 beneficiaries to Medi-Cal managed care.

The Local Initiatives and County Organized Health Systems constitute the "local community health plans" discussed in this paper. Local community health plans typically have the following characteristics:

- Established as a public agency, independent of the county[1];
- Formed through the ordinance(s) (or joint powers agreements) of one or more Board(s) of Supervisors[2];
- Governed by a commission whose membership is prescribed in the ordinance(s);
- Subject to California's Fair Political Practices Law and Ralph M. Brown Open Meeting Law; and
- Operates a health plan that contracts principally with public payors (e.g. DHCS for Medi-Cal managed care, Managed Risk Medical Insurance Board for Healthy Families, and Medicare for Special Needs Plans).

TABLE 1 Local Community Health Plans

LOCAL INITIATIVES
Alameda Alliance for Health
Contra Costa Health Plan
Health Plan of San Joaquin
Inland Empire Health Plan
L.A. Care Health Plan
Santa Clara Family Health Plan
Kern Health Systems
San Francisco Health Plan
COUNTY ORGANIZED HEALTH SYSTEMS
CalOptima
CenCal Health
Central California Alliance for Health
Health Plan of San Mateo
Partnership HealthPlan of California

Note: See Appendices B and C, respectively for Local Initiative Profiles and County Organized Health System Profiles which identify in which counties each of the plans currently operate. The governing board of a new Local Initiative for the counties of Fresno, Kings, and Madera has been formed. Its health plan is expected to be in operation by the end of 2010. The Ventura County Board of Supervisors has approved the formation of a governing board for a County Organized Health System. It is expected to begin operations by the end of 2010.

Table 1 lists the local community plans in two groups: Local Initiatives and County Organized Health Systems. A more detailed profile of each local community plan is included in **Appendix B** for Local Initiatives and **Appendix C** for County Organized Health Systems.

1. Origins of Local Community Health Plans in California

California pioneered the enrollment of Medi-Cal beneficiaries under financial risk arrangements with commercial health plans in the 1970s. However, enrollment slowed as commercial prepaid health plans found the Medi-Cal business only marginally profitable. A highly public spate of marketing and enrollment abuses in the 1970s and increased scrutiny by state government further dampened commercial interest in Medi-Cal prepaid health care.

Publicly sponsored health plans ("local community health plans") in California came to life in the early 1980s. Following the prepaid health plan scandals, the Medi-Cal program was faced with spiraling state budget costs, uneven and sometimes very poor quality, and widespread provider dissatisfaction. In response, county executives[3] in Monterey and Santa Barbara Counties suggested a novel local public and private

1 Health plans that are owned and operated by county governments are not local community health plans under the definition used in this paper. Examples of county owned and operated health plans include: Community Health Plan (Los Angeles County); Ventura Health Plan (Ventura County); and Valley Health Plan (Santa Clara County). Contra Costa County is the one exception. It chose to use its pre-existing County health plan as the Local Initiative.

2 More than one county board of supervisors can join together to form a multi-county local community health plan. Usually this is done through special state legislation, a joint powers agreement, or an existing state statute.

3 The key county executives were Robert J. Bowersox, MD, Director, Monterey County Health Department and Lawrence M. Hart, MD, MPH, Director and Health Officer, Santa Barbara County Department of Health Care Services.

partnership to reform Medi-Cal. By making a single, countywide public agency responsible for all Medi-Cal eligibles in the county and creating a larger risk pool, organizers hoped to realign financial incentives, emphasize primary care case management, respond more promptly to provider and beneficiary concerns, and improve access to services and quality of care. The Monterey and Santa Barbara efforts, termed "County Organized Health Systems," were granted status as Federal Medicaid Demonstration projects in 1981.

Medi-Cal managed care grew slowly during the 1980s, with the only significant expansion being the implementation of a new COHS in San Mateo County. By the early 1990s, however, continuing concerns about rising costs led the DHCS to conclude that a more organized system of care could be more cost-effective than fee-for-service delivery for most Medi-Cal beneficiaries and that it should accelerate the development of managed care systems.

The federal government had limited states' ability to expand COHS plans, primarily because of perceived abuses in other states where commercial carriers had been given responsibility for the programs. California was able to argue successfully for three additional COHS plans by demonstrating that its "public" version of COHS provided cost-effective, high-quality care, and was accountable to the local community by its public governance model.

Still, the political and legislative difficulty of creating more COHS plans required DHCS to develop an additional model if the state was to move toward greater managed care enrollment. DHCS' decision to move to *mandatory* enrollment in managed care in some counties piqued the interest of commercial plans, which recognized that they would have reduced marketing costs in a mandatory environment. At the same time, county health and hospital systems and other safety-net providers feared that to the extent commercial plans did participate in Medi-Cal, they would seek to enroll only the healthier beneficiaries, putting the safety net at risk. DHCS' managed care expansion proposal, in March 1993, addressed these concerns with a radical new plan that attempted both to protect the safety net and to spread the cost-savings anticipated from managed care more widely by incorporating a local community plan based on the COHS model and having it compete with a commercial plan. This became known as the Two-Plan Model.

2. Enrollment, Choice and Market Share

Over half of all Medi-Cal eligible individuals are currently enrolled in managed care plans in California – almost 3.5 million, more than in any other state. California also leads by a wide margin in the number of dual eligibles enrolled in managed care. **Table 2** presents the Medi-Cal enrollment in the Medi-Cal fee-for-service program and under Medi-Cal managed care.

Local community health plans currently cover 61 percent of all Medi-Cal beneficiaries enrolled statewide in Medi-Cal managed care as shown in **Table 3**. That number will climb to 66 percent by October 2010 when four additional counties (Fresno, Kings, Madera, and Ventura) are expected to convert to Medi-Cal managed care.

TABLE 2 Medi-Cal Enrollment by Program Fee-for-Service (FFS) vs. Managed Care January 2009.

PROGRAM	ELIGIBLE COUNT	% OF TOTAL
FFS Enrollment	3,336,010	49.0%
Managed Care	3,478,263	51.0%
Grand Total	**6,814,273**	**100.0%**

Source: CA Department of Health Care Services (DHCS), Demo0901 DHCS Web File.

TABLE 3 Medi-Cal Managed Care Enrollment By Plan Type and For Local Community Health Plans January 2009.

PROGRAM	ELIGIBLE COUNT	% OF TOTAL
County Organized Health Systems	**620,748**	**18.3%**
Local Initiative Health Plans	**1,436,638**	**42.4%**
Commercial Plans	971,727	28.7%
Geographic Managed Care	349,775	10.3%
PHP/Other Special Plans	12,042	0.4%
Grand Total	3,390,930	100.0%
Local Community Health Plans	**2,057,386**	**60.7%**

Source CA Department of Health Care Services (DHCS): Demo 0901 DHCS Web File.

One way of gauging the success of local community health plans is by their market share. Local community health plans compete successfully with other managed care entities for Medi-Cal business. According to data from DHCS, in Two-Plan Model counties where there is competition between a Local Initiative and a Commercial Plan ("contested counties"), almost 70 percent of all eligibles were enrolled in the local community health plan as of June 2008 (**Table 4**).

A higher proportion of beneficiaries continue to choose the Local Initiatives over the Commercial Plan alternative: new Medi-Cal beneficiaries and those switching plans select the Local Initiative over the Commercial Plan by a significant margin. Local community health plans receive on average almost 74 percent of all affirmative health plan choices (see **Table 5**).

TABLE 4 Medi-Cal Managed Care Enrollment Local Initiative Market Share in Contested Counties June 2008.

	COMMERCIAL PLAN	LOCAL INITIATIVE	LI %
Alameda	26,585	79,767	75.0%
Contra Costa	10,769	48,185	81.7%
Kern	25,781	94,408	78.5%
Los Angeles	420,478	741,896	63.8%
Riverside	33,460	140,266	80.7%
San Bernardino	49,048	154,148	75.9%
San Francisco	11,584	32,609	73.8%
San Joaquin	27,341	62,068	69.4%
Santa Clara	31,327	81,934	72.3%
Two-Plan Total	**636,373**	**1,435,281**	**69.3%**

Source: CA Department of Health Care Services; Demo0901 DHCS Web File.

TABLE 5 Medi-Cal Managed Care Enrollment Member Choice Rate in Two-Plan Model Counties June 2008.

	COMMERCIAL PLAN	LOCAL INITIATIVE	LI %
Alameda	750	2,208	74.6%
Contra Costa	369	1,541	80.7%
Kern	740	2,205	74.9%
Los Angeles	7,602	14,395	65.4%
Riverside	982	6,143	86.2%
San Bernardino	1,108	5,537	83.3%
San Francisco	197	708	78.2%
San Joaquin	557	1,583	74.0%
Santa Clara	695	2,111	75.2%
Total	**13,000**	**36,431**	**73.7%**

Source: CA Department of Health Care Services; Demo0901 DHCS Web File.

Healthy Families

Although established as Medi-Cal managed care plans, local community health plans in 14 counties are now participating in the Healthy Families Program (HFP), California's SCHIP program, which is administered by the Managed Risk Medical Insurance Board (MRMIB). HFP enrolls uninsured children from families with income above the Medi-Cal cut-offs, up to 250 percent of the Federal Poverty Level (FPL). MRMIB often contracts with multiple health plans in any given county. In this market, too, despite significant competition, often from multiple commercial plans, the local community health plans are very successful in enrolling children. In those counties in which local community health plans offer Healthy Families ("contested counties"), these plans have almost 31 percent of the market (**Table 6**). Excluding L.A. Care Health Plan, which has only recently offered Healthy Families, the local community health plans have 43 percent of their counties' HFP enrollment. Their closest competitor for example, Anthem Blue Cross (Anthem/BC), has 22 percent.

3. Local Community Health Plan Accomplishments

Despite their relatively short history, local community health plans have made some notable accomplishments in the following areas:

- Cost savings;
- Access to care;
- Serving seniors and people with disabilities;

TABLE 6 Healthy Families Enrollment Local Community Health Plan Market Share in Contested Counties April 2009.

COUNTY	LOCAL COMMUNITY HEALTH PLANS	ANTHEM/BC	TOTAL HFP	PUBLIC %
Alameda	9,250	30	20,526	45.1%
Contra Costa	4,296	-	12,778	33.6%
Kern	13,567	-	25,951	52.3%
Los Angeles	24,051*	74,079	233,300	10.3%
Riverside	25,229	26,135	77,316	32.6%
San Bernardino	22,526	19,986	67,287	33.5%
San Francisco	8,243	1	11,742	70.2%
San Joaquin	9,045	4,076	20,525	44.1%
Santa Clara	16,955	4,287	31,376	54.0%
Monterey	18,210	1,464	19,674	92.6%
Orange	33,275	29,037	86,278	38.6%
San Mateo	6,217	56	10,371	59.9%
Santa Cruz	1,954	3,981	6,362	30.7%
Santa Barbara	7,213	99	10,800	66.8%
Total Enrollment	**192,818**	**163,132**	**623,486**	**30.9%**
Excluding Los Angeles	**168,767**	**89,053**	**390,186**	**43.3%**

Source: Report MM015 as of May 5 2009

**The "Local Community Health Plan" entry for "Los Angeles" in the above Table combines enrollment from two sources: (1) the Healthy Families product enrollment through Community Health Plan, a licensed health plan owned by the County of Los Angeles, and (2) the Healthy Families product enrollment directly through L.A. Care Health Plan.*

- Protecting the safety net; and
- Achieving solutions to community health problems.

Cost Savings Compared to Medi-Cal Fee-for-Service
One of the most important continuing legacies of managed care in Medi-Cal is the cost savings it has produced for state and federal governments and taxpayers, while at the same time expanding coverage in terms of both numbers of beneficiaries and services. The federal government will not permit California to spend more for Medi-Cal managed care than it would have spent on its Medi-Cal fee-for-service program. California has similar regulations.

Medi-Cal managed care plans have saved California and the federal government billions of dollars since their inception as an alternative to the Medi-Cal fee-for-service program. Plans use a variety of measures that can lead to cost savings, including the linkage of enrollees to a source of usual care, and working in conjunction with disease management and information system technologies. They often provide incentives to promote the integrated use of these modalities by participating providers. The application of these measures has moved plans in the direction of the medical home concept. Not only have they likely produced cost savings, but also result in better care.

It is difficult to calculate a precise dollar amount since the DHCS at times has kept capitation rates confidential, and traditionally not reported the total annual savings. In some years, the Legislative Analyst's Office (LAO) estimates the dollar amount of state General Fund savings attributable to Medi-Cal managed care. For example: "Analysis of the 2004-2005 Budget Bill" (February 18, 2004), LAO wrote that the COHS plans provided more than $150 million in annual savings to Medi-Cal while improving care and health outcomes.

In the past when DHCS has published its estimates of the savings, they have varied, from as little as one percent of the capitation premiums paid to managed care plans in a particular year, to as much as 15 percent in another year. A conservative estimate would assume that the overall savings rate is at least five percent. In the last ten years, if the average savings was five percent, the state and federal governments would have saved over $2 billion dollars from the local community health plans alone. Since the local community health plans dominate the enrollment in Medi-Cal managed care, these plans have been the principal source of the savings achieved by the state.

Medi-Cal managed care has not only saved money compared to the Medi-Cal fee-for-service program, but remarkably, in the last decade, it has done so in the absence of increases in health plan premium rates. Richard Kronick, PhD, a Professor of Family and Preventive Medicine at UC San Diego, studied Medi-Cal managed care premium rates.[4] He found that over the last decade, 1999-2008, health care premiums for Medi-Cal (and Healthy Families) increased much more slowly than for enrollees in employer-sponsored insurance. He noted that the low rate of premium increases for Medi-Cal and Healthy Families enrollees is especially impressive considering that Medi-Cal premiums were among the lowest in the nation. Kronick estimated that private sector premiums increased by 138 percent from 1999-2008, while Medi-Cal premiums increased by only 23 percent. Healthy Families increased by 38 percent. These increases on an annual basis show the private sector

4 Kronick, Ph.D., Richard, "Understanding the Slow Growth in Medi-Cal and Health Families Premiums, 1999-2008," Findings, California Program on Access to Care, UC Berkeley School of Public Health-University of California Office of the President, April, 2008.

growing at 10.1%, while Medi-Cal grew at 2.3% and Healthy Families grew at 3.6%. Kronick called these differences extraordinary.

Kronick did not attempt to quantify these estimates in terms of aggregate premium costs, but estimates can help illustrate the magnitude of the cost effectiveness of having your premiums growing at such a low rate of increase. If the 2009 rates paid to the public managed care plans had grown at 138 percent in the last decade instead of the 23 percent average noted in the study, the aggregate increase in Medi-Cal premiums would have been over $4 Billion for FY 2009 alone. It would appear that low rate of increase in Medi-Cal premiums has contributed significantly to an overall constraint on state spending, yet improving access and quality for Medi-Cal managed care members.

Improving Access to Care for Plan Members and for the Uninsured

Most local community health plans have a specific goal to improve access to care as part of their mission statements. The local community health plans have taken a number of steps toward this goal, both with respect to plan members' access to care and to increasing coverage of uninsured individuals in the community. A few of the many examples of these efforts include:

- *Optional Medi-Cal Benefits:* A number of local community health plans elected to retain several of the optional benefits that were cut from the Medi-Cal Program in 2009, including services such as audiology, speech therapy, podiatry, creams and washes, and eye exams.
- *Specialty Care:* A local community plan has partnered with its county hospital to expand access to specialty services by identifying future specialty shortages and recruiting practitioners in those areas.
- *Uninsured Children:* One local community plan designed and implemented "Healthy Kids," a health insurance product for children 0-18 years who are not eligible for either Medi-Cal or Healthy Families. Following the initiative of this local community health plan, other local community health plans developed similar programs for uninsured children in their counties. There are over 65,000 children enrolled in local community health plans in Healthy Kids products. Healthy Kids programs are also discussed below under "Seeking Solutions to Community Health Problems."
- *Foster Children:* In partnership with county social services agencies, a local community health plan allows foster children to change providers whenever they need to do so and provides foster parents with continuous tracking of immunizations, medications, and other medical history information. Compared to the Medi-Cal fee-for-service, the program has resulted in more regular well-child visits and fewer emergency visits.
- *Uninsured Adults:* Local community health plans have worked with their local counties to develop new programs for the uninsured and the county indigent. There are over 20,000 In-Home Supportive Services ("IHSS") workers being provided health care benefits and almost 40,000 county indigents and Coverage Initiative Program recipients being managed by local community health plans.

- *Substance Abuse Treatment Benefit:* Realizing the limitations of the Drug Medi-Cal benefit, funded by the State Department of Alcohol and Drug Programs, for meeting the needs of pregnant women and 60-day post-partum women who are substance abusers, the local community health plan established a program to fill in the coverage gap. All plan members are now eligible for a basic outpatient benefit which includes pre-treatment readiness, day treatment, perinatal residential treatment, outpatient detox, continuous recovery services, and family and codependency support. Of this continuum, the pre-treatment readiness, continuous recovery services, and family and codependency support are covered by the plan even though they are not benefits covered under the Medi-Cal program.

Serving Seniors and People with Disabilities

Women and children make up the large majority of local community plan enrollees. However, since the 1980s, eligibility categories that include seniors and people with disabilities (SPDs) are mandatorily included in all COHS plans under full-risk arrangements. In Two-Plan Model counties, seniors and persons with disabilities who are eligible for Medi-Cal may voluntarily enroll under full-risk arrangements in a Local Initiative or participating Commercial Plan.

Local community health plans have established an extensive record of serving SPDs. The local community health plans provide services to more than 77 percent of those SPDs enrolled in Medi-Cal managed care (**Table 7**). The COHS plans have a long history in taking care of this population, first starting in 1983 when the Santa Barbara Health Initiative was created as a Federal Medicaid Demonstration Project. It has served all the SPDs in Santa Barbara County for more than 25 years.

With more than 30 percent of mandatory enrollment being SPDs, COHS plans have fine-tuned access, case management and other plan services to meet the needs of this vulnerable population. For example, COHS plans typically have policies to ensure that participating providers have handicapped accessible facilities; permit SPDs to choose a specialist as a primary care provider; and authorize services and supplies for extended periods of time which are sensitive to the medical needs of people with chronic problems.

Local community health plans give high priority to customer service when working with SPDs. Through operating experience and input from enrollees, local community health plans have tailored systems to meet their unique needs. While some local community health plans direct calls from SPDs to specially trained staff, plans typically assist the SPDs in obtaining health

TABLE 7 Medi-Cal Managed Care Enrollment of Seniors and Persons with Disabilities By Plan Type and For Local Community Health Plans June 2008.

PROGRAM	ELIGIBLE COUNT	% OF TOTAL
County Organized Health Systems	**193,377**	**51.5%**
Local Initiative Health Plans*	**97,010**	**25.8%**
Commercial Plans	44,542	11.9%
Geographic Managed Care	30,188	8.0%
PHP/Other Special Plans	10,496	2.8%
Grand Total	375,611	100.0%
Local Community Health Plans Total	**290,387**	**77.3%**

Source CA Department of Health Care Services (DHCS): Beneficiaries by Managed care Plan DHCS Web File.

care services, supplies and equipment; coordinating patient care needs with family members, providers, advocates; finding appropriate specialists and making appointments; arranging transportation to appointments; resolving medication issues; assisting in the coordination of carve-out services; connecting members with community resources other than Medi-Cal services, and reaching out to SPDs and their caregivers by being active in the community.

A number of local community health plans have initiated or been deeply involved in special projects to increase access to care for SPDs, including:

- Funding for community clinics to purchase adaptive equipment such as specialized exam tables, wheelchair accessible scales, automatic door openers, and hearing devices.
- Grants to develop, implement and expand health and wellness programs designed to help people with disabilities stay fit and healthy.
- Programs to train "*promotoras*" or community workers as health educators to reach out to SPDs.
- An in-home assessment of wheelchair fit to address medical and environmental appropriateness.
- Arrangements with county mental health programs to improve access to attention-deficit hyperactivity disorder (ADHD) evaluation services for children and adults with disabilities.
- Assuming responsibility for the health care of developmentally disabled former residents of Agnews Developmental Center, as part of an intensive de-institutionalization initiative to transition medically fragile consumers from institutional to community-based care in three Bay Area counties.
- Development of care coordination and complex case management programs focused on the most at-risk SPDs (e.g. providing in-home physician visits and medication assistance, integrating care by making sure the health system and social safety net are working together and continually connecting members back to medical homes and their primary care physicians to ensure coordination).

In a further testament to the commitment that local community health plans have to SPDs, several have launched licensed Special Needs Plans (SNPs) under contract to the Federal Centers on Medicare and Medicaid which combine both Medicare and Medicaid (Medi-Cal) benefits for dual eligibles. SNPs are a type of Medicare managed care plan that focuses on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple co-morbid conditions, and thus are more challenging and costly to treat. Dual-eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid (Medi-Cal).

Table 8 presents the local community health plans that currently operate Special Needs Plans, demonstrating a commitment to serving an especially vulnerable group of SPDs. Local community health plans have a lengthy and successful track record of meeting the needs of SPDs.

Protecting the Safety Net

Initially, the Two-Plan Model was implemented primarily in populous counties that had county hospitals, other disproportionate share hospitals (DSH), and/or extensive county-operated ambulatory care clinic networks. The Local Initiative was specifically designed to incorporate

TABLE 8 Medicare Managed Care Enrollment Special Needs Plans (SNP) April 2009.

LOCAL COMMUNITY HEALTH PLAN	ENROLLMENT
Alameda Alliance for Health	1,059
CalOptima	8,822
Contra Costa Health Plan	110
Health Plan of San Mateo	7,377
Inland Empire Health Plan	2,495
L.A. Care Health Plan	140
Partnership Health Plan of CA	3,348
Santa Clara Family Health Plan	3,936
Total SNP Enrollment	**27,287**

Source: Enrollment self-reported by Plans for this report.

these providers and others, and to maintain the vibrancy of the safety net. The state and the local community health plans recognize the importance of safety-net providers to the Medi-Cal program, as well as to the care of the medically indigent. Local community health plans play a key role in protecting the safety net. Without the safety net it would be impossible to have sufficient access in the Medi-Cal program. Medi-Cal revenue is crucial to the financial viability of safety-net providers. Local community health plans face the challenge not only to operate as financially viable institutions, but also to protect the safety net and the access to care that they afford now and in the future.

Safety-net providers have numerous opportunities to influence the policies of the local community health plans. Safety-net providers are typically represented on the plans' governing boards, and also participate on provider advisory boards, quality improvement committees, and peer review and credentialing committees. As a result, safety-net needs and concerns have a voice in the operations of local community health plans.

Under the Two-Plan Model, Medi-Cal beneficiaries are required to enroll in either the Local Initiative or the Commercial Plan. In the event the Medi-Cal beneficiary fails to make an affirmative plan choice, DHCS will assign (e.g. default) the beneficiary to one or other of the plans in which to enroll the beneficiary. DHCS has developed a formula for making these assignments based on plan performance, using HEDIS scores and the plan's utilization of safety-net providers. In **Table 9** below, the DHCS algorithm reflects that Local Initiatives have a higher percentage of default assignments, reflecting combined superior performance over their commercial plan competitors. Importantly, the algorithm recognizes that the Local Initiatives utilize safety-net providers in greater measure than the commercial plans. This supports the objective conclusion that the Local Initiatives are, in fact, protecting the safety net.

Local community health plan enrollment policies also support the safety net in each local public plan community. When Medi-Cal members are enrolled in

TABLE 9 Medi-Cal Two-Plan Model Default Enrollment Allocations December 2009—November, 2010

COUNTY	LOCAL INITIATIVE	DEFAULT RATE
Alameda	Alameda Alliance for Health	63.0%
Contra Costa	Contra Costa Health Plan	88.0%
Kern	Kern Health Systems	43.0%
Los Angeles	L.A. Care Health Plan	69.0%
Riverside	Inland Empire Health Plan	50.0%
San Bernardino	Inland Empire Health Plan	55.0%
San Francisco	San Francisco Health Plan	71.0%
San Joaquin	Health Plan of San Joaquin	64.0%
Santa Clara	Santa Clara Family Health Plan	73.0%
All Local Initiatives	**Weighted Average**	**64.0%**

Source: DHCS MMCD Program Data - Performance Measurement Section.

(or assigned to) a plan, but fail to designate a primary care provider, "default assignment" algorithms established by the plan distribute a favorable proportion of the enrollees to safety-net providers.

COHS plans also have a strong track record in supporting the safety net. In 2008, 46.4 percent of the days provided by the plans were at Disproportionate Share Hospitals (DSH). Almost 35 percent of their members were enrolled with safety-net primary care providers.

Some local community health plans have provided grant funding for infrastructure improvement to safety-net providers such as community clinics, helping to make them more competitive and position them for long-term growth. Support has even included funding for the establishment of new community clinics and reopening those that have closed.

Local community health plans' close ties with local safety-net providers have led to important recognition from the Healthy Families Program. Each year, the Managed Risk Medical Insurance Board designates a "Community Provider Plan" (CPP) in each county. The CPP is the health plan that has the highest percentage of the county's traditional and safety-net providers – defined as Child Health Disability and Prevention Program (CHDP) providers, clinics, and county and public hospitals – in its network. The Healthy Families monthly premium for children is determined by income category, which includes family size, family income, and the health plan chosen. The premium for the community provider plan is less than the premium for another participating plan in that county.

Table 10 identifies the Healthy Families CPP designation for 2009-2010. Local community health plans hold the CPP designation in 13 of the 14 counties in which these plans compete for enrollment. Finally, local community health plans' creation of access initiatives and new insurance products (e.g., Healthy Kids) support local safety-net providers by ensuring reimbursement for patients that these providers would otherwise see without sponsorship.

Seeking Solutions to Community Health Problems

California's local community health plans were founded in the coalescence of broad community interests around the betterment of health care services available to low-income residents. Local community health plans serve as a meeting point for public and private health care providers, county officials, and advocacy organizations. It is not surprising, then, that local community plan governing bodies often become a forum for discussion and action regarding health care for the publicly insured and uninsured in their communities.

Local community health plans – Local Initiatives and COHS, alike – have engaged deeply in addressing both local access to Medi-Cal and broader community health care problems. In many instances, local community health plans have provided a forum in which consumers and their families and advocates, physicians, hospitals, community clinics, county government officials, local health departments, and others come together to tackle some of the most intransigent challenges of the Medi-Cal program. In other cases, the plans have reinvested any profits in community health projects, program initiatives, and campaigns, or have led health promotion and disease awareness efforts that benefit

TABLE 10 Healthy Families Community Plan Designation Contested Counties 2009-2010.

COUNTY	MEDI-CAL MODEL TYPE	COMMUNITY PROVIDER PLAN	FINAL SCORE+
Alameda	LI	Alameda Alliance for Health	92.7%
Contra Costa	LI	Contra Costa Health Plan	97.9%
Kern	CP	Anthem Blue Cross HMO	98.5%
Los Angeles*	---	Community Health Plan (L.A. County)	88.8%
Riverside	LI	Inland Empire Health Plan	94.7%
San Bernardino	LI	Inland Empire Health Plan	83.2%
San Francisco	LI	San Francisco Health Plan	97.0%
San Joaquin	LI	Health Plan of San Joaquin	99.2%
Santa Clara	LI	Santa Clara Family Health Plan	96.6%
Monterey	COHS	Central California Alliance for Health	99.5%
Orange	COHS	CalOptima	88.5%
San Mateo	COHS	Health Plan of San Mateo	94.5%
Santa Cruz	COHS	Central California Alliance for Health	99.6%
Santa Barbara	COHS	CenCal Health	97.0%

Source: CA Managed Risk Medical Insurance Board, Report 2009-10 CPP Designations
**The Healthy Families product is offered by Community Health Plan, a licensed health plan owned by the County of Los Angeles.*
+ Final scores represent the percentage of the safety net that is under contract.

the entire community. These efforts go far beyond the typical activities of commercial health plans.

While the local community health plans have served as vehicles to address numerous local health care issues, their most significant initiatives fall into two categories: coverage expansion and information sharing.

- *Coverage Expansion for Uninsured Children*. It was a local community plan that conceived, developed, launched, and championed what has become the most significant health insurance expansion in California since SCHIP. The Healthy Kids program, expanded into 16 additional counties by local community health plans, is a partnership between local communities, foundations, and the plans to address the challenge of uninsured children. Low-income children who are otherwise ineligible for Medi-Cal or Healthy Families receive medical, dental, and vision coverage for a modest premium. Local community health plans have depended entirely on non-Medi-Cal sources – including local First 5 commissions, hospital districts, county tobacco settlement funds, and private foundations (including the David and Lucile Packard Foundation, the California HealthCare Foundation, the Blue Shield of California Foundation and The California Endowment) – to support Healthy Kids.
- *Coverage Expansion for Adults*. Many local community health plans have worked in partnership with their respective counties and communities to develop insurance programs for IHSS workers and coverage initiatives for uninsured adults.

- *Information Sharing*. California's local community health plans have been in the forefront of organizing community efforts to use information technology to improve providers' access to timely clinical data. For example, some local community health plans have taken a leadership role in efforts to develop universal county immunization registries – databases into which *all* providers in the county, regardless of where they practice or how their patients are insured, would record pediatric immunizations. Another local community plan has worked with local hospitals and clinics to develop and implement a Web-based system that allows hospital emergency rooms and clinics to share real-time health data on mutual patients. This technology also allows hospitals to schedule follow-up visits at local clinics at the time they discharge patients from the emergency room.

4. Standardized Health Plan Performance Measures

All Medi-Cal managed care plans are required to report their performance according to two standardized measures: the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Local community health plans perform at least as well as their competitors on both measures, and in most cases do significantly better.

Healthcare Effectiveness Data and Information Set (HEDIS)

The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance (NCQA), is used widely across the managed care industry to standardize the measurement of quality and access.[5] Medi-Cal managed care plans collect HEDIS data through medical charts, and claims and encounter data for hospitalizations, medical office visits and procedures.

In 2008, twenty-three HEDIS indicators were studied across all Medi-Cal managed care plans. The indicators addressed hospital-based ambulatory care, asthma treatment, care for adolescents, screenings for breast cancer and cervical cancer, diabetes care, childhood immunizations, prenatal and postpartum care, treatment for children with upper respiratory infections, well-child visits for infants and young children, and avoidance of antibiotics for the treatment of adults with acute bronchitis.

County Organized Health Systems performed best among Medi-Cal managed care models, scoring above the weighted Medi-Cal managed care average on 20 of the 23 indicators for which results were required to be reported. The Local Initiatives scored above the weighted average on 9 of 23 indicators, while the commercial plan contractors and the Geographic Managed Care Plans in San Diego (GMC-South) scored above the average on 6 of 23. The Geographic Managed Care Plans operating in Sacramento County (GMC-North) scored above the weighted Medi-Cal managed care average on 4 of the 23 measurable indicators.[6]

Overall, the various plan-types achieved the following average ranking on HEDIS 2008, with "5" denoting the model receiving the highest ranking among all Medi-Cal managed care models and "1" the lowest ranking model:

- COHS 4.48
- Local Initiative 3.11

5 Prior to July 2007, HEDIS was known as the "Health Plan and Employer Data Information Set."

6 The Commercial Plan category included: Anthem BC, Health Net, and Molina. The rates for Anthem BC and Health Net are weighted averages incorporating all the counties served by this plan-model combination. GMC-North (Sacramento County) included: Anthem Blue Cross, Health Net, Kaiser, Molina, and Western Health Advantage. GMC-South (San Diego County) included: Anthem Blue Cross, Care 1st, Community Health Group, Health Net, Kaiser-Southern California, and Molina. Data reported for ten Local Initiatives includes Anthem Blue Cross, which is designated as the Local Initiative in Stanislaus and Tulare Counties, but is not a local community health plan as defined in this report. It was not possible to isolate Anthem Blue Cross data for these two counties. It is assumed that the data reported for Anthem Blue Cross does not materially alter the data reported for Local Initiatives in the other 9 counties, which are operated by local public health plans as defined in this report.

- Commercial Plan 2.59
- GMC South 2.52
- GMC North 2.30

A small number of plans were also recognized individually by DHCS for outstanding performance on the HEDIS 2008 measures. Five of the six honored were local community health plans.[7]

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Local community health plans perform strongly in competition with other Medi-Cal managed care contractors in California when consumer satisfaction is measured, as well. The largest and most standardized version of a member survey used in Medi-Cal is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, a public-private initiative funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ). Results allow DHCS to determine how well the plans meet members' expectations, and help the plans improve quality of care.

The most recent Medi-Cal CAHPS survey, from 2007, gathered data on adult perceptions of their own care and, separately, on adult perceptions of care provided to their children. Overall, the local community health plans – both COHS and Local Initiatives – performed better than the other model-types on most of the measures rated among adult members. The health plans within GMC-South and the COHS performed best overall in ratings of children's care, while commercial health plans and GMC-North plans had the lowest scores. Local Initiatives fell in the middle.

The Healthy Families Program also uses the CAHPS survey to assess program participants' experiences and the degree to which they are satisfied with the medical care their children receive. The 2007 CAHPS found seven plans whose rating was significantly higher ($p < .05$) than the program average. Four of the seven were local community health plans:

- Health Plan of San Joaquin (LI)
- Santa Clara Family Health Plan (LI)
- CenCal Health (COHS)
- Central California Alliance for Health (COHS)

Similarly, three health plans were cited for high performance in the 2007 Healthy Families CAHPS survey for adolescents, scoring significantly above the program average. All three were local community health plans:

- Health Plan of San Mateo (COHS)
- Central California Alliance for Health (COHS)
- San Francisco Health Plan (LI)

While the CAHPS report for the Healthy Families Program did not provide ratings by plan-model type, as it did for Medi-Cal plans, an un-weighted average by model type shows the following results.

- COHS 90.0%
- Local Initiative 87.4%
- Other Plans 86.6%
- Commercial Plan 85.8%

7 DHCS recognized plans in the following categories: **Gold Quality Awards** – San Francisco Health Plan (SF County), Central California Alliance for Health (Monterey and Santa Cruz Counties); **Silver Quality Award** – CalOptima (Orange County); **Bronze Quality Award** – Anthem Blue Cross (SF County); **Honorable Mention Quality Awards** – CenCal Health Plan (Santa Barbara County), Partnership HealthPlan (Napa, Solano, and Yolo Counties).

Conclusions

Local community health plans have become the dominant plan providers of Medi-Cal managed care services. In fact, the current expansion of Medi-Cal managed care is occurring through the formation of new local community health plans. There are two types of local community health plans discussed in this report. The County Organized Health System model had its origins in the early 1980s as a Federal Medicaid Demonstration in California. The key features of the COHS have been public sponsorship and universal enrollment for Medi-Cal eligibles in the county, including seniors and persons with disabilities (SPDs). The Local Initiative model originated in the expansion of Medi-Cal managed care formulated by DHCS in the 1990s. The Local Initiatives, also publicly sponsored, compete for membership against a commercial plan. Under the Two-Plan Model, the majority of Medi-Cal eligibles must enroll in either the Local Initiative or the Commercial plan, while the SPDs may voluntarily enroll or remain in the Medi-Cal fee-for-service program.

Local initiatives are dominating the marketplace in competition with commercial health plans in two ways. First, when a Medi-Cal beneficiary must select either the Local Initiative or the commercial plan under the Two-Plan Model, those that fail to make a selection must be assigned. DHCS uses an algorithm based on quality and use of the safety net to distribute these assignments. In all but one case, the Local Initiative merits the majority of assignments. Second, the domination of the marketplace is also evidenced by the affirmative plan choices made by Medi-Cal beneficiaries. On average, more than 70 percent of the Medi-Cal beneficiaries who have to choose between the Local Initiative and the commercial plan affirmatively select the former. These two elements have propelled the enrollment in the Local Initiatives under the Two-Plan Model.

Medi-Cal managed care has produced a financial savings for the Medi-Cal Program. With local community health plans, accounting for the majority of enrollees in Medi-Cal managed care, producing the greatest savings. Importantly, with stringent Medi-Cal managed care requirements for access and quality, local community health plans have provided a better system of care for enrollees while achieving financial savings compared to the Medi-Cal fee-for-service program.

Beginning with the first County Organized Health Systems in the 1980s, local community health plans have established a track record of serving the SPDs. More than 30 percent of their enrollment comes from the mandatory enrollment of the SPDs. Local Initiatives are also enrolling the SPDs on a voluntary basis. Local community health plans have designed special programs and initiatives to serve the unique needs of this particularly vulnerable population. In fact, eight local community health plans have developed Special Needs Plans under the Federal Medicare Program that reflect a commitment to bettering the care for low-income SPDs who receive care under both Medi-Cal and Medicare.

In conclusion,

- Local community health plans have saved money for the state of California by providing Medi-Cal benefits at a lower cost than the Medi-Cal fee-for-service program.

- Local community health plans have been the vehicle for all of the state's recent successful efforts to expand Medi-Cal managed care. For example, COHS plans expanded into the counties of San Luis Obispo in 2008, and Merced and Sonoma in 2009. These expansions have added more than 100,000 Medi-Cal eligibles to Medi-Cal managed care.

- More than 69 percent of Californians in Medi-Cal managed care – more than two million people – are in local community health plans. Two new local community health plans, one Local Initiative and one County Organized Health System, covering four counties, are expected to be fully operational by the end of 2010. These new local community health plans will enroll an additional 200,000 Medi-Cal members, increasing the market share of local community health plans to more than 66 percent.

- Seven out of 10 new Medi-Cal beneficiaries choose to enroll in the Local Initiative in Two-Plan Model counties where the Local Initiative, the local community health plan, competes with a commercial plan.

- Quality measures for local community health plans are as good or better than for commercial plans participating in Medi-Cal managed care based on standardized plan performance measures mandated for reporting by the DHCS.

- COHS plans have an extensive record of serving SPDs successfully for many years through mandatory enrollment. Since their inception, Local Initiatives have welcomed the voluntary enrollment of SPDs. To meet the needs of SPDs, local community health plans offer programs like medical homes, disease management, information technology, provider network requirements, innovative customer service programs, channels for policy and program input, and targeted community investments.

- Local community health plans have a stake in the stability and competitiveness of local safety-net providers, and their investments in this system demonstrate that commitment.

- Because they are governmental entities, subject to the Brown Act and other public disclosure rules, local community health plans have earned respect for transparency and local control, and use their standing to broker community-wide discussion of local health care and health promotion strategies, beyond those affecting just the Medi-Cal population.

Appendix A Medi-Cal Managed Care Models

There are two broad categories through which Medi-Cal health care benefits are provided to California residents: fee-for-service and managed care. Within the managed care category, there are alternative variations of Medi-Cal managed care which occur throughout the state:

- Geographic Managed Care,
- Two-Plan Model, and
- County Organized Health Systems.

Today, more than 2.5 million Medi-Cal beneficiaries are enrolled in some form of Medi-Cal managed care. Both the fee-for-service system and the various forms of managed care are briefly described below.

Medi-Cal Fee-for-Service (FFS)

The default organization of Medi-Cal services delivery is through a "fee-for-service" program administered by the State Department of Health Care Services (DHCS) and its fiscal intermediary. Under the fee-for-service program, a Medi-Cal beneficiary is given an identification card which is presented to providers who participate. The beneficiary shoulders the responsibility to find a provider willing to accept Medi-Cal. DHCS' fiscal intermediary issues a provider manual with coverage policies and instructions on submitting claims and updates the manual as necessary. With respect to inpatient care, a selected number of hospitals participate in Medi-Cal based on negotiated rates of payment. DHCS has established criteria and a process for determining whether services are medically necessary. While the county social services agency determines eligibility for Medi-Cal, there is no local involvement in the administration of Medi-Cal health care benefits under the fee-for-service program.

Medi-Cal Managed Care

While evolution of the concept has occurred since Medi-Cal managed care first took place in the 1970s, it has meant an arrangement between DHCS and a health plan or group of providers in which DHCS pays a per month amount for each enrollee in exchange for the contractual obligation to provide Medi-Cal covered services as long as the Medi-Cal beneficiary is enrolled.

There are three principal Medi-Cal managed care contracting models: (1) Geographic Managed Care, (2) the Two-Plan Model, and (3) the County Organized Health System. In each of these models, contractors take full risk for the services covered in contracts with the state. The model used in any one county is based on the interaction of federal and state laws and policies, and the preference of the county board of supervisors. The following section briefly describes each of the key models of Medi-Cal managed care and the advantages of each from a local perspective.

Geographic Managed Care (GMC)

The GMC model provides for the operation of multiple Knox-Keene license plans to operate within a designated county or region consisting of multiple counties. Three counties – Sacramento, Placer, and San Diego – have GMC models. Under GMC, the state contracts on a capitated basis directly with a number of commercial managed care plans. Beneficiary enrollment in a plan is mandatory only for the CalWORKs-linked Medi-Cal

population. The GMC model typically requires a large county Medi-Cal enrollment so that the pool of potential enrollees is of sufficient size to be economically viable for multiple health plans.

Two-Plan Model

The Two-Plan Model was the cornerstone of the state's strategic plan to expand enrollment in Medi-Cal managed care in the 1990s. Under this model, DHCS contracts on an at-risk, capitated basis with one Knox-Keene licensed county-sponsored plan, called a "Local Initiative (LI)", and a competing, licensed commercial plan selected by DHCS. The LI is governed by a commission independent and separate from county government established according to ordinance by the board of supervisors, though the board has the option of seating itself as the commission. The commission is considered a public agency and is subject to California's open meeting laws. The commission holds the contract with DHCS and is at full risk.

Since mandatory enrollment in the Two-Plan Model is limited to the CalWORKs-linked population and non-Medicare eligible Aged and Disabled, from a state budgetary point of view, it lacks the cost containment impact of a COHS. Voluntary enrollment of some other Medi-Cal beneficiaries is permitted. Like under the COHS model, both the LI and the commercial plan cover most Medi-Cal services. But unlike the COHS model, skilled nursing care is covered on a limited basis, with DHCS picking up coverage beyond the plans' responsibility. DHCS covers the Medi-Cal services not offered under the Two-Plan Model. The Two-Plan Model operates in nine of the larger California counties.

County Organized Health Systems (COHS)

Under the COHS model, a county board of supervisors, by ordinance, creates a "health commission" to operate a single, county-wide, publicly-sponsored, and largely independent health plan to serve the entire Medi-Cal population. The commission is subject to state's open meeting laws. For its Medi-Cal operations, a COHS must meet selective Knox-Keene requirements, like proof of financial solvency, but is not required to be licensed. COHS contract with DHCS for a capitated rate based on Medi-Cal eligibility category. Most Medi-Cal benefits are covered by the COHS. A COHS may make a special arrangement with DHCS for some services, such as nursing home care, to remain under fee-for-service. The COHS commission is a public agency that operates independent of the county, and the county is at risk only to the extent of its contract with the COHS as a provider. COHS currently operates in nine counties, with three county organized health systems that are comprised of multiple counties.

Appendix B
Local Initiative Profiles

Alameda Alliance for Health

Counties	Alameda
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.35
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1996), Healthy Families (1998), IHSS Workers (2001); Medicare Advantage/Special Needs Plan (2008); Healthy Kids (2005; Terminated)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	84,963
Healthy Families	9,384
In-Home Support Services Workers (IHSS)	4,289
Healthy Kids	
AIM	
County Employees	
County Indigents and/or Coverage Initiative	
Medicare SNP	1,059
Total Enrollment	**99,695**

Contra Costa Health Plan

Counties	Contra Costa
Governance	County-operated
Enabling Statute	Welfare and Institutions Code Section 14087.38
Date of Operations	1973
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal PHP (1973); Medicare (1976); County Employees (1986); Healthy Families (1998); IHSS Workers (2001); Individuals and Families; Employer Groups; Major Risk Medical Insurance Program; Access for Infants and Mothers/AIM

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	51,138
Healthy Families	4,295
In-Home Support Services Workers (IHSS)	2,764
Healthy Kids	
AIM	34
County Employees	8,992
County Indigents and/or Coverage Initiative	25,032
Medicare SNP	110
MRMIP, Private Enrollees, Other Medicare	3,219
Total Enrollment	**95,584**

Note: Community health plan enrollments as of April, 2009.
Sources: Plan Websites; CA Legislative Information; CA Department of Managed Health Care; Plan Survey (2009).

Health Plan of San Joaquin

Counties	San Joaquin
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.31
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1996), Healthy Families (San Joaquin, 1998, Stanislaus, 2006, Merced, 2006); Healthy Kids (2003); IHSS Workers (2003); Access for Infants and Mothers/AIM

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	66,040
Healthy Families	18,523
In-Home Support Services Workers (IHSS)	1,203
Healthy Kids	2,370
AIM	15
County Employees	6,404
County Indigents and/or Coverage Initiative	-
Medicare SNP	-
NetworkPlus (Commercial)	3,347
Total Enrollment	**97,902**

Inland Empire Health Plan

Counties	Riverside, San Bernardino
Governance	Joint Powers Agency; Two County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.52
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (Riverside, 1996, San Bernardino, 1996); Healthy Families (Riverside, 1998, San Bernardino, 1998); Healthy Kids (Riverside, 2002, San Bernardino, 2002); Medicare Advantage/Special Needs Plan (Riverside, 2006, San Bernardino, 2006)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	331,202
Healthy Families	46,872
In-Home Support Services Workers (IHSS)	-
Healthy Kids	7,061
AIM	-
County Employees	-
County Indigents and/Coverage Initiative	-
Medicare SNP	2,495
Total Enrollment	**387,630**

Note: Community health plan enrollments as of April, 2009.
Sources: Plan Websites; CA Legislative Information; CA Department of Managed Health Care; Plan Survey (2009).

Kern Health Systems

Counties	Kern
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.38
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1996), Healthy Families (1998)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	97,436
Healthy Families	13,567
In-Home Support Services Workers (IHSS)	
Healthy Kids	
AIM	
County Employees	
County Indigents and/or Coverage Initiative	
Medicare SNP	
Total Enrollment	**111,003**

L.A. Care Health Plan

Counties	Los Angeles
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.96 et seq.
Date of Operations	1997
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1997); Healthy Families (1998); Healthy Kids (2003); Medicare Advantage/ Special Needs Plan (2008)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	747,174
Healthy Families	10,792
In-Home Support Services Workers (IHSS)	
Healthy Kids	29,454
AIM	
County Employees	
County Indigents and/or Coverage Initiative	
Medicare SNP	140
Total Enrollment	**787,560**

Note: Community health plan enrollments as of April, 2009.
Sources: Plan Websites; CA Legislative Information; CA Department of Managed Health Care; Plan Survey (2009).

San Francisco Health Plan

Counties	San Francisco
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.36
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1996); Healthy Families (1998); Healthy Kids (2002); IHSS Workers (1999)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	33,057
Healthy Families	8,328
In-Home Support Services Workers (IHSS)	10,533
Healthy Kids	3,984
AIM	-
County Employees	-
County Indigents and/Coverage Initiative	-
Medicare SNP	-
Total Enrollment	**55,902**

Santa Clara Family Health Plan

Counties	Santa Clara
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.38
Date of Operations	1997
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1997); Healthy Families (1998); Healthy Kids (2001); Medicare Advantage/ Special Needs Plan (2008)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	86,903
Healthy Families	16,620
In-Home Support Services Workers (IHSS)	
Healthy Kids	9,527
AIM	
County Employees	
County Indigents and/Coverage Initiative	
Medicare SNP	3,936
Total Enrollment	**116,986**

Note: Community health plan enrollments as of April, 2009.
Sources: Plan Websites; CA Legislative Information; CA Department of Managed Health Care; Plan Survey (2009).

Appendix C
County Organized Health System Profiles

CalOptima

Counties	Orange
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.54
Date of Operations	1995
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1995,1996,1998); Healthy Families (1998); Multipurpose Senior Services Program (2001), One Care (Medicare Advantage Special Needs Plan) (2005); Healthy Kids (2007)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	329,183
Healthy Families	32,814
In-Home Support Services Workers (IHSS)	-
Healthy Kids	1,121
AIM	-
County Employees	-
County Indigents and/or Coverage Initiative	-
Medicare SNP	8,822
Multipurpose Senior Services Program	208
Total Enrollment	**372,148**

CenCal Health

(formerly Santa Barbara Regional Health Authority)

Counties	Santa Barbara, San Luis Obispo
Governance	Joint Two County Health Authority
Enabling Statute	Health and Safety Code Section 101675 et seq.
Date of Operations	1983
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal: Santa Barbara County (1983), San Luis Obispo County (2008); AIM: Santa Barbara County (1993); Healthy Families: Santa Barbara County (1998), San Luis Obispo County (2006); In Home Support Services Workers: Santa Barbara (2005); Healthy Kids: San Luis Obispo (2005), Santa Barbara County (2005)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	83,581
Healthy Families	7,318
In-Home Support Services Workers (IHSS)	410
Healthy Kids	1,514
AIM	56
County Employees	-
County Indigents and/Coverage Initiative	-
Medicare SNP	-
Total Enrollment	**92,879**

Note: Community health plan enrollments as of April, 2009. Source: Plan Websites, CA Department of Managed Health Care; Plan Survey (2009). Sources: Plan Websites; CA, Legislative Information, CA Department of Managed Health Care.

Central California Alliance for Health

Counties	Santa Cruz, Monterey, Merced
Governance	Three County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.54
Date of Operations	1996
Knox-Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal: Santa Cruz (1996), Monterey (1999), Merced (Scheduled for 2009); Healthy Families: Santa Cruz (1998), Monterey (2000); Healthy Kids: Santa Cruz (2004); AIM: Monterey (2009); IHSS: Monterey (2005)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	96,748
Healthy Families	19,715
In-Home Support Services Workers (IHSS)	363
Healthy Kids	2,095
AIM	109
County Employees	
County Indigents and/Coverage Initiative	
Medicare SNP	
Total Enrollment	**119,030**

Health Plan of San Mateo

Counties	San Mateo
Governance	Single County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.51
Date of Operations	1987
Knox Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal (1987); Healthy Families (1998); Part-time County Employees/Health Worx (2001); Healthy Kids (2003); Medicare Advantage/ Special Needs Plan (2006)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	52,948
Healthy Families	6,065
In-Home Support Services Workers (IHSS)	1,001
Healthy Kids	6,229
AIM	-
County Employees	-
County Indigents and/or Coverage Initiative	14,807
Medicare SNP*	7,377
Total Enrollment*	**88,427**

**Medicare SNP members are also Medi-Cal members so total enrollment should be 81,050.*

Note: Community health plan enrollments as of April, 2009. Source: Plan Websites, CA Department of Managed Health Care; Plan Survey (2009). Sources: Plan Websites; CA, Legislative Information, CA Department of Managed Health Care.

Partnership Healthplan of California

Counties	Solano, Napa, Yolo, Sonoma
Governance	Four County Health Authority
Enabling Statute	Welfare and Institutions Code Section 14087.54
Date of Operations	1994
Knox Keene License	Full Service
Licensed Products/ Year Initiated	Medi-Cal: Solano (1994), Napa (1998), Yolo (2001); Healthy Kids: Solano (2005), Napa (2005), Yolo (2005), Sonoma (2006); Medicare Advantage/Special Needs Plan: Solano (2007), Napa (2007), Yolo (2007); County Medical Services Program/ CMSP: Solano (2002-2005)

Enrollment by Product

PRODUCT	ENROLLMENT
Medi-Cal	94,916
Healthy Families	-
In-Home Support Services Workers (IHSS)	-
Healthy Kids	1,763
AIM	-
County Employees	-
County Indigents and/Coverage Initiative	-
Medicare SNP	3,348
Total Enrollment	**100,027**

Note: Community health plan enrollments as of April, 2009. Source: Plan Websites, CA Department of Managed Health Care; Plan Survey (2009). Sources: Plan Websites; CA, Legislative Information, CA Department of Managed Health Care.

Appendix D
Federal and California Statutes Used for Local Community Plan Formation

Both California and federal statutes control the formation of local community health plans.

California statutes provide for the formation and governance of the two types of local plans – county organized health systems and local initiatives.[1] The governance of the two types of plans is very similar. The key provisions of the statutes are:

- Authorize the county board(s) of supervisors to appoint a governing body (e.g. health authority or commission) with representatives having a diverse interest in the administration of Medi-Cal.
- Provide for the separation of the "health authority" or "health commission" from county government.
- Assert that the debts of the health authority or commission are not the debts of the county/counties.
- Indicate that the county/counties is/are successor to the assets of the health authority or commission.
- Allow for community health care providers to sit on the governing body.
- Establish the governing body as a public agency and subject to certain laws pertaining to county appointed bodies, including adherence to California's Ralph M. Brown Open Meeting Law.

Some counties have chosen to obtain statutes that apply only to their County Organized Health Systems or Local Initiatives. However, these statutes share more in common with the more general statutes that are referenced below.

Federal statutes limit the number of COHSs in California and place a ceiling on the percentage of Medi-Cal beneficiaries in the state that can be enrolled in COHS plans.[2] Congress has guarded the limits and ceilings in the statute and permitted only incremental changes to the statute. Nevertheless, the state and individual counties have sponsored changes to the federal statute to allow new COHS projects.

1 California Welfare and Institutions Code Section 14087.54 (for County Organized Health Systems) and California Welfare and Institutions Code Section 14087.38 (for Local Initiatives).

2 Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396 b note) as added by Section 4734 of the Omnibus Budget Reconciliation Act of 1990, as amended by section 704 of the Medicare, Medicaid, and SCFHIP Benefits Improvement of 2000, and as amended by Section 205 of the Medicare Improvement for Patients and Providers Act of 2008.

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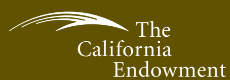

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