



CALIFORNIA
HEALTHCARE
FOUNDATION

Caring for Medically Indigent Adults in California: A History

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

by

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About the Author

This history was compiled by Deborah Reidy Kelch, who at the time of its writing, was an independent health researcher and president of Kelch Associates Consulting.

About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's healthcare delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

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I. Overview

Counties have a statutory obligation to meet the health care needs of low-income and indigent people with no other source of care.

CALIFORNIA COUNTIES, BY LAW AND BY TRADITION, ARE a core element of the health care “safety net.” Counties have a statutory obligation to meet the health care needs of low-income and indigent people with no other source of care. This population includes medically indigent adults (often referred to as MIAs)—those without public or private health coverage who cannot afford to pay for their own medical care. From the early days of the state and county governments in the mid-1800s, county responsibility for MIAs has been governed by very broad language and subject to constantly shifting local, state, and federal funding streams and financial support.

County indigent care programs vary widely. Each county decides how much emphasis to place on care for the uninsured, as opposed to other health and spending priorities. Counties also make their own decisions on how to balance inpatient and emergency services with primary care and outpatient services, as well as the mix of public and private providers that will be used to deliver services.¹ Some counties own, operate, and fund large public delivery systems serving both uninsured and insured patients. Other counties purchase limited benefits for a narrowly defined indigent population from local hospitals and community clinics. Still others rely on a combination of county facilities and community providers. For an overview of the role of counties in health care services see *The Crucial Role of Counties in the Health of Californians: An Overview*.²

The role of counties in caring for medically indigent adults is perhaps most easily understood in the context of history. This paper highlights major historical milestones that have affected county-supported services for MIAs. It shows the inextricable link between funding and policies for public coverage programs, like Medi-Cal, and county health care programs for the uninsured. In addition, it underscores the complexities of the state–county fiscal relationship and the potential impact of state budget and policy decisions on county medical care programs. The lessons of history regarding these linkages can inform budget and policy decisions moving forward.

II. The Early Days: Before Medicaid

Welfare and Institutions Code §17000

Every county and every city and county shall relieve and support all incompetent poor, indigent persons, and the incapacitated by age, disease or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means or by state hospitals or other state or private institutions.

The Legal Mandate

The deep roots of county health delivery systems became established during California's earliest days.

California divided itself into counties in 1850, shortly after becoming a state. The Pauper Act of 1855 mandated county governments to provide support and care for the indigent population, but health care was not generally considered part of this early obligation.³ The 1901 Pauper Act added a more comprehensive mandate for counties to “relieve and support” all incompetent poor persons, and, in 1933, the California legislature enacted Welfare and Institutions Code §17000, which remains in effect today. The broad language of §17000 (see box) is a key factor in the continuing legal and policy debates surrounding the responsibilities of county governments for indigent health care, one example of which is the variation among counties in defining who is eligible for county-supported health care services as a medically indigent adult.

The Delivery Systems

In the late 1800s, counties financed a network of health facilities and almshouses that by 1875 numbered at least two dozen statewide. In their earliest incarnation, these public facilities were often little more than warehouses where the very poor went to die.⁴ By the early 1900s, California had one of the most extensive public hospital systems in the nation, and a 1925 state Department of Public Welfare survey identified 69 county hospitals spread across all but four California counties.⁵ By 1935, city- and county-funded hospitals provided 23.4 percent of all the hospital beds in California, compared with 15.9 percent nationally.⁶ County hospitals provided a broad range of inpatient and outpatient hospital services to individuals who met county indigent requirements, whether or not they were otherwise receiving public financial assistance.⁷ The major responsibility for supporting county hospitals rested on the counties, financed primarily through property taxes, with minor contributions from other sources.⁸

III. The Great Society

The shift in financing of health care from the counties to the state and federal governments resulted in a period of dramatic medical inflation.

Medicaid and the Implementation of Medi-Cal

Beginning in the 1930s, and continuing through the Post World War II era, employers began to voluntarily provide health insurance for their workers. Employer demand for coverage options for their workers prompted the development of private insurance programs, such as Blue Cross and Blue Shield, and prepaid delivery systems, such as Kaiser Permanente.

By the mid-1960s, it was clear, however, that employer-sponsored programs were failing to provide for the health care needs of the elderly and poor.⁹ President Lyndon Johnson introduced the Great Society and War on Poverty programs, which included passage of Medicare and Medicaid. The 1964 Economic Opportunity Act also provided federal stimulus for the creation of neighborhood health centers in poor urban and remote rural communities.

California's version of Medicaid, the California Medical Assistance Program, was implemented in 1966 and became known as Medi-Cal. Eligibility was initially limited to low-income individuals linked to a federal "categorical" program. These included aged, blind, and disabled persons, as well as individuals receiving grants under the Aid to Families with Dependent Children (AFDC) program. Counties were required to pay a county share-of-cost to the state for those individuals covered by Medi-Cal; however, medical care for individuals not eligible for Medi-Cal remained the responsibility of the counties.

The Medi-Cal program also included the "county option," which allowed counties to get additional funding for indigent care programs. Counties selecting the county option would pay the state 100 percent of the county's medical care costs before Medi-Cal (1964 to 1965), and the state would cover unreimbursed county medical costs above those pre-Medi-Cal levels.¹⁰ The county option essentially supported county medical care for "non-linked" persons such as unemployed, single adults not eligible for Medi-Cal, and the working poor. The passage of Medi-Cal, including the county option, resulted in a significant shift in financing of health care from the counties to the state and federal governments. This shift resulted in a period of dramatic medical inflation and rising government expenditures.

At the same time, newly available funding for private hospitals through Medi-Cal, Medicare, and employer-sponsored health plans reduced demand for county hospitals: Of the 66 county hospitals operating in 1965, 15 were closed, sold, or leased by 1973. An additional ten hospitals closed by 1978.¹¹ Increasingly, public hospitals were relying on Medi-Cal and Medicare revenues to help cover the growing cost of uncompensated care for those not eligible for public or private coverage.

IV. Medi-Cal Reform and the State Bailout

By 1982, Medi-Cal was consuming one of every eight state General Fund dollars, and the Medi-Cal budget was approaching \$5 billion.

Medi-Cal Reform Round One: The Medically Indigent Persons Program

In 1971, the California legislature enacted a major Medi-Cal restructuring to stem rising costs.¹² They eliminated the county option and established a new method for determining the level of county contributions to Medi-Cal. The new formula set in statute a specific dollar amount for each county's Medi-Cal share in 1972 to 1973, and increased each county's contribution in subsequent years based on the taxable assessed value of certain types of property.

In addition, the state extended Medi-Cal eligibility to non-categorically linked minors and adults unable to pay for their medical care; program beneficiaries became known as “medically indigent persons,” or “MIPs.” Undocumented immigrants were not eligible for the program. Coverage for MIPs was not a federal Medicaid option and was, therefore, paid entirely with state Medi-Cal funds (including the county contributions). Upon full program implementation, the average monthly enrollment of MIPs was 270,000. The MIP component was one of the fastest-growing elements of the Medi-Cal program in the decade following its passage, and costs increased 400 percent from the inception of the program in 1971 to 1978.¹³

The Aftermath of the 1978 Voter Tax Revolt: State Moves to Bail Out Counties

In 1978, California voters “revolted” against increases in local property taxes and passed a statewide ballot initiative, Proposition 13, which limited local property tax rates to 1 percent of assessed valuations (compared to the prevailing average of about 2.5 percent). In addition, Prop 13 rolled assessments back to 1975 values and allowed increases of no more than 2 percent a year unless a property is sold. As a result, local property tax revenues dropped immediately by 52 percent.¹⁴

Following the passage of Prop 13, and the resulting decline in local revenues, the legislature enacted several “bailout” programs. In the 1978–79 budget, the state assumed each county's share of Medi-Cal costs,¹⁵ and also provided nearly \$2 billion in state

surplus funds to local governments in the form of block grants.¹⁶ Importantly, the legislation prohibited counties from reducing local spending on health programs relative to other programs. This was the first instance of a county financial “maintenance of effort” (MOE) for indigent health services, an obligation that still exists on a limited basis. The county MOE was calculated by formula as “net county costs” for health services — county expenditures for health minus revenues for health.

In 1979, the legislature took more permanent steps to relieve counties from Prop 13 revenue losses by diverting a share of the school districts’ portion of property tax revenues to local agencies, including counties, through passage of AB 8.¹⁷ To obtain AB 8 funds for health services, counties had to submit a health services plan and budget to the state DHS, meet MOE requirements, and limit spending of health dollars to public health and inpatient/outpatient medical care. In addition to medical care for indigents, AB 8-eligible activities included programs such as communicable disease control, environmental health, and medical care for people in county jails. The AB 8 allocation formula for health services was based on population (\$3 per person in the county) and a county’s prior spending on health (50 percent of net county costs in 1977–78, plus 16 percent).¹⁸ The legislature also permanently repealed the county share of cost for Medi-Cal¹⁹; counties paid any costs for health services above the AB 8 allocation with county general purpose revenues.

The year after passage of Prop 13, voters passed Proposition 4, which added Article XIII B to the state constitution, imposing a limit on the rate of growth in state and local government spending (sometimes referred to as the Gann limit).²⁰ Eventually this provision was changed to limit the initiative’s impact on state budget policy.²¹ However, Article XIII B included §6, which required the legislature to provide funds to local governments in the case of a new mandated program or higher level of service enacted after January 1975. It would take several years for the implications of the state-

mandated program language to be fully understood and implemented, but this constitutional provision set the stage for ongoing court battles regarding the state’s obligation to pay for indigent health care at the county level.

Medi-Cal Refom Round Two: The Elimination of Medically Indigent Adults from Medi-Cal

In 1982, California (and the nation) was in the midst of a recession and the state faced a \$2.9 billion budget deficit. By this time, Medi-Cal was consuming one of every eight state General Fund dollars, and the Medi-Cal budget was approaching \$5 billion. The legislature enacted a three-prong approach to reducing Medi-Cal expenditures: (1) reductions in Medi-Cal provider payments; (2) establishment of Medi-Cal hospital contracting through the California Medical Assistance Commission; and (3) transfer of responsibility for adults in the MIP program (known as Medically Indigent Adults or MIAs) from Medi-Cal to the counties.²² By excluding from Medi-Cal adults ages 21 to 64 who had been enrolled in the program under the MIP category, health care for MIAs once again became the responsibility of counties under Welfare and Institutions §17000.

As part of excluding MIAs from Medi-Cal, the legislature created the Medically Indigent Services Account (MISA) and provided \$261.5 million to counties for the first six months of the program, approximately 70 percent of the Medi-Cal costs for the MIA population. The policy rationale for a lower funding level was that counties would not be required to meet Medi-Cal standards in serving MIAs.²³ In addition, key informant interviews for this report revealed that, at the time, Los Angeles County actively supported the program transfer as a way to increase patients, and revenues, in the county hospital system and provided a loan to the state to cover transition costs. The legislation accompanying the return of the MIAs to county responsibility required counties to include indigent

care in their AB 8 plan for county health services and to spend the AB 8 allocation before accessing MISA funds. This policy was designed to ensure that counties did not use the new dollars as a way to cut county spending on health.²⁴

Two types of configurations emerged — larger counties that operated their own MIA programs and smaller counties that contracted back to the state as the legislation permitted. Larger counties administering their own MIA programs and funding had total discretion in program design, including benefits, delivery systems, and provider payment methods. As expected, many counties developed local MIA programs with benefits below Medi-Cal levels. Typical benefit cuts were elimination of elective surgeries, dental coverage, vision care, and medical transportation services.²⁵ Some counties implemented narrow definitions of medical necessity to manage program costs. Counties with their own hospitals and clinics tended to provide more generous benefits than those contracting with community providers to serve MIAs.²⁶ The resulting wide diversity among large county MIA programs continues to today.

Smaller, mostly rural counties with populations under 300,000 (in 1980) exercised their option to contract back with the state, in what became known as the County Medical Services Program (CMSP). The early CMSP was directly administered by the state and mirrored the Medi-Cal program in covered benefits and provider payments. Initially, the state was at risk for cost overruns, but beginning in 1992–93, capped its contribution to CMSP at \$20.2 million. In 1994, legislation transferred the CMSP program from the state to a CMSP Governing Board and placed participating counties at risk for any program growth exceeding the state's capped contribution. By 1999–00, the state stopped making contributions to the CMSP program. Currently, providers eligible to participate in the Medi-Cal program are eligible to participate in CMSP. CMSP provider payments are made on a fee-for-service basis to more than 2,000 participat-

ing health care professionals and more than 200 hospitals and clinics annually in 34 counties.²⁷

Following the 1982 Medi-Cal restructuring, demand for county hospital services increased. The state's uninsured population rose dramatically from 4.5 million in 1987 to 6 million by 1990.²⁸ By 1986, more than 71 percent of public hospital patients were either in Medi-Cal or uninsured, compared to only 19 percent in other hospitals. Despite the increased demand for public hospital services, declining Medi-Cal and indigent care reimbursements meant that public hospital closures continued. By the mid-1980s, half of the 64 public hospitals were closed. The remaining public hospitals experienced frequent closures to new patients, while other funding cutbacks forced suspension of capital improvements. In the wake of these public hospital closures, counties made diverse choices in how they would meet their statutory obligation to MIAs; those differences persist today. Counties with no remaining public hospital shifted from being provider counties serving a broad cross-section of the indigent population — Medi-Cal, MIA and other uninsured — to payer counties purchasing indigent health care services from other hospitals, typically private or UC hospitals.

V. New Revenues

Proposition 99 funding for county indigent care declined dramatically from nearly \$350 million in 1990 to just over \$27 million in 2003–04.

Proposition 99

In 1988, California voters approved Proposition 99, which increased taxes on tobacco products and provided a new funding source for care for the uninsured. The implementing legislation established the California Healthcare for Indigents Program (CHIP) for larger counties, and the Rural Health Services (RHS) program for smaller counties.²⁹ Proposition 99 funds are allocated through these programs for health care services for individuals who cannot afford to pay their medical care costs and who do not have other public or private coverage. As a condition of receiving Proposition 99 funds, counties have a statutory maintenance of effort (MOE) obligation and must report expenditures and patient data to the state. In addition, counties receiving the funds must provide necessary follow-up treatment indicated by a Child Health and Disability Prevention program screening.

Proposition 99 funds were also used to enhance CMSP benefits and to defray the costs of uncompensated emergency care provided by private physicians and hospitals. In the years following passage of Proposition 99, the legislature established several new state programs using those dollars. These included: the Major Risk Medical Insurance Program (MRMIP) for persons who cannot otherwise obtain private health coverage because of their health risk or health condition; the Access for Infants and Mothers (AIM) program, which provides prenatal services to low-income women; and the Breast Cancer Early Detection Program (BCEDP), which provides screening to low-income women.

However, Proposition 99 has been a continually declining revenue source as the statewide anti-tobacco media and education programs funded by the initiative were successful at decreasing tobacco use. While revenues declined, caseloads in the new Proposition 99-funded state programs grew, reducing revenues available for indigent care. As a consequence, Proposition 99 funding for county indigent care (CHIP and RHS programs) declined dramatically from nearly \$350 million in 1990 to just over \$27 million in 2003–04. No Proposition 99 funds have been allocated to CMSP since fiscal year 2001–02.

The budget, financial, and patient data submitted by counties receiving Proposition 99 CHIP and RHS funds are among the few state-level sources of data on expenditures and service levels in county indigent care programs. The Medically Indigent Care Reporting System (MICRS) is generated from these reports. Unfortunately, early in the implementation of the CHIP and RHS Proposition 99 funding programs, smaller counties opted out of the RHS program because the requirements were perceived as too costly when balanced with the relatively low level of funds received. In recent years, several of the larger counties receiving CHIP dollars have also chosen not to participate.

Medicaid Supplemental Payments

In response to the growing financial pressures on county and other hospitals providing a “disproportionate share” of services to low-income people (Medi-Cal, medically indigent and other uninsured patients), Congress in 1988 authorized supplemental payment adjustments (disproportionate share hospital payments) in the Medicare and Medicaid programs. Under California’s Medi-Cal Disproportionate Share Hospital (DSH) program, passed in 1991,³⁰ public entities — counties and the University of California — make intergovernmental transfers to the state, which, in turn, uses the funds to obtain matching federal Medicaid funds. Medi-Cal DSH funds are then distributed to public and private hospitals that serve a disproportionate share of Medi-Cal and uninsured persons, according to a complex formula established in state law; the formula is based on the type of hospital and volume of care to low-income populations. In 2003–04, 126 California hospitals received \$990 million in federal DSH funds.³¹ The amount of DSH funding each hospital can receive is limited under federal law.

California also adopted a unique program of supplemental payments in 1988–89, the Emergency Services and Supplemental Payments Fund (now referred to as the SB 1255 program), which also relies on intergovernmental transfers. In part, the SB 1255

program was enacted in response to a fiscal crisis in emergency and trauma care in Los Angeles County. Under the program, supplemental payments to hospitals are negotiated on a hospital-by-hospital basis with the California Medical Assistance Commission (CMAC), which also negotiates inpatient Medi-Cal rates. To qualify for the supplemental payments, hospitals must provide certain emergency care services. Like DSH funds, SB 1255 supplemental payments are limited under federal rules. In 2003–04, the state provided \$1.7 billion (\$850 million federal) in SB 1255 funds to 82 hospitals.³²

DSH and SB 1255 funds indirectly support county health services for indigent persons, including MIAs. In counties with public hospitals, DSH funds defray costs of uncompensated care in the county hospital system. To a large extent, these hospitals have become dependent on Medi-Cal and Medi-Cal DSH as their major revenue sources. According to the Legislative Analyst, county hospitals receive about three-quarters of their total revenues from Medi-Cal, Medi-Cal DSH, and SB 1255 supplemental payments.³³ In counties that rely on private hospitals to provide services for MIAs, private hospitals may also receive DSH or SB 1255 funds, which are designed to relieve financial pressures related to low Medi-Cal reimbursements and uncompensated care.

Over time, state and federal budgetary actions and legislative changes have significantly eroded the level of Medi-Cal DSH funds available, placing significant cost pressures on public hospitals and county-operated indigent care delivery systems. In the early 1990s, the state began using a portion of DSH funding for the overall Medi-Cal program by charging increased “administrative fees” to the public hospitals transferring funds to the state in the DSH program, sometimes referred to as the “DSH take-out.”³⁴ In 1993, Congress enacted caps on hospital DSH payments, limiting growth in federal support of the safety net in California and other states. The Balanced Budget Act of 1997 reduced DSH funding by 20 percent and fixed each state’s federal DSH

allotment through the year 2002. California subsequently acted to stabilize the Medi-Cal DSH program by reducing administrative fees charged by the state and restructuring funding formulas so that public hospitals would have greater flexibility and would receive at least 50 percent of Medi-Cal DSH funding. But when the state experienced budget deficits in 2001–02 and 2002–03, it again increased DSH administrative fees, further reducing funds for public health systems.

Several events have elevated the issues related to California's Medi-Cal supplemental payment and hospital financing programs to the forefront of state budget and legislative deliberations in 2005. In recent years, the federal government has taken steps to restrict the use of intergovernmental transfers (IGTs), and most observers believe it will continue to place limits on IGTs in the future. In addition, two waivers will expire in mid-2005: California's current Medicaid waiver for its selective hospital contracting program (including the SB 1255 supplemental payments program); and the federal Medicaid waiver for a Los Angeles County demonstration project to stabilize the county's safety net. As of this writing, the federal government, the California legislature, and key stakeholders are reviewing a Medi-Cal Redesign proposal included in the governor's budget for 2005–06, which includes changes to Medi-Cal DSH and restructuring of hospital financing under the Medi-Cal program.

VI. Litigation, Realignment, and Managed Care

In 1991–92, California faced a \$14.3 billion budget shortfall and the legislature enacted a “realignment” of health and social service programs between the state and counties.

Courts Clarify County Responsibility for MIAs

Because of ongoing reductions in state funding for indigent health, a number of counties initiated legal action in the 1980s asserting that the elimination of eligibility for MIAs under Medi-Cal was a reimbursable mandate and the state owed the counties for the costs of the program.³⁵ With the exception of San Diego, all of the counties that went to court over the MIA program eventually dropped their lawsuits in the context of the 1991 Realignment (see below). In 1997, the California Supreme Court ultimately found in the San Diego County case that the MIA transfer was a reimbursable mandate.³⁶ Subsequently, the Commission on State Mandates ruled that the state did not owe San Diego County money; however, following an appellate court decision, the Commission finally determined that the state owed San Diego \$3.4 million for its MIA program. Because the San Diego case was not a class action, it did not have direct application to other counties. Therefore, the issue of the MIA program as a reimbursable state mandate remains an open question. San Bernardino County has filed a test claim that is still pending before the Commission. The results of the test claim will have implications for other counties and could establish state liability for the MIA program going back to the 2000–01 fiscal year, based on when the test claim was filed.

Legal advocates for the poor also sued to expand and clarify the county obligation for medical care under §17000. In *Hunt v. Superior Court of Sacramento* in 1999, the California Supreme Court ruled that counties cannot limit §17000 medical care exclusively to individuals receiving General Assistance, and cannot limit the amount of medical care to \$40 per month, the medical care component of General Assistance cited in Welfare and Institutions Code §17000.5.³⁷ The court found “[the duty of counties] to provide medical care to... residents pursuant to §17000 extends beyond the class of residents financially eligible for general assistance” and “in determining eligibility for subsistence medical care pursuant to §17000, counties must consider a resident’s financial ability to pay the actual costs of obtaining such care.”

Shifting Roles for State and Counties

The federal Immigration Reform and Control Act (IRCA), passed in 1986, allowed nonresidents in the country illegally to qualify for legal residency in some instances. California received more than \$2 billion over a five-year period in federal State Legalization Impact Assistance Grants (SLIAG) to cover the costs of this population, primarily health care at the state and local level and English language classes. In 1990, the state reduced payments to counties for indigent health care by \$175 million, in part because of the federal IRCA funds counties were receiving.

Then, in 1991–92, California faced a \$14.3 billion budget shortfall and the legislature enacted a “realignment” of health and social service programs between the state and counties.³⁸ The realignment had three major components: (1) program transfers from the state to the counties; (2) changes in state/county cost-sharing ratios for certain social services and health programs; and (3) increased state sales tax and the vehicle license fees (VLF) earmarked for supporting the higher financial obligations of counties.³⁹ Affected programs included community mental health and the AB 8 public health financial support for counties. Realignment revenues were allocated by formula to three accounts: Social Services, Health Services, and Mental Health.

Health realignment funds can only be used for indigent health care or the old AB 8 public health programs (such as communicable disease control, environmental health, and medical care in county jails), consistent with a county’s AB 8 health spending plan. Counties that did not allocate AB 8 funds to a particular program prior to the realignment can no longer use health realignment funds for that program.

Under the realignment allocation system, revenues received one year become the base level of funding for the following year. Sales tax growth funds are allocated first to caseload-driven programs, such as foster care and In-Home Supportive Services (IHSS). Any remaining growth in the sales tax, and

all growth in VLF revenues, goes to health and mental health, including county medical services programs.⁴⁰ Thus, the amount of funds available for health realignment is heavily impacted by changes in VLF revenues.

Importantly, the realignment legislation eliminated county reporting requirements for the AB 8 programs. Counties are no longer required to submit local health plans and budgets to the state. This means that there is no state system to collect data from all 58 counties regarding their health care expenditures by fund source or by program area. As a result, it is not possible to fully review and understand the impact of realignment on indigent health care or public health.⁴¹

With county lawsuits regarding the MIA program unsettled at the time, the realignment legislation also included several “poison pill” provisions. One of these would have invalidated the health realignment program if the courts or the Commission on State Mandates found that the state created a reimbursable mandate with the MIA transfer. This language was intended as an incentive for counties pursuing a lawsuit to settle or drop the case. San Bernardino and Los Angeles counties did drop their lawsuits, although San Diego County pursued legal action. As a result of the San Diego outcome, the legislature in 2004 deleted the MIA mandate poison pill from the realignment law rather than risk the entire health realignment program.

Managed Care and Other Changes

California first experimented with managed care in Medi-Cal in the early 1970s and continued to administer managed care programs in a few counties through the 1980s. In 1992, facing an \$11 billion state budget gap, the legislature granted broad authority to the state DHS to significantly expand managed care for Medi-Cal patients.

Many counties and other safety-net providers were concerned that an increase in private managed care

plans in Medi-Cal could destabilize providers who relied on Medi-Cal as a major revenue source, including county indigent care delivery systems. The final DHS expansion plan included mandatory enrollment of low-income families on Medi-Cal in managed care in 13 additional counties. In 12 counties, the plan called for a mainstream plan administered by a private managed care organization and a “local initiative” developed at the county level. A Geographic Managed Care (GMC) approach with multiple competing health plans was proposed for Sacramento County.⁴³

To ensure that safety-net providers, such as public hospitals and clinics and nonprofit community clinics, would still be able to participate in Medi-Cal, local initiative plans were required to contract with clinics and public hospitals. By the end of 1997, nearly 1.5 million individuals in the Medi-Cal program were enrolled in some form of Medi-Cal managed care. By 2005, Medi-Cal managed care plans were operating in 22 counties serving 3.2 million Medi-Cal beneficiaries.⁴³

Beginning in the late 1990s, California incrementally increased eligibility and simplified enrollment in the Medi-Cal program. The state expanded eligibility for low-income pregnant women; parents with incomes below the Federal Poverty Level (FPL); and elderly, blind, or disabled persons who earn up to 133 percent of the FPL. It also provided 12 months of uninterrupted coverage for children from the date they were determined eligible. In addition, the state invested in outreach and enrollment programs to increase Medi-Cal enrollment among those eligible but not enrolled. These state policies increased the numbers of children enrolled and reduced the overall number of uninsured children.

However, the Medi-Cal expansions did not extend to most uninsured adults, and the MIAs continue to be a county responsibility under §17000. Because Medi-Cal expansions mean that most low-income pregnant women qualify for pregnancy-related services under Medi-Cal, county medically indigent

adult programs and the CMSP program exclude coverage for pregnancy services.

The State, Counties, and MIA Programs Post-Realignment

Since passage of the original realignment program, several proposals to revise or to expand realignment have been put forward in response to significant state budget shortfalls. Most recently, the 2003–04 governor’s budget proposed to realign 12 percent of state General Fund obligations, including additional health and social services programs and certain state-funded child care programs. None of the proposals to alter realignment has succeeded.

Health realignment for the first time provides counties with a dedicated and increasing revenue source for indigent care, but counties report that the growth in funding has not kept pace with the numbers of uninsured persons and the cost of indigent health care. Counties report that indigent care costs represent an increasing share of health realignment funds and county general funds. Moreover, in many counties, realignment funds in the health and mental health accounts have been transferred to the social services accounts and used to pay for the rising costs of caseload-driven social services programs, especially foster care and IHSS.

Although other revenue sources for indigent care, such as Proposition 99 and Medi-Cal DSH funds, have declined, county expenditures for indigent health care, as reported to the state through the Medically Indigent Care Reporting System (MICRS), have grown. The MICRS data is limited in scope and does not account for the wide differences in county indigent care programs, financing, and delivery systems. However, it is the only state-level data reflecting county spending on indigent care programs. In 2001–02 (the last year such data were available), 23 of the 25 counties participating in MICRS reported expenditures of \$1.5 billion total funds to serve approximately 1.4 million indigent patients. This compares to 1987–88, when 27

counties reported total expenditures of \$1.3 billion for 1.3 million patients.

Currently, counties participating in CMSP rely exclusively on realignment funds and county general funds to support the program. For the last five years, beginning in 1999–2000, the state has suspended its statutorily required \$20 million contribution to CMSP. Since then, CMSP has reduced provider payments, benefits, and eligibility; increased county contributions; and drawn down its contingency reserve.

VII. The Future of Indigent Health Care

Additional public hospital closures could occur, depending on budget choices at the federal, state, and county levels.

TODAY, RESPONSIBILITY FOR THE MIA POPULATION remains at the county level, but the money that counties receive from the state to support the programs generally is fixed or declining. Meanwhile, state budgetary actions in recent years have reduced county discretionary funding that might be used to support indigent health care. These actions include shifts in property taxes from local governments to school districts; suspension of state payments for reimbursable state mandates; and increasing county share of costs for programs such as the Early Periodic Screening, Detection and Treatment (EPSDT) mental health program for severely emotionally disturbed children.

Some budget and policy changes in the last decade have increased funding at the county level or reduced spending obligations, while others have done the opposite. The detailed and constantly changing fiscal relationship between the state and counties is beyond the scope of this paper. But it is important to recognize that state policy changes that affect county general purpose revenues may impact county health and mental health programs for indigent people.

The number of uninsured Californians remains high, despite recent gains in coverage for children and certain categories of low-income adults. This increases demand for indigent care services at the same time that counties face financial limitations on their ability to be responsive. As county-run hospitals and clinics experience fiscal problems, additional public hospital closures could occur, depending on budget choices at the federal, state, and county levels. Counties that rely on private providers, such as nonprofit hospitals and community clinics, to provide services to MIAs may find it more difficult to adequately pay for the costs of those services. The overall impact of these challenges on services for indigent adults could be substantial.

As part of the 2004–05 state budget, counties, cities, and special districts agreed to contribute \$1.3 billion in property tax revenues in 2004–05 and again in 2005–06 for a total of \$2.6 billion. In exchange, local governments received constitutional protection from future funding reductions in the form of Proposition 1A, passed by voters in November 2004. It is too early to know what

impact these changes will have on county services for MIAs. One certain result is that the state will be unlikely to impose any new mandates on counties since the compromise more fully ensures that the state would bear the costs of any new requirements.

At the same time, the future of funding for county indigent care programs continues to be the subject of court action. In January 2005, San Diego County residents filed a class-action lawsuit alleging that the county illegally denied them medical care because their monthly incomes exceed the county's eligibility level. The lawsuit seeks coverage of medical care for the plaintiffs and an order to prevent the denial of medical care to other county residents in similar circumstances.⁴⁴

VIII. Conclusion

State policymakers suffer from a lack of information about county programs.

CALIFORNIA HAS FOR DECADES MAINTAINED A BROAD statutory obligation for counties to provide medical care to indigent persons not eligible for other programs. However, the state has avoided statutory language specifying the level or type of services counties must provide. From time to time, the courts have been called on to examine the county obligation and set guidelines, but litigation continues.

The state's reliance on the broad language of §17000, enacted more than 70 years ago, was intended to ensure that counties provide a minimal level of medical care with local discretion to design delivery systems, methods, and funding levels. As a result, there is wide diversity among county medical care programs serving MIAs. However, because the programs are not state-run or directly state-funded, there is no single, statewide data source that accurately identifies county program standards, care models, and funding levels. This lack of information makes it difficult for state policymakers to monitor existing programs effectively, to assess unmet needs in communities, or to identify the potential impact of new legislative ideas or state programs.

Appendix

History of Medically Indigent Adult (MIA) Programs in California

YEAR EVENT

1901	State Pauper Act of 1901. Adds to state law a comprehensive mandate for counties to “relieve and support” all incompetent poor persons, which for the first time is interpreted to include medical care services.
1933	Section 17000 Obligation. California enacts legislation to clarify counties’ obligation to be the caretaker of last resort for indigent health care and income support.
1966	Federal Medicaid and Medicare. The federal government enacts these two major health coverage programs. California’s Medi-Cal (Medicaid) program includes a county match requirement.
1971	Medically Indigent Adults. California creates a new state-funded Medi-Cal eligibility category for adults ages 21 to 64 not linked to a federal aid program.
1978	Proposition 13. California voters pass a ballot measure to cut property taxes. Reduces the primary source of general purpose revenues for counties.
1979	State funding for county health services. AB 8 (Chapter 282 of 1979) allocates new state revenues to counties for public health programs such as public health nursing, epidemiology, health education, public health laboratories, etc. Establishes a county maintenance of effort, or minimum county spending level. The AB 8 allocation formulas and process, and the county maintenance of effort for those programs, was eventually carried into realignment in 1991. Repeals the county share of cost for Medi-Cal. AB 8 focused on public health but also allowed counties to use the funds for indigent health care services and health services in county correctional facilities.
1983	MIA “transfer.” California eliminates Medi-Cal coverage for medically indigent individuals ages 21 to 64, not otherwise categorically linked. This essentially returns responsibility to the counties under Welfare and Institutions Code § 17000. Counties receive funding equal to 70 percent of state costs for the program. Small counties are permitted to contract back with the state through the County Medical Services Program (CMSP).
1988	Proposition 99. California voters increase tobacco taxes and dedicate the revenues to tobacco prevention and health care programs. \$350 million is allocated to county medical services through the California Healthcare for Indigents Program (CHIP) for large counties, and through Rural Health Services (RHS) for smaller counties. A county maintenance of effort (MOE) is set at 1988–89 county spending levels for health services. By 2003–04, Proposition 99 funding for these programs declines to \$27 million.
1991	Realignment. Transfers responsibility for many mental health, social services, and health programs to counties; provides counties with dedicated tax revenues from the sales tax and vehicle license fees to pay for these changes.
1994	CMSP transfer. State caps its contribution to the CMSP at \$20 million and transfers program control from the state to the CMSP Governing Board. Shifts program revenues from state General Fund to Realignment, Proposition 99, county participation fees and third-party reimbursements and recoveries.
1997	San Diego v. State of California. California Supreme Court rules that the 1982 elimination of Medi-Cal eligibility for MIAs constituted a reimbursable state mandate.
1999	Hunt v. Superior Court of Sacramento. California Supreme Court rules that counties’ duty to provide medical care under §17000 extends beyond those eligible for general assistance; counties must consider a resident’s ability to pay the actual costs of obtaining subsistence care.
2004	Proposition 1A. California cities, counties, and special districts agree to a \$2.6 billion shift of local property tax revenues to the state in exchange for constitutional protections of local revenues in the future and limits on the ability of the state to impose new unfunded local mandates.

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