INDIGENT CARE PROGRAMS IN SELECTED STATES WITHOUT COPN PROGRAMS

Arizona	The **Arizona Health Care Cost Containment System** (AHCCCS) is a comprehensive, statewide managed care program which combines state and federal Medicaid dollars and local contributions from counties to single pool used to fund a range of services for groups ordinarily covered by Medicaid (families with children, the aged, blind and disabled) *and* for indigent persons. The system represents a partnership of state and public and private managed care health plans which mainstreams Medicaid recipients into private physician offices, an arrangement that opens private physician networks to Medicaid recipients. AHCCCS Health Plans are paid an upfront, or prospective, monthly capitation amounts for each member enrolled in the plan. The program operates under an 1115 Research and Demonstration waiver granted by the Department of Health and Human Services. **Eligibility** is not determined under one "roof," but by various agencies, depending on the category of recipient. For example, pregnant women, families and children generally enter AHCCCS by way of the Department of Economic Security. The blind, aged or disabled who receive Supplemental Security Income enter through the Social Security Administration. Eligibility for categories such as KidsCare, long term care and Medicare Cost Sharing programs is handled by AHCCCS itself. Each eligibility group has its own income and resource criteria. **Provision of services** may be through county facilities or through private providers; counties are required to reimburse private providers for services care provided to indigent patients, including emergency care (at Medicaid rates). Counties are also required to provide indigent patients with mental health, nursing home and adult foster care services; adult foster care patients must be provided all necessary home health and outpatient services. **Other populations** - AHCCCS also services the "medically needy" - individuals who meet the same basic criteria for eligibility as medically indigent but have slightly higher incomes, and who may be required to pay small co-pays; indigent children aged 13 or younger; public employees; employees of small businesses may enroll if their employers choose to contract with the program. While AHCCCS shifts responsibility for many indigent citizens to the state, by statute counties are required to provide medical care for the poor; counties still remain responsible for providing health care to indigent patient not enrolled in AHCCS.

California	Provision of healthcare for indigent citizens remains a county responsibility. However, California does have a "**Community Benefit" law** which requires private nonprofit acute hospitals to conduct community needs assessment every three years and to develop a community benefit plan in consultation with the community and submit the plan annual to the Office of State Health Planning and Development, which oversees the state health planning program. This law is based on the belief that "significant public benefit would be derived if private, not-for-profit hospitals reviewed and reaffirmed periodically their commitment to assist in meeting their communities health care needs by identifying and documenting benefits provided to the communities which they serve." "Community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, and may include health service rendered to vulnerable populations including charity care and the unreimbursed cost of providing services to the uninsured or underinsured, or the unreimbursed cost of services including community oriented wellness and health promotion, preventative services, outreach clinics in socioeconomically depressed areas; financial or in kind support of public health program, donations of funds, property or other resources, enhancement of access to health care or related services that contribute to a healthier community , and other service offered without regard to financial return because the meet community need in the service area of the hospital and other services including health promotion, health education, prevention or social services.

Colorado	The **Colorado Indigent Care Program** (CICP) distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding deliver discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. To qualify, applicants must have income and resources combined at or below 250% of the Federal Poverty Level (FPL), and cannot be eligible for Medicaid or CHP+. There are no age limitations for CICP eligibility. Applicants can have Medicare and any other commercial health insurance policy, but these policies must be exhausted before CICP reimburses the health care provider. Benefits vary from clinic to clinic and from hospital to hospital. By statute, CICP providers are required to prioritize care in the following order: (1) emergency care for the full year, (2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons, and (3) any other medical care. The provider network consists of 49 hospitals, 18 clinics and 51 satellite facilities. Funding is through the Health Care Services Fund, created at C.R.S. 25.5-3-112. In fiscal year 2005-06, the Colorado General Assembly appropriated $14,962,408 to the Fund. CICP is not an insurance program but rather a financial vehicle for providers to recoup their medical cost at a "discount." The program is administered by the Colorado Department of Health Care Policy and Financing.
Minnesota	**General Assistance Medical Care** §256d.01 to § 256d.54 provides payment for medical services for low income individuals who do not qualify for state medical assistance (Medicaid) provided that (1) the individual is currently receiving general assistance or (2) the person is a resident of Minnesota and (i) has gross income not in excess of 75% of the federal poverty guidelines adjusted for family size and equity in assets of less than $1000, or (ii) the person has income above 75% of the federal poverty guidelines adjusted for family size but not more than 175% of the federal poverty guidelines adjusted for family size, and not more than $10,000 in assets ($20,000 for a family of 2 or more), and has applied for in patient treatment, or (3) would be eligible for medical assistance except that the person resides in an institution for mental diseases. Services provided include inpatient and outpatient services, prescription drugs, equipment for diabetes patients, physician's services medical transportation, optometric services, chiropractic services, and a variety of mental health services. **Cost of the program** the state pays 100% of the program pursuant to 256S.03 Subd.6.

Minnesota (cont'd)	**Medical Assistance for Needy Persons** Chapter 256B authorizes the commissioner to contract with health insurers, nonprofit health service plans, HMOs and vendors of medical care and organizations participating in prepaid programs to provide medical service to medical assistance recipients and to contract with public or private entities or to operate a preferred provider program to deliver health care services to medical assistance, general assistance medical care and MinnesotaCare program recipients. The contracts are paid out of a fund established in the state treasury, which receives federal and state funds, county funds and other moneys available and paid into the state treasury for medical assistance payments and reimbursements from counties, for their share of payments. The counties actually administer medical assistance in their respective counties under the supervision of the state agency and the commissioner of human services. Eligibility is based on residency, income and assets. Covered services include: inpatient hospital services, emergency services skilled and intermediate nursing care, skilled nursing facility and hospice services, physician services, certain home health services, certain long term care services
New Mexico	27-5-2 "The individual count of this state is the responsible agency for … the hospital care or the provision of health care to indigent patients domiciled in that county for at least three months or for such period of time, not in excess of three months … and to provide a means whereby the county can discharge this responsibility through a system of payments to hospitals or health care providers for the care and treatment of, or the provision of health care services to indigent patients."
	The County Local Option Gross Receipts Tax Act and Indigent Hospital and County Healthcare Act establish guidelines for New Mexico's county governments to collect funds to provide resources for the **Indigent Care Fund**. Although County Indigent Fund participation is not mandated by the legislation, in 2005 30 of NM's 33 counties participated in the program. Counties collect funds for indigent care services through gross receipt tax, mill levy and general fund appropriations. The Indigent Hospital and County Health Care Boards, created in participating counties to administer CIF claims, have been granted latitude by the legislature to establish guidelines for CIG eligibility and to determine services that are covered under CIF.

Pennsylvania	Pennsylvania's state funded **Medical Assistance** program provides free health care coverage to Pennsylvania residents who fit into one of the eligibility groups that are covered by the MA Program and who have income, and sometimes resources that fall below the level set by the State for their category of MA eligibility. Income limits vary by and within eligibility group. Infants and pregnant women are eligible if they have incomes up to 185% of the federal poverty level ($32,653/year for a household of four); the limit is much lower for adolescents. Income and resource eligibility limits for adults vary dramatically depending on the applicable eligibility group. Income eligibility for children varies depending upon the children's' ages. Eligibility groups include (i) the categorically needy - aged, blind or disabled individuals, (ii) the medically need - aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income and resources are above the limits prescribed for the categorically needy but are within limits set under the Medicaid State Plan and (iii) recipients of general assistance - individuals who receive assistance funded solely by state funds under Article IV of the Pennsylvania Public Welfare Code. Pregnant women, children under the age of 21, families with dependent children and children who receive state and federal adoption assistance or foster care maintenance assistance payments are also eligible. Coverage varies by eligibility group, but MA generally covers hospital care, doctors' visits, nursing home care, laboratory tests and x-rays, family planning, drug and alcohol treatment, and mental health care. Most eligibility groups also cover prescription drugs. Children can receive anything that is "medically necessary," even if it is not generally available under the MA program. Persons eligible for nursing facility care who instead choose to receive home or community based services through a Medical Assistance "waiver" program can receive a wide range of services, as well.

Texas	The **Texas County Indigent Health Care Program** (CIHCP), created by the Indigent Health Care and Treatment Act, §61.001 et seq., imposes strict, accounting based rules for indigent health care on counties. Hospital districts and public hospitals are subject to similar standards. Under the CIHCP, the Texas Department of State Health Service (DSHS) establishes minimum eligibility standards an application, documentation and verification procedures that are consistent with analogous procedures utilized in TANF-Medicaid program and that the counties should use in determining CIHCP eligibility; defines basic and department-established optional health care services in accordance with the TANF-Medicaid program; establishes payment standards for basic and DSHS-established optional health care services in accordance with TANF-Medicaid program; provides technical assistance and training to counties, hospital districts and public hospitals; processes eligibility disputes between providers of health care assistance and governmental entities or hospital districts and administers the state assistance fund. Counties may qualify for state assistances funds when they exceed 8% of the county's general revenue tax levy for basic and DSHS-established optional heath care services provided to eligible county residents. IN order to receive money from the State Assistance Fund, counties are required to report their monthly indigent health care expenditures to DSHS. Hospital districts and public hospitals are required to establish an application procedure and to provide health care to eligible residents who reside in the hospital district's or public hospital's service area and meet the minimum resource and income limits. Counties that are not fully served by a public facility, i.e. a hospital district or a public hospital, are responsible for administering an indigent health care program for eligible residents of all or any portion of the county not served by a public facility